HB

123

<TARGET><BILL>HB 123</BILL><SUBJECT>HB 123</SUBJECT><COMM>HHSS30</COMM></TARGET>

Representative Ivy Spohnholz

House Health & Social Services Committee Chair

Serving House District 16: College Gate, Russian Jack, Nunaka Valley, & Reflection Lake
Committee Member: Education, Energy, Military & Veterans Affairs, Legislative Budget & Audit

Sponsor Statement
House Bill 123

"An Act relating to disclosure of health care services and price information; and providing for an effective date."

HB 123 empowers consumers to make informed decisions about their health care options by ensuring accessible information on medical pricing. The bill will require health care providers to publish health care price information in public spaces and on their websites and to submit that price information to the Department of Health and Social Services. Individual providers must disclose the total undiscounted costs of their 25 most commonly provided health care services and procedures. Larger medical facilities would provide the same price information for their 50 most common health care services and procedures.

Alaska has the second most expensive health care costs per person in the nation as a result of a small insurance market with limited provider competition. Health care spending in Alaska increases faster than the rate of inflation despite the fact that Alaska's use of health care services is lower than the nationwide average.[1] Because of the murkiness around health care prices, consumers have little power to influence the cost of desperately needed medical services.

Medical price transparency across the nation could save the U.S. $36 billion in health care spending.[2] More than 30 states are pursuing legislation to increase price transparency across the nation; however, Alaska currently has no price transparency law in place. Price transparency can allow consumers to take financial control of their health care and exercise more choice in their providers. Transparency can also begin the public dialogue between stakeholders in the health care industry regarding the variation of health care costs within Alaska.

HB 123 provides a simple approach to comprehensive, consumer-friendly health care price information for consumers. It may also help reduce the price of health care spending and increase the accessibility to quality health care, while being unburdensome to health care providers and facilities. Empowering consumers with price information allows patients to compare providers and "shop" for high-value, cost-effective care. While health care prices are negotiable, health care is not. Alaskans deserve to know what health care services and procedures will cost before they step into the doctor's office.

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[1] 2011 (State of Alaska Health Care Commission 2011 Annual Report)
[2] 2012 (Truven Health Analytics)

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Sectional Analysis

House Bill 123

"An Act relating to disclosure of health care services and price information; and providing for an effective date."

Section 1

AS 18.15.360(a) authorizes the Department of Health and Social Services to collect, analyze, and maintain databases of information related to health care services and price information collected under AS 18.23.400.

Section 2

AS 18.23.400 is a new section that mandates the disclosure and reporting of health care services and price information.

Subsection (a) (p. 2, lines 7-11) states that health care providers will compile a list of the 25 most commonly performed health care services once a year by January 31st.

Subsection (b) (p. 2, lines 12-16) states that health care facilities will compile a list of the 50 most commonly performed health care services once a year by January 31st.

Subsection (c) (p. 2, lines 17-25) states that both the health care provider and health care facility will submit the list to the Department of Health and Social Services, and publish the list in a public area and on their website, if they have one.

Subsection (d) (p. 2, lines 26-30) states that the Department of Health and Social Services will then gather the compiled lists from the health care providers and facilities and post the information on the Department of Health and Social Services website. The information will include the name and location of the health care providers and facilities. This will be updated annually into the department's database.

Subsection (e) (p. 2, line 31, p. 3, lines 1-4) states that if a health care provider or health care facility has fewer than 25 health care services or fewer than 50 health care services performed, the provider or facility will compile a list of all of the health care services and procedures performed by the provider or facility.

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Subsection (f) (p. 3, lines 5-11) states that if the health care provider or health care facility fails to comply there will be a civil penalty. The penalty for health care providers will be $50 a day after March 31st up to $2,500.

Subsection (g) (p. 3, lines 12-31, p. 4, lines 1-13) goes over the definitions for department, health care facility, which excludes the Alaska Pioneers' Home and the Alaska Veterans' Home, an assisted living home, and a long-term care nursing facility licensed by the department. Health care provider and health care service are also defined, as well as price, recipient, and third party.

Section 3
This bill will take effect on January 1, 2018.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill -- the bill itself is the best statement of its contents.

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*Price Transparency in the News: Selected Articles, 2012–2015**

Article Title	Subjects	Summary	News Source	URL
Attention, shoppers: Prices for 70 health care procedures now online!	startup that averages local costs	Startup website Guroo (by the Health Care Cost Institute) gives the average local costs for 70 common diagnoses and medical tests in most states, working with three major insurers to compile the figures. Advocates say it's a step but caution that that we are still in the early days of transparency and that the information is not perfect. But Guroo, given its size, influence, and the amount of data it has, has a chance to become the dominant portal for health care prices.	NPR, 2.26.15, Jay Hancock	http://www.npr.org/blogs/health/2015/02/26/389085619/attention-shoppers-prices-for-70-health-care-procedures-now-online
Indiana Hospitals launch website to make medical costs more transparent	new tool by hospitals	Indiana Hospital Association has launched a new website to look up and compare hospital's prices for types of procedures in the state. "The Indiana Hospital Association says this is a move for more transparency, something the government has instructed them needs to happen."	ABC 57 News (Indiana), 2.23.15, Brandon Pope	http://www.abc57.com/story/28173575/indiana-hospitals-launch-website-to-make-medical-costs-more-transparent
Blue Cross North Carolina's price tool could shake up medical industry	review of BlueCross BlueShield Report and pricing tool	Eyes are on North Carolina as BlueCross's pricing disclosure has gone live and discloses prices for more than 1,200 nonemergency procedures; execs say it's a good start to a conversation on health costs but caution that the numbers can be misleading (as it doesn't show varying complexities of cases for the procedure) and might lead patients to taking on higher risk (say, by choosing an outpatient facility when they are a higher-risk patient for which a hospital setting might be more suitable). BlueCross claims that thus far, one high-priced provider has contacted the company to reduce insurance payments, and advocates say the transparency might be helpful for physicians for consideration when making referrals to patients.	Kaiser Health News, 2.4.15, John Murawski and Ann Doss Helms, Charlotte Observer	http://kaiserhealthnews.org/news/blue-cross-north-carolinas-price-tool-could-shake-up-medical-industry/
School district pays for health care but can't get itemized bill	anecdotal story about self-insured group's inability to know prices for what it covers	Anecdotal story about school district's inability to get price data because insurers and providers keep the rates secret (even from the employers who are hiring them). This makes it impossible for the employer to truly know what is driving up the costs. "The school district is subject to the state's open records laws, but Cigna, the insurance carrier they use for employees, refused to share accounts of what was actually paid out, citing trade secrets. Even though the county school district, which is taxpayer-funded, takes on that risk, it's not allowed to see the contracted prices."	NPR, 11.29.14, Sammy Mack	http://www.npr.org/sections/health-shots/2014/11/29/366543309/paying-for-health-care-but-kept-in-the-dark

