SB

222

SENATOR FRED DYSON

SPONSOR STATEMENT

SB 222—*"An Act requiring certain hospitals to make certain disclosures on patient billings.*

Hospital costs to patients have undoubtedly climbed in recent years. These rising costs can be attributed to the interaction of many factors including: increasing costs for new drugs, technologies, and procedures; deregulation of hospital charges and removing previous limits; cutbacks in reimbursements from government programs, health maintenance organizations, and insurance policies; mandates upon hospital emergency rooms to treat all patients who enter; and the fact that indigent, uninsured patients frequently default on their bills.

Private insurers and government agencies can leverage large groups of patients, which enables these payers to negotiate discounts with the hospitals for the services that they fund. Generally, the larger the group, the larger the discount. Because hospitals strive to cover their expenses, charges are increased for identical services for those people too poor to afford insurance or those who pay their own bills. The patients who suffer the most are not always the poorest. The very poor can receive Medicaid, and many middle-class families have health insurance coverage that pays the bulk of their bills. It is working class families, with some assets, but no insurance coverage, who pay the most for services in our current system.

Under federal laws for Medicaid and Medicare, hospitals are required to charge the same amounts for identical services, regardless of who is paying the bill. However, hospitals may agree to accept lower payments against those charges. In other words, even though hospitals [are required to] charge everyone the same amount, everyone does not pay the same amount.

SB 222 focuses on the issues of pricing transparency and equity. This bill requires certain hospitals to disclose, on the bills that they submit to patients, information including:

- The discount rates that the hospital charges for identical services for patients in the other payer groups;
- The cost subsidy for indigent individuals that makes up a portion of the patient's bill—the cost to charge ratio;

During Session (January-May): Alaska State Capitol • Juneau, Alaska 99801 • (800) 342-2199 • (907) 465-2199 • (907) 465-4587 FAX
During Interim (June-December): 10928 Eagle River Road • Eagle River, Alaska 99577 • (907) 694-6683 • (907) 694-1015 FAX
Senator.Fred.Dyson@Legis.state.ak.us • www.akrepublicans.org

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INSIDE

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CONTENT

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American Legislative Exchange Council
1129 20th Street N.W., Suite 500
Washington D.C. 20036
Phone (202) 466-3800
Fax (202) 466-3801
www.ALEC.org

Adding Gouging to Injury

Hospital Pricing for the Uninsured

By James Frogue

Go to any shopping mall, super market, restaurant, or gas station and the prices of various products are clearly displayed, sometimes obnoxiously so. If you or a loved one are without health insurance and must go to an emergency room, good luck finding out prices of the various services and procedures ahead of time. That is about to change whether hospitals like it or not.

There is a growing awareness that pricing transparency is sorely needed in our health care system. Any auto mechanic can tell you the price of a manifold replacement on your '98 Explorer in about 30 seconds. Tell an ER doctor that you are uninsured then ask how much for an appendectomy and three days of in-patient care and you'll get the dull stare of a dairy cow. For doctors and hospitals to claim it is somehow different for them ignores the fact that the number of parts and procedures that a mechanic and doctor must know both run into the many thousands. Yet somehow you can get reasonably accurate estimates out of garages whether it is an emergency or not, or whether you have insurance or not.

The result for uninsured patients is that they get charged far more for services than do any government program or private insurer. A recent extreme example out of Florida found a paper surgical gown that goes for 36 cents wholesale, having a "list price" to consumers of $79. That is a mark up of over 20,000 percent! *USA Today* ran an article in February that chronicled the efforts of an uninsured family struggling to pay a $116,000 hospital bill. Had the family been covered, the bill to an insurer could have been as low as $25,000.

Patients are about to start asking hospitals much harder questions regarding prices. On January 1st of this year, federally qualified Health Savings Accounts (HSAs) became available to all Americans. HSAs allow individuals to have a high deductible insurance policy for unforeseen, catastrophic events and a smaller account underneath that deductible to cover lower cost treatments. As Americans move to HSAs in droves, they will demand pricing transparency from physicians, clinics, and hospitals. After all, those patients will for the first time care about costs because they can count the dollars leaving their HSA. This kind of smart shopping will be very much a good thing for patients and the health care system in general, though it will make Enron-style accounting more difficult down at Springfield General.

Some state legislators have already run out of patience with these opaque pricing practices and their effect on uninsured constituents. This year State Senator Tom Dempster of South Dakota spearheaded an effort in his state legislature to require hospitals to post the prices of their 25 most commonly performed procedures and 25 highest

Continued on Page 4

James Frogue is the Director of the Health & Human Services Task Force for the American Legislative Exchange Council.

