FRESENIUS MEDICAL CARE

April 3, 2018

Senator David Wilson, Chairman
Senate Health & Social Services Committee
State Capital Building
Juneau, Alaska

Subject: HB123, relating to disclosure of health care costs

Dear Senator Wilson:

Thank you for this opportunity to offer comments on House Bill 123, which relates to the disclosure of health care costs.

Fresenius Medical Care operates 9 outpatient dialysis facilities in Alaska, serving approximately 300 dialysis patients with hemodialysis and home dialysis training in Anchorage, Fairbanks, Juneau, Soldotna, and Wasilla.

While we fully understand and appreciate HB123's goal of providing health care price information for consumers, there are some circumstances related to dialysis services that warrant your consideration.

Of our 300 Alaska dialysis patients, only 11% have commercial coverage as their primary insurance. All others are Medicare, Medicaid, or VA primary. At any given time, a good portion of our commercial patients are in the process of waiting to become Medicare eligible. Most patients under age 65 move to Medicare after 90 days of starting dialysis because that's when they are eligible for Medicare due to End Stage Renal Disease, unless they have an Employer Group Health Plan. An EGHP is primary for 30 months and then Medicare becomes primary after that (Medicare Secondary Payer Rule).

Unless there's some reason that prohibits someone from qualifying for Medicare (i.e., not enough work quarters) or Medicaid, commercial insurers have a relatively short amount of time to pay for dialysis. Costs may, therefore, appear high if there is no opportunity to explain that commercial insurers will only temporarily pay primary. Once coverage switches to secondary, thereafter over the long term patients pay the 20% Medicare doesn't cover.

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Posting price information for dialysis services provides little, if any, useful or relevant information to the patient. Further, posting price information to a web site prohibits an opportunity for dialogue or explanation of the likelihood that almost all dialysis patients will eventually convert to secondary coverage within a relatively short period of time.

Given that such a relatively small percentage of dialysis patients have commercial payer coverage, we believe the best outcome would be to be exempted from the bill.

To the extent we will be required to disclose price information, we are concerned about posting to a web site that offers minimal opportunity for dialogue with the patient. We would ask for consideration for removal from internet requirements in order to allow for interaction and communication with the patient in order that they can understand and consider the likely payment methodology before making decisions about their treatment.

Thank you for considering this request.

Sincerely

Wendy Funk Schrag

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March 30, 2017

The Honorable Ivy Spohnholz
Alaska House of Representatives
State Capitol, Room 421
Juneau, Alaska 99801

RE: SB 123 -- Disclosure of Health Care Costs

Dear Representative Spohnholz:

The Alaska State Medical Association ("ASMA") is strongly in favor of increased transparency in the provision of healthcare services. We believe that improved transparency is one of a large number of changes to the healthcare system that are needed in order to improve the "value" of care the patients receive. We feel strongly that transparency should extend not only to providers and hospitals but also to insurance companies, the pharmaceutical industry and the medical device industry.

We know that it may take several steps to "get this right" but we would like to be as helpful as possible during this legislature in developing Alaska's first version of transparency legislation. Unfortunately, we think that the Anchorage ordinance and House Bill 123, although well intended, actually does very little to provide patients with actionable meaningful information. In the case of the Anchorage ordinance at a high cost.

For almost all patients, knowing the "rack rate" or "cash rate" for medical care would be very misleading as to what the actual charge would be or the patients actual cost. The foundation of the bill's concept is to create transparency and empower the patient/consumer to make informed decisions. However, the "rack rate" will almost never provide price transparency and will almost always provide misleading information to the consumer. While one provider could have a significantly lower "rack rate" than another provider, the higher "rack rate" might be significantly cheaper for a patient than the "lower rack rate" for that insured due to differing contractual payment rates. For example, one provider may charge $500 dollars for an office visit and another provider may charge $400. The seemingly more expensive provider may have a contract with Premera in which the negotiated rate is only $350 while the seemingly "cheaper provider may have a contract with Premera in which the negotiated rate is actually $380. Another concern is the unintended consequence of impacting patient choice due to the fear of high "rack rates" when a review of benefits may show there is no charge (some preventive care) or very low copays.

You asked that if ASMA believed HB 123 was insufficient or ineffective we provide suggestions on how to improve it. This is a fair request. We suggest the following structure would have a good chance of meeting the transparency goals in HB 123 by providing patients with good faith estimates that would be more closely aligned to a patients likely costs, both for the procedure and patient out of pocket. We suggest the following three steps:

1) All invoices, payment requests, hospital bills and explanation of benefits statements must be required to have CPT codes, HCPCS codes or equivalent codes on them. Currently they are often vague and will list "line items" like "doctor visit" and "knee surgery" which makes comparison very difficult. All health care providers (including services such as durable medical equipment, physical therapy, chiropractic care etc.) should be required to do this, as should all insurance companies. While this step is "post" receiving care it creates a culture of using CPT codes in documents that will over time increase the ability to pre-inform patients of costs and provide better actionable data for future decisions. Without specified codes, patients may compare "different levels" of office visits inappropriately instead of comparing a 99214 to a 99214 for example.

2) A Good Faith Estimate form should be created by the State with a requirement that patients have the right to review a Good Faith Estimate with an office or hospital before receiving care. The Good Faith Estimate would list the expected CPT or billing codes and a good faith estimate of likely charges. While these might be the "rack rates," providers will be able to explain what those mean and what they don't mean. We believe that most providers would be able to go deeper than a "rack rate" and provide patient specific estimates based on their insurance coverage. It would need to be clear that this is not a "promise" but a good faith attempt to provide fair pricing information to the patient. There would need to be an explanation that it is impossible to know everything in advance (if a patient is expecting to have a sleep study but ends up having chest pain and an urgent cardiac work up that is completely unexpected, we would not want this to be "binding" for all services or charges.)

3) Insurance companies would be required to work from the Good Faith Estimate form and give the expected rates of actual payment experience based on the contract with that provider that the insurance company has negotiated along with information about how much deductible is met and expected copay. That information should be required to be made available to the patient and the medical practice/hospital so that false or misinformation can be clarified. A timeframe that is reasonable should be established for this, maybe three days.

With the combination of a Good Faith Estimate and disclosure of CPT or billing codes on a standardized form the patient would have the ability to either rely on the Good Faith Estimate comparison or seek actual information from their insurance company.

An additional thought would be to allow a provider to either elect to post the information as your bill currently provides or instead elect to post information that the provider will provide Good Faith Estimates on charges and how to obtain them. This would provide a competitive advantage to providers who engage patients and try to provide them with more accurate information.

We are happy to discuss our ideas by phone or in person, but strongly feel that efforts to move toward transparency need to be ones that provide meaningful benefit to consumers while not creating false competition in the community based on anticipated costs that don't reflect the true amount a patient would end up paying.

Sincerely,

Graham A. Glass, M.D. President
Alaska State Medical Association