Article Title	Subjects	Summary	News Source	URL
Association between availability of health service prices and payments for these services	original research	Objective: To determine whether the use of an employer-sponsored private price transparency platform was associated with lower claims payments for three common medical services. … Main Outcomes and Measures: The primary outcome was total claims payments (the sum of employer and employee spending for each claim) for laboratory tests, advanced imaging services, and clinician office visits. ... Conclusions and Relevance: Use of price transparency information was associated with lower total claims payments for common medical services. The magnitude of the difference was largest for advanced imaging services and smallest for clinical office visits. Patient access to pricing information before obtaining clinical services may result in lower overall payments made for clinical care.	JAMA, 10.22/29.14, Christopher Whaley, et al.	http://jama.jamanetwork.com/article.aspx?articleid=1917438
Price tags on health care? Only in Massachusetts	review of the state's newly mandated price tools for all private insurers	"These tools are not perfect, but they are unlike anything else in the country. While a few states are moving toward more health care price transparency, none have gone as far as Massachusetts to make the information accessible to consumers." The theory is that providers are likely the greatest users of the tool, as a way to check their own prices in line with competitors.	Kaiser Health News, 10.9.14, Martha Bebinger, WBUR	http://kaiserhealthnews.org/news/price-tags-for-health-care-in-mass/
Half of Americans think expensive medical care is better. They're wrong.	high cost of care, public opinion, research (Associated Press—NORC Center for Public Research poll)	Forty-eight percent of Americans said they thought higher quality care comes at a higher cost; 37% said there is no real relationship. Providing price data alone without associated quality data could lead patients to pick the most expensive, and seemingly best, provider.	Vox.com, 7.21.14, Sarah Kliff	http://www.vox.com/2014/7/21/5922835/half-of-americans-think-expensive-medical-care-is-better-theyre-wrong
Many unaware of new rules on health care costs	public opinion, results of survey of state residents	In a survey by consulting and research firm Mass Insight, 87% of respondents said it is important to have clear info about medical costs ahead of time, but 82% don't have info allowing them to compare cost and quality. More than 90% said that quality is most important when choosing a health care service, but 55% said cost is a factor when choosing. Beginning in October 2014, insurance companies in Massachusetts must provide answers to consumers' questions about the cost of services with short turn-around time.	Boston Globe, 7.5.14, Felice J. Freyer	http://www.bostonglobe.com/lifestyle/health-wellness/2014/07/04/consumers-want-know-cost-health-care-poll-finds/H51LNvNtuv8hV81Rby999J/story.html

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Same surgery, different price: Patient gets $15,000 bill second time	anectodal story on consequences of price disparity	A patient, Erickson, had the same surgery on both his knees, one in 2010 and one in 2013. He had the same insurance, used the same hospital and the same doctor, and had the same procedure done. For the first procedure (on his right knee), everything was covered. For the second procedure (on his left knee), he was charged $15,000. This was because the device used for postsurgery rehabilitation wasn't covered by his insurance. Erickson tried and failed to appeal; it's the patient's responsibility to ensure his medical provider is in his insurer's coverage network. Despite Erickson's ensuring that his doctor and hospital were in his insurer's network, the device he was given wasn't covered. As to why he wasn't charged $15,000 the first time, the insurance's spokesman posited it could be because the fee listed was the chargemaster price and, after receiving the insurances contribution ($4,000), they decided not to pursue the remaining amount that Erickson would have owed. The spokesman reiterated that despite Erickson's belief that the device was covered due to his first surgery, he should have double-checked before his second.	LA Times, 7.3.14, David Lazarus	http://www.latimes.com/business/la-fi-lazarus-20140704-column.html
HFMA attendees urged to adapt to new consumerism era	recap of HFMA's annual meeting in Las Vegas, TransUnion consumer survey	The Healthcare Financial Management Association's (HFMA) introduced the Healthcare Dollars and Sense Initiative at the 2014 Annual National Institute, which focuses on financial communications and transparency. Eighty-four percent of respondents to the TransUnion survey indicated that pretreatment cost estimates would have a somewhat, or very, positive impact on whom they would choose as a provider, ranking just below outstanding bedside manner (86%) and prompt test results (89%). Only 12% of respondents said it was very easy to get cost information, while 20% said it was very difficult.	Modern Healthcare, 6.28.14, Beth Kutscher	http://www.modernhealthcare.com/article/20140628/MAGAZINE/306289964/1246
New hospital price data released for South Florida, nation	Florida, Agency for Health Care Administration, price disparity, tool for improving transparency	Florida has no laws that compel transparency, but there is a state-mandated website managed by the Agency for Health Care Administration that includes a price range for some procedures. However, the prices listed are only a guideline, not a guarantee, which can be confusing for consumers. The prices published by Centers for Medicare and Medicaid Services (CMS) are only for procedures and exclude many other factors that can affect the overall cost, including things like physicians' fees and room and board. Medicare rates are also not an accurate reflection of the rates paid by private insurers.	Miami Herald, 6.3.14, Daniel Chang	http://www.miamiherald.com/2014/06/03/4156276/new-hospital-price-data-released.html
Viewpoints: New medical price databases may help consumers drive down costs	transparency legislation, consumer responsibility, uninsured patients	For health care transparency to feasibly occur, there needs to be consumer responsibility for using price to select medical procedures and doctors. Such consumer responsibility has been lacking in American medicine since the middle of the last century, when insurance companies began to supplant individuals as decision makers. For patients who are uninsured, it is often difficult for them to negotiate their bill in the same way that insurance companies do for their insured patients if the system is not transparent. In response to this problem, California's Assembly passed a bill (AB 1558) that would provide for basic price information and lead toward greater transparency.	Sacramento Bee, 5.29.14, Roger Smith; reposted on Center for Health Reporting	http://centerforhealthreporting.org/article/viewpoints-new-medical-price-databases-may-help-consumers-drive-down-costs