Continued from Page 1

revenue generators. It doesn't say anything about what those prices must be or how often they can change. A chalkboard and 15 minutes of a clerk's time would have been sufficient to meet this requirement. His bill cleared the Senate and a key House committee. Yet by the time that bill made it to the House, it faced every hired gun in Pierre and met the same fate as George Custer. But state legislators elsewhere have taken lessons from the Mount Rushmore State and this issue will now spread like wildfire. Legislators in Florida, Wisconsin, and elsewhere are considering similar legislation. Custer may have lost the battle, but the U.S. Army won the war.

In defense of hospitals, they are under constant financial assault by federal and state politicians whose only idea for saving money in health care is to cut Medicare and Medicaid reimbursement rates to providers. Often having little choice but to see these people, hospitals must make up the difference with their private pay patients. Insurance companies are wise in the ways of the pricing game so they are able to negotiate favorable rates. Uninsured patients cannot and therefore suffer the highest bills. Thus the least able to pay are the most charged.

The Ralph Naders of the world would suggest price controls on what hospitals can charge the uninsured. This vintage 1965 solution overlooks the simple fact that it is government price controls in Medicare and Medicaid that are causing the current problems leading to overcharging of the uninsured in the first place. Short of worthy, but expensive, tax credit proposals to help the uninsured afford private coverage of their choice, shining a light on hospital pricing practices would be a big step toward creating a world of informed consumers and therefore a free market.

Hospitals may, for now, be able to resist pressure from lawmakers to post their prices. But hospitals will not be able to resist questions from millions of consumers with HSAs in the near future. Hospitals would be wise to move forward with pricing transparency. Doing so would not only keep politicians off their backs, it would be smart business in the long run while simultaneously helping America's 43 million uninsured.

Continued from Page 3

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the American economy. ALEC's fir
the issue will be on April 30th with a
a luncheon session on May 1st at th
Summit in Austin, Texas.

THE WALL STREET JOURNAL. ONLINE

March 17, 2003

PAGE ONE

One Critical Appendectomy Later, Young Woman Has a $19,000 Debt

Ms. Nix Confronts Facts of Health-Care: The Uninsured Are Billed Sharply More

By LUCETTE LAGNADO
Staff Reporter of THE WALL STREET JOURNAL

INSURING YOUR HEALTH

- Greater Savings, More Risk For People Who Self-Insure[2] 03/12/03
- Some Policies Quit Paying for Key Parts of Treatment[3] 03/12/03
- White House Proposes Giving States Power to Shape Health-Care Plans[4] 02/01/03
- For more health coverage, visit the Online Journal's **Health Industry Edition** at wsj.com/health[5] and receive daily health e-mails[6].

NEW YORK -- Dreams of a bright career in a big city lured Rebekah Nix here from the western plains of Texas two years ago. An appendectomy sent her home.

But not because she was ill. Ms. Nix, 25 years old, was fleeing the nearly $19,200 in medical bills that had piled up on her bedroom dresser. The college graduate and former magazine fact-checker couldn't fathom how two days in a hospital could cost so much, until she learned that people like her -- who don't have health insurance -- often are expected to pay far more for their medical care than large insurers, health-maintenance organizations or even the U.S. government.

The hospital where Ms. Nix was treated, New York Methodist in Brooklyn, typically bills HMOs about $2,500 for an appendectomy with a two-day stay, compared with the $14,000 -- plus doctors' fees -- that Ms. Nix was billed. The hospital gets paid about $5,000 from Medicaid, the state and federal health program for the poor, and about $7,800 from Medicare, the federal program for the elderly, for the same procedure.

"Why does a single person get stuck with the whole bill?" Ms. Nix asks. "An uninsured person would have a lot less money than those government agencies or insurance companies."

Rebekah Nix

Ms. Nix stumbled onto a troubling fact of health-care economics: Most major U.S. hospitals are required to set official "charges" for their services, but then agree to discount or even ignore those charges when getting paid by big institutions such as insurance companies or the government. As a result, almost no one but uninsured individuals ever faces the official charges. In some ways, hospital charges are like automobile "list prices" or hotel "rack rates" -- posted prices that everybody knows nobody pays. But in the case of hospitals, the pricing disparity isn't publicly known and falls most heavily on the vulnerable. America's 41 million people without health insurance tend to be young, working-class and unaware that they are being billed more than everyone else for the same services.