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Solving the mystery of health-care prices could save $100 billion	price transparency as money-saving initiative	A policy paper from West Health estimated that greater price transparency could save $100 billion over 10 years. Of course, that is only a fraction of a percent of projected health spending over the next 10 years. A downside to price transparency is that it could lead to more spending if not combined with quality data. The Health Care Cost Institute announced in May 2014 that it partnered with three of the nation's largest insurers to create an all-payer claims database that would make data available to patients, insurers, providers, and regulators in 2015.	Vox.com, 5.21.14, Adrianna McIntyre	http://www.vox.com/2014/5/21/5723452/could-more-price-transparency-in-health-care-really-save-100-billion
Brace yourself for price transparency in healthcare	CMS, physician reimbursement, price disparity	In April 2014, CMS released information about the reimbursement to doctors who provide Medicare services. Not included in the released information were Medicare Advantage patients and information regarding private insurance and Medicaid. The opinion piece discusses what new information can be gleaned from this release, including that we now have an itemized list of how much Medicare pays each doctor for each individual service and suggests that prospective patients can use this information to help inform their decisions. The list also includes what Medicare was billed by the doctor and what Medicare paid.	HIT Consultant, 5.15.14, Margalit Gur-Arie	http://hitconsultant.net/2014/05/15/brace-yourself-for-price-transparency-in-healthcare/
Medical costs vary widely at central San Joaquin Valley hospitals	price disparities, chargemasters, consumer shopping, transparency legislation	This article looks at the drastic price disparities in the San Joaquin Valley in California, where a joint replacement might cost $40,812 or $122,651, depending on which hospital you choose. Those full retail prices are hardly ever paid since insurance companies all negotiate the prices and reimburse at lower amounts. Because the prices don't reflect the amount normally paid and have no reflection on quality, the full retail price is pretty much meaningless. This is becoming more and more important, not just for the uninsured, but for those whose insurance providers are asking them to share more and more of the cost. As transparency increases, consumers have more and more incentive to shop for health care and make their decisions based on cost. California has proposed two transparency-related bills. Some states, like New Hampshire, have enacted an all-payer claims database to increase transparency. The database, which uncovered a big disparity in rates, lead to reduced or moderated rates throughout the state, although there didn't seem to be an increase in consumer shopping.	Fresno Bee, 5.10.14, Barbara Anderson	http://www.fresnobee.com/2014/05/10/3920370/under-the-microscope-central-san.html

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Health-care industry takes steps toward price transparency	tools for improving transparency, recommended changes	In April 2014, some two dozen stakeholders issued a report with recommendations on how to provide patients with more information about the cost of health care services. This group includes hospitals, consumer advocates, doctors, and health systems. The recommendations look to who should be responsible for providing pricing information and what information should be provided. The report recommended providing a clear indication of whether the provider was in-network and where to find in-network providers; providing the out-of-pocket-costs for the patient; providing other information such as safety scores and clinical outcomes; and providing estimated costs for standard procedures for uninsured patients and making clear how complications could cause an increase in price. These recommendations acknowledge that the industry is changing and that providers need to be more accommodating to the price-sensitivity of patients.	Denver Post, 4.21.14, Jason Millman, The Washington Post	http://www.denverpost.com/smart/ci_25595655/health-care-industry-takes-steps-toward-price-transparency
Price transparency in healthcare: A movement takes hold	tools for improving transparency	The Denver-based Center for Value in Improving Healthcare (CIVHC) is analyzing claims data for medical procedures to provide cost and quality insights. The CIVHC plans to have a price-comparison tool available later in 2014 for common medical procedures for Colorado consumers. The consumer can enter a search code and find providers and costs in their area. For uninsured patients, the metrics will include median charges that will be a starting point for negotiations.	Behavioral Healthcare, 4.17.14, Alison Knopf	http://www.behavioral.net/article/price-transparency-healthcare-movement-takes-hold
Price transparency stinks in health care. Here's how the industry wants to change that.	coverage of new HFMA report	About two dozen industry stakeholders, including lobbying groups for hospitals and health insurers, issued recommendations in the HFMA report delineating who in the health care system should be responsible for providing pricing information and what kind of information to provide, depending on a person's insurance status. The report's major recommendations include how to provide patients with the total estimated price of the service; a clear indication of whether the provider is in-network or where to find an in-network provider; a patient's out-of-pocket costs; and other relevant information such as patient-safety scores and clinical outcomes.	Washington Post, 4.16.14, Jason Millman	http://www.washingtonpost.com/blogs/wonkblog/wp/2014/04/16/price-transparency-stinks-in-health-care-heres-how-the-industry-wants-to-change-that/
Startup Spotlight: MD Clarity	MD Clarity, Florida, physicians, tool for improving transparency	MD Clarity seeks to offer a cloud-based health care solution to systematically reduce health care costs by making pricing and quality data accessible to patients and health care providers, as well as making sure that physicians are adequately paid for their services. The initial goal was to find a way to make patient out-of-pocket costs projections easier for physicians to obtain for their patients. MD Clarity has since expanded to include the ability of patients to access their current benefits and to easily pay while at the doctor's office. MD Clarity, which launched in the summer of 2010, is working on further growing and expanding the product offerings to a broader variety of clients.	Miami Herald, 1.26.14, Nancy Dhalberg	http://miamiherald.typepad.com/the-starting-gate/2014/01/startup-spotlight-md-clarity.html

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Revealing times: Hospitals, physicians face mounting policy and market pressure to disclose prices	efforts to increase transparency (federal, state, and private)	A recently introduced bill from Sens. Ron Wyden and Chuck Grassley aims to make Medicare payment data broadly accessible on the Internet. The Centers for Medicare and Medicaid Services (CMS) published data disclosing what hospitals charge and what Medicare pays them for common procedures; however, providers complained because the numbers didn't reflect what patients and insurers are actually billed. In 2013, North Carolina passed a state law requiring the state's hospitals and ambulatory surgery centers to disclose on a state website what they're paid by public and private insurers for 140 procedures. The article includes names of several doctor-owned facilities that have begun posting prices online. Of course, many providers, backed by the strong stance from the American Medical Association (AMA), oppose release of data on payments to individual providers because it violates their privacy and could hurt bargaining positions.	Modern Healthcare, 1.18.14, Joe Carlson	http://www.modernhealthcare.com/article/20140118/MAGAZINE/301189936
Miami Children's Hospital part of a trend: revealing some price information	Miami Children's Hospital, fixed prices, patient education, tool for improving transparency, Florida	In January 2014, Miami Children's Hospital started giving patients more of the information they would need to estimate the out-of-pocket costs for their medical care. They reduced the prices on their chargemasters by 30%, bringing the prices to a figure that more accurately represents what insurers pay. They are also working on developing fixed prices for several of the hospital's most common services. These changes are an attempt to educate patients about what services they are actually paying for, as opposed to the old chargemaster prices, which might have little relation to what the ultimate cost would be.	Miami Herald, 1.1.14, Daniel Chang; story reposted on Kaiser Health News, 1.19.14	http://khn.org/news/hospital-pricing-miami/
PwC survey reveals the top health industry trends of 2014	PwC Health Research Institute report	The Top Health Industry Issues for 2014 report reveals that hospitals and health systems will become more retail-focused as they respond to demand for price transparency and cost savings. Other top issues include a greater push by large employers to use private exchanges to provide health care benefits to workers; leaner health care innovation models; a movement to use social, mobile, analytics, and cloud technologies together to improve the practice of medicine and care coordination; and a redefined health care job market that uses technology to engage digitally with patients.	FierceHealthcare, 12.12.13, Ilene MacDonald	http://www.fiercehealthcare.com/story/pwc-survey-reveals-top-health-industry-trends-2014/2013-12-12 http://www.pwc.com/us/en/health-industries/top-health-industry-issues/transparency.jhtml
Paying till it hurts: As hospital prices soar, a stitch tops $500	price regulation, hospital chains and mergers, California	Due to the lack of price regulation in the private market, hospital costs are soaring. On average, a single day as an inpatient costs over $4,000, with some of the most expensive hospitals charging over $12,500 a day. The private health market has little to no price regulation, which allows hospitals, one of the most powerful players in the system, the ability to control their own prices. Much of this power comes from the consolidation and mergers that have happened, creating hospital chains that dominate in their area. California Pacific Medical Center is one such chain that has become very proficient in the business of medicine. Their prices include a $2,200 bill for three stiches in the emergency room (negotiated down to $1,813 by the insurance company). Research has shown that mergers often bring prices up not only at the hospitals that have merged, but also at other, smaller hospitals in the region.	NY Times, 12.2.13, Elisabeth Rosenthal	http://www.nytimes.com/2013/12/03/health/as-hospital-costs-soar-single-stitch-tops-500.html?pagewanted=all

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More patients rely on price transparency for care decisions	TransUnion consumer survey, public opinion research	A TransUnion health care survey of 1,039 insured patients in November 2013 revealed that more patients are turning to hospitals and insurers to provide information on costs. Fifty-five percent of respondents said they now pay more attention to details on medical bills not just out-of-pocket expenses. Patients who experienced a transparent billing process were more likely to give the highest ratings for their quality of care.	FierceHealthcare, 11.22.13, Ilene MacDonald	http://www.fiercehealthcare.com/story/more-patients-rely-price-transparency-care-decisions/2013-11-22
TransUnion Survey: Healthcare cost transparency major factor in patients' choice of providers, health plans during open enrollment	TransUnion consumer survey, public opinion research	The TransUnion survey found that a majority of patients (55%) have started paying more attention to the details of their medical bills over the past year. Notably, increased consumer awareness of cost is not limited to out-of-pocket costs like premiums, co-pays, and co-insurance payments. Two-thirds of respondents (67%) say they want to know the details of both their own out-of-pocket costs and those covered by insurers. Additionally, three-quarters (75%) of respondents indicated that previous bills and costs have been either very important (42%) or extremely important (33%) in their decisions to enroll or stay enrolled in health plans. At least 60% of respondents said that health reform has made them "more concerned" about the cost of coverage (63%), out-of-pocket cost (62%), and the total cost of care (60%), while roughly half said the same about access to specialists (50%) and getting appointments (47%). The survey also revealed that patients who experience a clear, transparent billing process and especially those who received more information about the expected costs on the front end of the process are far more likely to give the highest ratings to their overall quality of care. Nearly three-quarters (73%) of patients who rated their quality of care highly also gave high marks to billing experiences, while 69% of those who rated their quality of care as poor also gave poor marks to their billing experiences.	Marketwired, 11.20.13, News room	http://www.marketwired.com/press-release/transunion-survey-healthcare-cost-transparency-major-factor-patients-choice-providers-1854520.htm
Good deals on pills? It's anyone's guess	price disparity, pharmaceuticals	This article outlines services that make prices for pills more transparent and reasons why transparency has a lot of room to grow. Is it fair for health insurance policies to force consumers to shop for best prices by forcing them to pay a portion of bills?	New York Times, 11.9.13, Elisabeth Rosenthal	http://www.nytimes.com/2013/11/10/sunday-review/good-deals-on-pills-its-anyones-guess.html?pagewanted=all
Can this man save healthcare?	Surgery Center of Oklahoma, proposed solutions	Dr. Keith Smith of the Surgery Center of Oklahoma posts prices, which are considerably lower than the national average, online. The article says that the reason health care is so expensive is because consumers have no incentives to economize. Dr. Smith believes that third-party payers should be cut out, and consumers and producers should negotiate directly. As a result of a mini–price war between hospitals, the Oklahoma and Kansas area has some of the cheapest open-heart surgery available in the nation.	The Freeman, 10.21.13, Jordan Bruneau	http://www.fee.org/the_freeman/detail/can-this-man-save-healthcare

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How healthcare can work when it is a right, not a privilege	comparative healthcare, California	While touring London, Mona Davis thought she had come down with a cold. Her cold worsened, and she was directed to St. Thomas' hospital; she was taken to the A&E (Accident and Emergency, equivalent to an ER) and seen there. Within five hours, she had been looked over, had a chest X-ray and blood tests, been diagnosed with pneumonia, been written a prescription, and been shown how to use an inhaler. The only charge she had to show for this was $37 to fill her three prescriptions. After Davis returned to Southern California, her husband also began feeling unwell and went to the ER, where he had tests done and a chest X-ray taken, and, two days later, he had to return to double-check one of his blood tests. His total bill was almost $17,000. The difference, Lazarus claims, is that Britain, like many other developed countries, holds the idea that health care is a right and not a privilege, and, therefore, everyone is entitled to affordable medical treatment.	Los Angeles Times, 10.3.13, David Lazarus	http://articles.latimes.com/2013/oct/03/business/la-fi-lazarus-20131004
Why pricing transparency does matter	high cost of care, uninsured patients	The article is a personal account of the high cost of care for the uninsured.	FierceHealthcare, 9.18.13, Ilene MacDonald	http://www.fiercehealthcare.com/story/why-pricing-transparency-does-matter/2013-09-18
The people have spoken: Reveal medical prices now!	Health Care Inc. Northwest unscientific poll, tools for transparency	In an unscientific poll by Health Care Inc. Northwest, 95% believed hospitals should be required to reveal prices for all procedures. Pricinghealthcare.com is gathering pricing data for Portland on its website by using crowd sourcing. Okcopay.com has pricing data for eight cities and will show prices for 72 different procedures with some measures of quality and convenience. It's open to people without insurance and those who aren't covered by their plans for certain services.	Portland Business Journal, 8.20.13, Elizabeth Hayes	http://www.bizjournals.com/portland/blog/health-care-inc/2013/08/the-people-have-spoken-reveal-medical.html?page=all
Who is most responsible for rising health costs? Readers, weigh in	insurance companies, high cost of care	Because Portland Business Journal readers want to know the prices of various medical procedures, the journal also wondered who the readers thought was most responsible for rising health care costs: doctors, hospitals, insurance companies, or the government. The attached survey found that 30% of readers thought that insurance companies were most responsible.	Portland Business Journal, 8.20.13, Elizabeth Hayes	http://www.bizjournals.com/portland/blog/health-care-inc/2013/08/who-is-most-responsible-for-rising.html