At the same time, charges at virtually all hospitals have soared in recent

years. That's partly due to the rising costs of new procedures and drugs. Also, deregulation of the hospital industry removed limits on charges in almost all states. But some hospitals say they are raising charges to offset what they view as overly harsh reductions in their reimbursements by HMOs, insurers and the government. That would mean hospitals are effectively subsidizing their lower income from patients who are insured or have a government safety-net by boosting fees paid by the uninsured.

"It is a reflection of the insanity of the system," says Bruce Vladeck, a hospital-policy expert who ran Medicare in the 1990s. "The most vulnerable members of society" are being asked to "pay cash at list."

BEHIND THE BILL

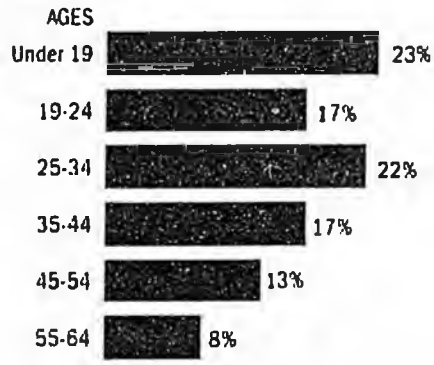
See a list of charges[0] and discounts in hospitals across the country for a relatively common procedure.

In many areas, hospitals have cranked up their charges far beyond the cost of providing treatment. Before deregulation in 1997, hospital charges in New York state couldn't be more than 30% above costs. They now are an average of 87% above costs, says the Greater New York Hospital Association, an industry trade group, citing federal data. In California, charges have ballooned to 178% above costs. By contrast, in Maryland, where hospital charges are still strictly regulated, charges average only 28% above costs, says Hal Cohen, a Maryland health consultant.

At many hospitals, the practice of cutting prices for big insurers, HMOs and the government has become so routine that the discount is calculated automatically and appears on bills alongside the original charge. The amount of the discount usually depends on how aggressively a particular insurer bargained with the hospital, or on terms struck with a government program, or how much other hospitals in the area are discounting. But uninsured patients aren't told that big institutions get these reduced rates. Some hospitals then retain collection agencies to pursue the uninsured with hard-nosed tactics such as suing, garnisheeing wages and slapping liens on homes.

YOUNG AND EXPOSED

U.S. uninsured population by age in 2001



Total Uninsured: 41 million

Note The number of uninsured older than 65 is 0 8% because they are covered by Medicare
Source: Kaiser Commission on Medicaid and the Uninsured/Urban Institute analysis

"Hospitals have a choice as to who will bear the costs," says Elizabeth Warren, a Harvard Law School professor who is studying the effects of health-care costs on the uninsured. "There is someone to negotiate on behalf of the insurance companies. There is someone to negotiate on behalf of the state ... . But there is no one to negotiate on behalf of people without insurance."

Hospitals say they have no choice but to give steep discounts to powerful payers, even if that means uninsured patients end up being faced with higher bills. Mark Mundy, president and chief executive of New York Methodist, says his private, not-for-profit hospital looks to competitors in setting its charges, and must offer discounts to HMOs and insurers or they won't do business with it. As for the government, it pays whatever it wants. "Pricing makes no sense, we all know that," Mr. Mundy says.

Hospitals also point out that most uninsured patients don't pay their bills -- the rate of default varies across the country -- yet hospitals are required by law to treat all emergencies. "Anybody that shows up in my ER, the first question isn't, 'Can they pay?' The question is, 'What are we going to do,' " to care for them? Mr. Mundy says. "If I had 5,000 Ms. Nixes, how do I handle them and keep this place alive?" Mr. Mundy says many

uninsured patients, especially those who aren't indigent, could afford insurance and should bear at least some responsibility for their care. He adds that New York Methodist, unlike many hospitals, doesn't charge interest on unpaid bills.

Advocates for the uninsured say poor people without insurance should be charged the same, low rates that Medicaid pays. Instead, they are asked to pay "what the Emir of Kuwait pays," says Elisabeth Benjamin, a health attorney with the Legal Aid Society in New York. Royalty and other wealthy foreigners flock to U.S. hospitals, where they're among the few uninsured patients who can afford to pay full freight.