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The cure for the $1,000 toothbrush	PPOs, alternate payment methods, cost-plus plans, tools for improving transparency	After facing a 68% increase in company premiums by a Blue Cross preferred provider organization (PPO), Texas 811 dropped Blue Cross and turned to GPA, a locally based company that administers claims. Because of the increase in mergers and growth of hospital chains, hospitals now control negotiations with PPOs, which includes the ability to get high prices, secrecy clauses, and other contract advantages. PPOs negotiate discounts with the hospital over chargemaster prices, which the insurance company pays, generally without asking questions. Some PPO contracts even contain a clause that prohibits arguing over prices. According to hospital executives, the ban on challenging prices is justified because it's the overall price of the procedure that matters and not the line-item review. Now companies, like GPA, are using a different system whereby they are paying the hospital its costs, along with a profit. Clients that use this system, so far, usually use a 15–20% reduction in medical spending in the first year after switching. Despite these reductions, most employers haven't chosen this path. There are several reasons for this. Many employers don't realize that insurance companies aren't doing their own audits. There are a few hospitals that don't accept "cost-plus" rates. Additionally, the cost-plus plan comes with uncertainties that not all employers believe their work force is willing to accept. More transparency can also cut costs through reference pricing. Reference pricing leads to patients shopping around and also other hospitals lowering their prices.	NY Times Opinionator, 8.13.13, Tina Rosenberg	http://opinionator.blogs.nytimes.com/2013/08/13/the-cure-for-the-1000-toothbrush/
Revealing a health care secret: The price	Surgery Center of Oklahoma, transparency through Internet sources	The Surgery Center of Oklahoma has been posting prices on a website for the past four years. On NewChoiceHealth.com, a website that compares prices offered by different facilities in the same city, the Surgery Center of Oklahoma is consistently the cheapest option. Their disclosure of prices in health care is unique. Due to the political and market power of health care providers, the sellers are often the only ones who know the price. Price opacity is only getting worse as hospital chains consolidate. Transparency, however, has been increasing in some ways, mostly through the Internet. The required CMS reporting of the cost of doing procedures is now available on the Web, and Sebelius released two other databases, one that shows what Medicare paid for some of the most common inpatient services across the United States and one that is a database of hospital's chargemaster prices. Additionally, websites are now appearing that allow patients to compare the self-pay prices in their area and even solicit bids.	NY Times Opinionator, 7.31.13, Tina Rosenberg	http://opinionator.blogs.nytimes.com/2013/07/31/a-new-health-care-approach-dont-hide-the-price/?_php=true&_type=blogs&_r=0
N.C. makes move to improve health cost transparency	North Carolina, transparency legislation	In June 2013, North Carolina passed the Health Care Cost Reduction and Transparency Act of 2013 that will created an online database of what hospitals paid, on average, for 100 of their most frequently performed treatments as well as the cost of the 20 most common surgical procedures and 20 most common imaging procedures. Not only will this allow patients to go online and compare the prices of treatment, it will also tell them what Medicare and Medicaid pay for the treatment, what the five largest insurers in the state would pay, and what price an uninsured person would pay and the average price they could negotiate for the treatment.	Triad Business Journal, 7.29.13. Owen Covington	http://www.bizjournals.com/triad/blog/2013/07/after-failing-grade-nc-should-improve.html?page=all

Article Title	Subjects	Summary	News Source	URL
Mass. taking steps to open up the mysterious world of medical prices	Massachusetts, transparency legislation	In response to an earlier editorial published in The Boston Globe ("Hospital prices should be published"), Massachusetts' undersecretary of the Office of Consumer Affairs and Business Regulation addressed what Massachusetts was doing in terms of transparency. In 2012, a law was passed that required insurers to provide price information for procedures among various providers on a website and at a toll-free number. These tools were put in place so that consumers can feel comfortable asking questions and shopping around.	Boston Globe, 6.24.13, Barbara Anthony	http://www.bostonglobe.com/opinion/letters/2013/06/23/massachusetts-taking-steps-open-mysterious-world-medical-pricing/XhpiSnKOtwc4RhxP6mTfrK/story.html
Hospital prices should be published	price transparency editorial	Hospitals have great discretion over what prices they charge. At one hospital in Boston, the average cost of treatment for a heart attack (without complications) was $36,111. At a hospital 12 miles away, the same diagnosis was treated, on average, for just under $6,000. Such disparities are the result of patients largely paying little attention to the price. Instead, paying was left to the insurers, who negotiated the price but didn't make the results of those negotiations public. However, with the change in many newer policies, patients are being asked to pay more out of pocket, making them more price-conscious. In acknowledgment of this, Mount Sinai Medical Center in Miami pledged to publish what insurers were charged for procedures.	Boston Globe Editorial, 6.17.13	http://www.bostonglobe.com/editorials/2013/06/17/hospital-vow-price-transparency-could-revolutionize-health-care/r7ylsshhRg7eXBUXIb15ol/story.html
Hospital pricing needs to be simpler, more equitable (letter titled "Baptist Health: A Leader in Hospital Pricing Transparency")	CMS, chargemaster, tool for improving transparency, Florida	The 2013 CMS release of what U.S hospitals charge is not particularly meaningful or understandable. Hospital chargemasters are not an adequate guide for the amounts paid by Medicare or Medicaid and are generally unrelated to the amount paid by commercial health insurers. Furthermore, there is no standardized system for the chargemasters. Not only do prices vary from hospital to hospital, the numbers of items listed on the chargemaster vary. Although the CMS release did highlight the problems with hospital pricing systems, it did little to inform patients what they would actually be paying. The article was really a letter from the president and CEO of Baptist Health South Florida suggesting that hospital pricing systems should be replaced with a simpler and more equitable system, such as the one Baptist Health South Florida. This system uses a Central Pricing Office that allows patients to obtain an out-of-pocket estimate for their scheduled service and offers other potential discounts for patients.	Miami Herald, 6.11.13, Brian Keeley; Baptist Health South Florida, 6.12.13	http://baptisthealth.net/brian-keeley-blog/baptist-health-a-leader-in-hospital-pricing-transparency/
The $2.7 trillion medical bill	comparative health care	Colonoscopies are the most expensive screening test that Americans routinely undergo. The article mentions the opaqueness of medical bills with random charges. The United States doesn't regulate pricing (aside from Medicare and Medicaid), unlike in other countries. This article is part one of an eight-part series on the high cost of care.	New York Times, 6.1.13, Elisabeth Rosenthal	http://www.nytimes.com/2013/06/02/health/colonoscopies-explain-why-us-leads-the-world-in-health-expenditures.html

Article Title	Subjects	Summary	News Source	URL
Cedars-Sinai stands out for steep pricing; it's the only hospital near the top in every category in Medicare report. But few patients pay the full amount.	high cost of care, California	Cedars-Sinai Med Center in LA ranks among the most expensive in the country. The hospital has long justified its costs because it is committed to research and training; it also takes on patients with complex issues that other hospitals can't. However, other elite hospitals like Mayo Clinic aren't as expensive.	LA Times, 5.17.13, Chad Terhune and Ben Poston	http://articles.latimes.com/2013/may/17/business/la-fi-cedars-hospital-prices-20130517
Hospital pricing practices gouge patients: Our view	Editorial arguing for greater price transparency in health care services	Subheading: "Hospitals commonly charge not just a little more than the typical Medicare reimbursement rate, but five or 10 or even 20 times more."	USA Today, 5.15.13, The Editorial Board	http://www.usatoday.com/story/opinion/2013/05/15/hospital-charges-costs-pricing-editorials-debates/2163795/
In Miami, more hospital prices may see light of day	Florida, improving transparency	Mount Sinai Medical Center in Miami Beach pledged to make public the contractual rates it charged private insurers for diagnoses and treatments and challenged other hospitals in the area to do the same. Although this challenge was declined by some hospitals, there is a sense that transparency was the direction in which the industry as a whole was going. Such transparency will hold the hospitals accountable and also means that price of care will become a much bigger factor for consumer decisions. Another factor that will lead to patients shopping around is that insurance companies are moving toward high-deductible plans. However, most hospitals don't currently publish prices for treatment or only publish some prices, making shopping around difficult. There is a concern that providing raw pricing would be more confusing for patients than helpful, due to the complex way pricing works.	Miami Herald, 5.14.13, Daniel Chang	http://www.miamiherald.com/2013/05/14/3397479/in-miami-more-hospital-prices.html
The value in price transparency: It's time for hospitals to look inward for reasons behind cost disparity	Bitter Pill article, chargemaster, price disparity	This is an editorial that calls for hospitals and delivery systems to look inward at why they are so out of line with competitors. In May 2013, CMS released hospital charges and payments, which revealed a wide disparity between diagnosis-related group (DRG) payments made to various hospitals in the same regions. The controversy surrounding CMS's report and the Bitter Pill article prompted the editor to write this piece.	Modern Healthcare, 5.11.13, Merril Goozner	http://www.modernhealthcare.com/article/20130511/MAGAZINE/305119987

Article Title	Subjects	Summary	News Source	URL
American health care as a source of humor	CMS, chargemasters	This article is about the 2013 CMS spreadsheet on hospital charges and payments of the 100 most frequently billed inpatient cases for 3000+ hospitals. The spreadsheet includes a column that lists the average payments that Medicare made to the hospitals as well as one that lists the average covered charges, the latter of which is often significantly higher than the Medicare payments. The average covered charges are decided by the (largely nonsensical) chargemaster, which hardly anyone ever actually pays.	NY Times Economix, 5.10.13, Uwe Reinhardt	http://economix.blogs.nytimes.com/2013/05/10/american-health-care-as-a-source-of-humor/
Hospital prices for same services vary widely	CMS, chargemaster, insurance negotiations, price disparity	In 2013, the Department of Health and Human Services released a list of typical hospital charges. Not only do prices vary from area to area and hospital to hospital, but whether a patient has an insurer to negotiate their bill for them also makes a huge difference in what the bill will be. A single trip to the hospital in California for chest pains might range from a listed price of $22,616 to almost $50,000. When that same trip is negotiated by Medicare or Medicaid, the price instead will probably be somewhere in the $4,000–$7,000 range. There seems to be no rhyme or reason to why the prices are what they are or why hospitals come down to specific prices while negotiating with insurers.	Sacramento Bee, 5.9.13, Cynthia Craft	http://www.sacbee.com/2013/05/09/5406420/hospital-prices-for-same-services.html
IMS: US medicine spending shows rare dip in 2012	pharmaceuticals, decrease in spending	In 2012, spending on prescription medicines fell due to a combination of consumers cutting back on their use of health care services and an increase in generic versions of widely used drugs. Spending decreased by 1%, although after accounting for population growth and economic expansion, the decline was around 3.5%. Consumers were cutting back not only because of their own financial situation, but also because employers were raising health costs for their workers, including a jump in use of consumer-directed plans. Out-of-pocket expenses for those with consumer-directed plans are seven times higher than they were five years ago and three times higher on average.	AP, 5.9.13, Linda Johnson	http://news.yahoo.com/ims-us-medicine-spending-shows-rare-dip-2012-103739752.html
New data reveal puzzling differences in hospital charges	CMS spreadsheet, price disparities	There are huge disparities in cost for the same items and procedures not just geographically, but within the same cities. In Kansas City, patients can be treated for angioplasty at Olathe Medical Center for $38,510 or, thirty minutes away at Research Medical Center, for $100,493. While there are factors that go into the different rates for different procedures, they aren't necessarily apparent and don't make sense from a consumer standpoint, and there often isn't a relationship between the charges and the quality of care administered.	Tony Pugh and Alan Bavley, Kansas City Star, 5.8.13; story reposted on Topeka Independent Living Resources Center	http://www.tilrc.org/assests/news/0513news/0513fed08.html
Hospital billing varies wildly, government data shows	price disparity, CMS	Written after CMS's spreadsheet release, this article provides a general overview of the price disparity in hospitals, the use of the chargemasters, and the role of Medicare, Medicaid, and third-party insurance companies in negotiating prices. It also reiterates that there is no explanation about specific cost disparities, and it highlights that a lack of transparency and a public focus on health insurance premiums mean that what hospitals are actually charging has largely been ignored.	NY Times, 5.8.13, Barry Meier, Jo Craven McGinty, and Julie Creswell	http://www.nytimes.com/2013/05/08/business/hospital-billing-varies-wildly-us-data-shows.html?pagewanted=all

Article Title	Subjects	Summary	News Source	URL
One hospital charges $8,000—another, $38,000	CMS, price disparities	Written just before the CMS spreadsheet was released, this article primarily highlights disparity of prices. Within D.C., the average bill for a lower-joint replacement at George Washington University was over three times the amount ($69,000) of the same procedure at Sibley Memorial (≈$30,000). At CJW Medical Center in Richmond, Va., a lower limb replacement averaged more than $117,000, but it averaged $25,600 in Winchester, Va. The disparity exists not just within regions but across the United States. California, Florida, Nevada, New Jersey, Pennsylvania, and Texas routinely have higher prices, while Idaho, Montana, and North Dakota tend to have the lowest. Additionally, for-profit hospitals have a tendency to bill Medicare at a nearly 30% higher rate, although, in many cases, the hospitals that submit the higher bills actually received lower payments than competitors. A concern was also expressed that an increase in transparency would lead to the misassumption that there is automatically a link between higher costs and higher quality of care, although this is not always the case.	The Washington Post Wonkblog, 5.8.13, Sarah Kliff and Dan Keating	http://www.washingtonpost.com/blogs/wonkblog/wp/2013/05/08/one-hospital-charges-8000-another-38000/
Avoiding emergency rooms	ER care	Many of the problems patients go to the emergency room with could easily be diagnosed and treated through a primary care physician (PCP), but the patient ends up going to the ER because their PCP is unreachable when needed. Up to half the problems brought to the ER do not require hospital care. For the patient, an ER trip can result in a lot of wasted time, a lot of (often unexpected) money spent, and even unnecessary hospitalization, tests, and other procedures. By and large, the medical profession hasn't filled the gap left when doctors don't work 24/7, causing many middle-class insured patients without real emergencies to turn to the ER, which is open 24/7, for care. In a brief issued in 2010, the New England Healthcare Institute reported that up to $38 billion is wasted on the unnecessary overuse of ERs. This problem has been exacerbated by patients' ability to research symptoms on the Internet, especially when combined with their inability to get an appointment with their doctor either immediately or for the next day. A potential solution to this would be to increase walk-in or urgent-care clinics and to have patients with chronic conditions devise a care plan with their doctors that reduces the chances of needing emergency care.	NY Times Well blog, 4.15.13, Jane Brody	https://www.washingtonpost.com/news/wonk/wp/2013/05/08/one-hospital-charges-8000-another-38000/
Viva Mexico's rational health care system	price disparity, comparative healthcare	This article is a personalized account that compares Mexican health costs with those of America. Mexico has universal health care for its citizens. However, even with an American citizen having to foot the full bill, a nine-day hospital visit came out to about $6,375. Using chargemasters from 24 hospitals in California, the author calculated the cost of the same stay in California and found the average cost would have been $125,000, noting the vast fluctuation in costs from hospital to hospital. That total wouldn't have included the separate billing for procedures, testing, and specialists, all of which had been included in the Mexican bill.	Sacramento Bee, 4.7.13, Joe Livernois	http://www.sacbee.com/2013/04/07/5320435/viva-mexicos-rational-health-care.html