Ms. Nix's billing problems started on a Saturday afternoon last April when she arrived in agony at New York Methodist. The previous night, she had felt stabbing pains in her abdomen while celebrating her 25th birthday with friends at a Manhattan bar. She had left early, staggered home to Brooklyn, and went to bed figuring she had food poisoning or the flu. When she awoke to the same unrelenting pain, her boyfriend's mother, a registered nurse, insisted she go to the nearest hospital. As she sat in a hard metal chair in the emergency room, she began to worry: How much is this going to cost?

Ms. Nix had arrived in New York a little less than two years earlier, fresh from graduating Phi Beta Kappa from Southwestern University in Georgetown, Texas. Growing up in Midland, Texas, she saw her hometown as a "desolate wasteland" where social gatherings often revolved around high-school football. Her ticket out was a summer internship at Ms. Magazine in Manhattan, which she loved. "This is the greatest city to be young in," she says. "I had no intention of ever leaving."

Joe Del Tufo/FilmMagic

But the internship paid just $150 a month. Ms. Nix helped support herself by working as a waitress while sharing a basement apartment that cost her $350 a month in rent. The magazine soon hired Ms. Nix as a full-time fact-checker with an annual salary of $30,000 and health benefits. But it was struggling financially, and Ms. Nix was laid off after the Sept. 11 terrorist attacks. The magazine, as required by law, offered to maintain her health insurance if she paid $330 a month, but Ms. Nix demurred. She figured she couldn't afford it on unemployment payments of $1,122 a month, and thought she could land another job with benefits. Besides, she thought, she was young and had always been healthy.

In the months before her illness, she tried offering her fact-checking services as a free-lancer, but jobs were sporadic. She was determined to be independent, so she didn't want to tell her divorced parents that she'd lost health coverage. Her mother, who runs a small medical-supply business she founded near Midland, might have been able to help. Her father, an independent oil consultant, struggles financially. By going without coverage, Ms. Nix became one of the estimated 39% of uninsured Americans who are between the ages of 19 and 34, according to the Kaiser Commission on Medicaid and the Uninsured in Washington.

In the emergency room at New York Methodist, someone asked her to collect a urine sample in a paper cup. She kept it at her side for six hours, until at last she was admitted to the clinical area of

the emergency room and asked to wait on a gurney. Ms. Nix remembers telling nurses and doctors that she had no money and no insurance. No one seemed to mind, she says. Still, she'd heard horror stories about how costly a hospital could be and decided to try to leave as soon as possible.

When she woke up on Sunday morning, she was still on the emergency-room gurney, and the pain seemed to have subsided. "Maybe I am going to go home," she told a doctor. "I don't have health insurance." According to Ms. Nix, the doctor responded: "It is $1,000 to come to the ER, and it is another $1,000 to come in again." Ms. Nix resigned herself to staying. But while undergoing two CT-scans, she recalls telling doctors, "I don't want any extras."

Tests confirmed she had appendicitis. Her surgeon, Piotr Gorecki, removed her appendix using laparoscopy, a method that requires a shorter hospital stay than traditional invasive surgery. The one-hour surgery went smoothly. Ms. Nix was recovering in her room when an attending doctor ordered that she be given a nicotine patch. She regularly used one to control a smoking habit, but she balked at it now, worried about the cost. The doctor insisted, she says.

Ms. Nix left the hospital on Monday afternoon, 42 hours after being admitted. She had a prescription for painkillers but decided not to fill it because of the expense. She also decided to skip a follow-up visit that Dr. Gorecki had recommended. Two weeks later, she received a letter from the hospital offering advice on how she could apply for Medicaid. The letter also gave the first hint as to how much she would be billed: "Note: hospital bill is $12,973."

In mid-June, she learned that Medicaid had turned her down because her income was too high. New York's Medicaid rules say a single person's income can't exceed $352 a month, unless she's certified as disabled. The hospital urged Ms. Nix to appeal at a hearing before a state administrative-law judge, and she arranged to do so.

In July, Ms. Nix received her hospital bill. It showed charges for two days at $1,550 a day, even though she spent the first night on the emergency-room gurney. It also listed operating-room charges of $5,340, a charge of $540 for the recovery room and a charge of $850 for the emergency room. Every test administered in the emergency room was charged separately. Her two CT-scans together came in at $2,120. One charge, which showed up in a more-detailed bill, brought a wan smile to her face: $8 for the nicotine patch. Lyn Hill, a spokeswoman for New York Methodist, says Ms. Nix was admitted at 10 p.m. Saturday and remained through Monday, so it was appropriate to charge her for two nights, regardless of where she slept.