Article Title	Subjects	Summary	News Source	URL
Bitter pill: Why medical bills are killing us	price disparity and transparency, high cost of care	Basically the initial take Brill has while working on the now complete "America's Bitter Pill," except that this piece does focus a lot on price transparency and the inflated costs used by hospitals to calculate "charity care," as one problem highlighted. [Need subscription for full article access.]	Time, 4.4.13, Steven Brill	http://time.com/198/bitter-pill-why-medical-bills-are-killing-us/
Need price for healthcare? Ask for it	California, San Joaquin Valley, tools for improving transparency, chargemaster	This article looks at the efforts that two hospitals in the San Joaquin Valley are making toward transparency. Mercy Medical Center reports all of its hospital charges to the Office of Statewide Health Planning and Development every year, and, in turn, the office makes that information available on its website. Mercy also has financial counselors available to help patients. Memorial Hospital Los Banos maintains and publicly posts its chargemaster prices, although those charges are not what they generally get paid. It is difficult to provide exact charges to patients, however, because the cost of treatment changes for individuals in each care setting.	Merced Sun-Star, 4.2.13, Yesenia Amaro; story reposted on Los Banos Enterprise, 4.6.13	http://www.losbanosenterprise.com/2013/04/06/205762/need-price-for-healtcare-ask-for.html
Burgess, Green legislation provides patients transparent cost information	H.R. 1326 Health Care Price Transparency Act of 2013	Introduced by Michael C. Burgess, MD (TX-26) and Gene Green (TX-29), this legislation aims to make health care more affordable by promoting greater transparency about the costs of health care services for patients.	Congressional Member site, 3.26.13	http://burgess.house.gov/news/documentsingle.aspx?DocumentID=325562
Many states don't require disclosure of prices for medical procedures	report on national report card on price transparency for 29 states	Summary report on states' efforts to regulate and make public price transparency.	Washington Post, 3.25.13, Russ Mitchell	http://www.washingtonpost.com/national/health-science/many-states-dont-require-dislcosure-of-prices-for-medical-procedures/2013/03/25/77937080-8fdb-11e2-9abd-e4c5c9dc5e90_story.html
South Carolina's failing grade on health care pricing transparency shows need for action	response to report card on states' price transparency regulations	This press release advocates for legislation that would reforms state Medicaid budgets to allow the agency to regulate for price transparency.	South Caroline Health Connections MEDICAID (SCDHHS), 3.25.13	https://www.scdhhs.gov/press-release/south-carolina%E2%80%99s-failing-grade-health-care-pricing-transparency-shows-need-action
Cataloging health care's excesses	Bitter Pill article	The article recaps highlights from the Bitter Pill article and elaborates on how health care is too expensive.	New York Times, 3.4.13, Albert Hunt, Bloomberg News	http://www.nytimes.com/2013/03/04/us/04iht-letter04.html?_r=0

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ER visit costs hard to predict with $4 to $24,000 swings	price disparity, high medical spending	The disparity in hospital charges for the same care is huge and often unpredictable. Often, neither doctors nor patients know what the final charge is going to be. The variation in prices depends on a number of things, including whether a person is insured, what sort of insurance that person has, and what procedures are done. Medical spending increased by 3.9% in 2011 and is expected to keep increasing. Given the way the system works, hospitals have incentive to make these final charges higher, and it is up to the patient (or the patient's insurance) to bargain to a lower price.	Bloomberg.com, 2.28.13, Ryan Flinn	http://www.bloomberg.com/news/2013-02-27/er-visit-costs-hard-to-predict-with-4-to-24-000-swings.html
4 ways to control your health care costs	high cost of care	This article suggests four different ways that readers can control health care costs. The recommended methods are 1) just ask (patients should tell their doctor they are worried about costs and ask for less-expensive options); 2) befriend your local pharmacist (patients should talk with their local pharmacist about possible complications and duplications in the medications prescribed by different doctors and ask about generic alternatives); 3) do your research (read and understand insurance plans and learn the "fair price" for various care options); and 4) fight back (complain or appeal and use an outside reviewer when bills are still higher than expected).	cnn.com, 2.22.13, Jacqie Wilson	http://www.cnn.com/2013/02/21/health/cut-personal-health-care-costs/
Price for a new hip? Many hospitals are stumped	JAMA Internal Medicine article Feb. 2013; high cost of care	A paper published in the JAMA Internal Medicine reported findings from a study on the variability of health care costs. Without quality data to accompany price data, there's no way to know whether a cheap procedure is shoddy or a good value.	New York Times Well blog, 2.11.13, Elisabeth Rosenthal	http://well.blogs.nytimes.com/2013/02/11/price-for-a-new-hip-many-hospitals-are-stumped/
Doctors urged to be more mindful of costs of procedures they order	high cost of care, physician's role	This article is about the importance of physicians being aware of health care costs. Often, doctors are not only entirely oblivious to costs, but have been taught not to think about them. However, they should be aware of costs for two main reasons: to prevent the minor abnormalities of a bill that lead to snowballing charges, and to understand what patients can afford so they can consider alternatives for patients who are either uninsured or underinsured.	Chicago Tribune, 8.29.12, Lisa Pevtzow	http://articles.chicagotribune.com/2012-08-29/health/ct-x-0829-doctor-payment-20120829_1_healthcare-blue-book-doctors-order-tests-medical-bills
When surprise hospital bills attack	price transparency, patients making informed decisions	Patients have a right to know about their medical care and medical costs. However, hospital billing is complicated and often indecipherable. A major area of complication is in-network versus out-of-network care. In 2012, Texas terminated the rules that meant patients would receive additional information or warnings about whether they would be on the hook for more money if they were hospitalized at an in-network facility but the doctor who was seeing them was an out-of-network specialist. Surprise fees such as this, as well as others (for example, facility fees that charge extra for nonhospital services and for outpatient clinics that are affiliated with the hospital) exist across the country and can push patients into putting off care when they need it.	FierceHealthcare, 8.24.12, Alicia Caramenico	http://www.fiercehealthcare.com/story/price-transparency-when-surprise-hospital-bills-attack/2012-08-24