The total: $13,110. Soon after, she received $5,000 in separate bills from Dr. Gorecki, an anesthesiologist and other doctors who had seen her at Methodist. Much like hospitals, some doctors also routinely accept lower payments from insurers, HMOs and government programs. Dr. Gorecki, whose charge to Ms. Nix was $2,500, says Medicare typically pays him only $589 for a laparoscopic appendectomy, and Medicaid usually pays an even skimpier $160. The New York Health Plan Association, an HMO trade group in Albany, N.Y., says Brooklyn surgeons get an average of $600 for a laparoscopic appendectomy.

Ms. Nix's bank account held less than $2,000. She tossed some of the bills on her dresser, unopened, and tried not to think about the debt. But often she could think of nothing else. "I knew that I was going to be in major trouble financially," she says.

Her last hope was the Medicaid hearing, which was held on a sweltering July morning at the city's Medicaid headquarters. The building was jammed with applicants standing in lines and sitting in

rows of plastic chairs, waiting to see case workers. Judge Michael Vass sat at a desk facing Ms. Nix. She recalls his telling her: Your case "is bad, but there are people who come in here and they have cancer and they make too much for Medicaid. Unless you are over 65 or under 18 or deaf or blind, you are not going to get Medicaid." Ms. Nix burst into tears.

She wasn't sure what to do. Her parents offered conflicting advice. Her mother, whose work has familiarized her with the medical system, told Ms. Nix to get tough with the hospital and negotiate a deal to pay a few dollars a month. Her father told her she should repay the debt she'd incurred, whatever the hardship. Without Methodist's care, he reminded her, she could have died.

In late August, a new hospital bill arrived, listing the total amount due as $14,182. The hospital had added an additional charge of $1,072 earmarked for the Bad Debt and Charity Care Pool, a state fund that compensates hospitals for caring for the uninsured. Ms. Nix was stunned by the irony. "Tack on another grand I can't pay, but use it to help someone else!" she says.

The inequity in health-care pricing is rooted in a policy that was designed to prevent it. Rules dating back to the establishment of Medicare in the 1960s require hospitals participating in the program to set uniform charges for all procedures. The idea was to prevent hospitals from charging some classes of patients, such as Medicare beneficiaries, more than others. Hospitals were free to set charges -- typically kept on voluminous lists called charge masters -- as they wished, depending on costs, local competition and state regulatory limits.

In the early years of the program, charges roughly correlated to hospitals' costs plus a modest profit, and reimbursements closely tracked charges. Then, in the mid-1980s, Medicare started pegging most payments to standardized diagnostic codes rather than to hospitals' charges. As HMOs became more powerful in the late 1980s and early '90s, they negotiated their own rates with hospitals.

Ms. Nix contacted the hospital and the doctors who had worked on her, seeking a break. Dr. Gorecki, the surgeon, immediately slashed his fee to $1,000 from $2,500 -- a break he often gives to the uninsured. Ms. Nix says she has sent him two checks for $20 each. The hospital was somewhat less obliging. It offered to reduce her bill by 20%. Ms. Nix says the hospital demanded that she agree to pay within a month or two, but Ms. Hill, the New York Methodist spokeswoman, says the hospital gave Ms. Nix a full year to pay. Under those terms, she would have faced monthly payments greater than $900 a month.

Ms. Hill says three or four uninsured inpatients a month, out of an average of about 90 uninsured inpatients treated, call with concerns about their bills, and they are routinely offered a 20% discount off charges before the bill is assigned to a collection agency. Even so, Ms. Hill says, uninsured patients "almost never pay." New York Methodist says that it racked up $50 million last year in "bad debt and charity care," or about 14% of its annual budget.

However, those figures are based on the hospital's charges, not its costs. Also, the hospital is able to mitigate some of these losses by tapping into the New York Bad Debt and Charity Care pool. In 2001, the latest year for which figures are available, Methodist collected $13 million to $14 million from the pool. A state health-department spokesman says the pool on average reimburses hospitals for their costs at about 50 cents to 70 cents on the dollar.

On Oct. 21, Ms. Nix sent a letter to the hospital. "I understand that I am indebted to Methodist hospital," she wrote. "The staff was so kind to me during my stay." But, noting that her bills for

the surgery totaled nearly $19,200, she wrote: "This is more money than I will make this year, almost twice as much." She added: "I do not wish to pay nothing for the life-saving services I received," but she said she couldn't pay what Methodist wanted. She had consulted bankruptcy lawyers and was considering returning to Texas.

The hospital didn't respond to the letter. Ms. Nix soon started telling shocked friends that she was leaving. On Nov. 5, she stuffed everything she could into two suitcases and flew home on a ticket her mom had given her.

After The Wall Street Journal contacted New York Methodist about Ms. Nix, the hospital told her it would reduce her bill to $5,000 -- essentially what Medicaid would have paid, says Methodist's Ms. Hill. The hospital also said it would give Ms. Nix one year to pay, provided she pay $3,000 up front, which she has yet to do. She says she hopes to start paying the hospital back within a year.

In Midland, she has taken over her younger brothers' old bedroom. Life is slower, and she has gone to some high-school football games. "I miss the glamour of the city," she says. For the past few months, she has been working part-time at her mother's medical-supply firm, where she earns $7 an hour for filing and filling out forms. She also has been doing unpaid research for her father. Her mother's company couldn't offer her health benefits because they were too expensive to provide. Two weeks ago, Ms. Nix finally purchased health insurance.

Write to Lucette Lagnado at lucette.lagnado@wsj.com[1]

Behind the Bill: Who Pays What

Hospitals are required to list official charges for all procedures. But big players such as HMOs, insurance companies and the government routinely negotiate or demand big discounts. Uninsured patients are almost always faced with full charges. Below, a sampling of charges and discounts for a relatively common procedure: a diagnostic bilateral mammogram.

Hospital (Location)	Official charge	Medicaid	Medicare	HMOs, Health plans	Policy on Uninsured
UCLA Medical Center (Los Angeles)	$460	$127	$90	Up to $242	Gives discounts based on individual's ability to pay, says CFO Sergio Melgar
Oregon Health & Science University (Portland)	$240	$65	$59	Average $128	Works with uninsured patients to help them find financial aid; offers sliding scales, payment plans
Jamaica Hospital (Queens, N.Y.)	$351	$50	$96	$40 to $78	Has sliding fee scales for uninsured, says CEO David Rosen
Johns Hopkins Hospital & Health System (Baltimore)	$261	$156	$173	$186	State regulation of charges reduces disparity between bills to insured and uninsured
Grinnell Regional Medical Center (Grinnell, Iowa)	$285	$73	$79	$119 to $190	Works with uninsured to set a payment schedule

Note: Charge includes hospital and physician fees.
Source: the hospitals

Back to top[6]

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Updated March 17, 2003

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CS FOR SENATE BILL NO. 222( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-THIRD LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATOR DYSON

A BILL

FOR AN ACT ENTITLED

"An Act relating to hospital patient billings."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 18.20 is amended by adding a new section to read:

Sec. 18.20.078. Patient billing requirements. A hospital licensed under AS 18.20.010 - 18.20.130 shall comply with the patient billing requirements of AS 45.45.920 if AS 45.45.920 applies to the hospital.

*** Sec. 2.** AS 45.45 is amended by adding a new section to read:

Sec. 45.45.920. Patient billings. (a) A covered hospital shall disclose on each patient billing

(1) the price that the covered hospital charges other patients who pay negotiated rates for the same medical service item; and

(2) the cost subsidy for indigent individuals that is included in the price billed to the patient.

(b) When billing a patient, a covered hospital shall provide to a copaying patient the same negotiated rate that the hospital provides to the patient's insurer. In

this subsection, "co-paying patient" means a patient who has a medical insurance policy with an insurer and is responsible under the policy for paying part of the hospital's patient billing for medical service items provided to the patient.

(c) In this section,

(1) "cost subsidy for indigent individuals" means the cost that is included in the charge for medical service items billed by a hospital to compensate the hospital for the uncollected costs that the hospital incurs to provide medical service items to indigent individuals;

(2) "covered hospital" means a hospital that receives government money for the purchase, construction, repair, equipping, or operation of the hospital;

(3) "government money" means money from a state or municipal governmental unit or the federal government, and includes money received by a hospital under AS 18.25 or AS 18.26;

(4) "hospital" means a person licensed as a hospital under AS 18.20.010 - 18.20.130;

(5) "medical service item" includes a hospital room, medication, and medical supplies;

(6) "negotiated rate" means a rate negotiated for a category of patients by another person, including an insurer, but does not include a rate negotiated by a patient or the patient's relatives directly with the hospital for the patient's own medical service items;

(7) "patient billing" means a billing for a patient that is provided to a patient for a medical service item.