Article Title	Subjects	Summary	News Source	URL
Finding common ground on price transparency	Surgery Center of Oklahoma	This editorial looks at the Surgery Center of Oklahoma, which posts the price of more than 100 procedures it performs. The prices are total-package prices, so they include things such as the surgeon's and anesthesiologist's fees. The center's chief medical director G. Keith Smith claims that since the Surgery Center started posting its prices, other local hospitals have lowered theirs, although they still don't post the information anywhere. Smith would like to see every hospital post its prices, thus creating a free market that would keep prices low.	FierceHealthFinance, 7.24.12, Ron Shinkman, editor	http://www.fiercehealthfinance.com/story/finding-common-ground-price-transparency/2012-07-24
Surgery prices vary significantly across hospitals	price disparity	A report by a consumer advocacy group (CALPIRG Education Fund) concluded that the prices of surgical procedures vary from hospital to hospital, even among hospitals in the same region. As of 2010, hospitals in the highest-charging areas had prices that were 2.7 times greater than hospitals in the lowest-charging areas. The report also found that hospitals that had larger market clout could charge more for their procedures. The report found no correlation between price and quality and more transparency is needed from hospitals about how they arrived at their charges, how much was actually paid, and what the actual cost of providing care was.	FierceHealthcare, 7.17.12, Alicia Caramenico	http://www.fiercehealthcare.com/story/surgery-prices-vary-significantly-across-hospitals/2012-07-17

* From most to least recent.

Center for American Progress

Shining Light on Health Care Prices

Steps to Increase Transparency

By Maura Calsyn April 3, 2014

Introduction and summary

As a nation, we pay too much for health care, in large part because of the excessive prices charged by health care providers, manufacturers, and suppliers. A key reason why those prices are so high is because almost all health care prices are hidden, which hinders market competition and keeps patients and their health care providers from making fully informed decisions.

Imagine receiving a bill for $8,000 for car or home repairs without having first had a chance to receive a price estimate or the opportunity to comparison shop. That scenario is preposterous, yet it is exactly how we pay for our health care. Each year, our nation spends more than $8,000 per person on health care,[1] but patients have little to no idea how much each procedure, medication, or hospital stay actually costs. And unlike many other goods and services, higher health care prices do not necessarily reflect higher quality.[2]

In the rare cases in which prices are publicly available, they are usually of little value to patients. For example, listed prices are not the same as a patient's out-of-pocket costs, and the listed price most likely reflects only one part of a patient's treatment. In order to lower health care costs, we must fix each of these problems—health care prices must not only be transparent, they must also be easy to understand.

Secrecy in health care pricing distorts the market in other ways, and it is not just patients who are kept in the dark about health care prices. For instance, doctors make referrals without knowing the prices charged by other providers; they select medical devices for use in procedures without knowing the costs of the products or whether less-expensive alternatives may produce similar or even better outcomes. A recent study found that orthopedic surgeons correctly estimated the cost of a device only 21 percent of the time.[3]

In fact, at almost any point in the health care delivery system, the lack of meaningful, readily available price information raises costs.

Fortunately, policymakers across the political spectrum as well as private-sector entrepreneurs are starting to focus on this issue. More than 30 states now require disclosure of at least some minimal level of health care price information, and last year, the Centers for Medicare & Medicaid Services released large amounts of Medicare claims data for the first time.[4]

Even with these promising changes, health care prices are still maddeningly opaque. This report outlines specific recommendations to increase price transparency in health care, including immediate steps that the Obama administration can take:

- The Department of Health and Human Services, or HHS, must ensure that the Affordable Care Act's, or ACA's, requirement that insurers provide cost-sharing information is implemented in a consumer-friendly way.
- The ACA's cost-sharing disclosure requirements should be modified so that the plan's quoted costs for episodes of care are guaranteed.
- HHS should encourage the development of statewide, all-payer claims databases.
- Hospitals and other institutional health care providers should provide uninsured and out-of-network patients with episode-based costs, which would also be guaranteed.
- Insurers' provider directories should include rankings of higher-value providers to encourage patients to seek out their services.
- Medicare's Compare websites' star rating systems should include an overall "value" score for each health care provider, calculated using both quality and price data.
- Federal law should increase price transparency in the device industry, allowing hospitals and physicians to comparison shop without revealing prices to competitors.

Enacting these recommendations will significantly improve price transparency and improve the value of the health care services patients receive.

Why price transparency matters

Masking the price of health care items and services prevents competition based on price and value at numerous points in the health care system.[5] This lack of competition can artificially inflate prices, which in turn increases the nation's health care spending.[6] Price increases above inflation also contribute to the system's excessive rate of growth.[7] One study estimates that the system's lack of transparency adds about $36 billion in system-wide costs each year.[8]

For example, hospitals are able to charge private health care payers—insurers and employers—different prices based in large part on the hospital's relative market power, and higher prices do not necessarily reflect the quality of its services.[9] This contributes to vast price differences and unnecessarily high prices for hospital services in parts of the country. The Institute of Medicine has found that in the commercial insurance market, "regional differences in price mark-ups, not utilization, are the prime influence on geographic variations in spending."[10] If more cost and quality data were available, private payers could select high-value providers more easily.

But at the same time, hospitals also pay inflated prices due to a lack of price transparency. Not only do device manufacturers keep their prices secret, but they may also bar a hospital from sharing price information with physicians who perform procedures at the hospital.[11] For many cardiac and orthopedic procedures, the cost of these devices is the most expensive part of the patient's care.[12] As a result, doctors and hospitals are unable to work together to identify high-value devices, which disadvantages hospitals during negotiations with device manufacturers.

Access to price and quality information is critical to doctors for other reasons. For example, doctors participating in new payment models such as accountable care organizations, or ACOs, that hold providers responsible for the overall costs of a patient's care need this information in order to refer their patients to high-value specialists.

The lack of price transparency is now becoming an increasingly visible consumer issue. While uninsured patients are responsible for paying the full price of various health care services, the impact of higher prices on insured consumers has, in the past, generally been limited. Excessive prices raise premiums, but insured consumers had otherwise been largely shielded financially from inflated prices.[13] Patients may have paid more for out-of-network providers, but otherwise insurers absorbed price differences.

Today, all patients—not just the uninsured—are responsible for a larger share of health care costs. Nearly one-third of all privately insured adults are enrolled in high-deductible health plans, and employers and insurers continue to design plans with larger deductibles and increased cost-sharing.[14] Many plans offered through the ACA's marketplaces have higher deductibles, and consumers selecting new marketplace plans must consider those expenses in addition to premium amounts. Uninsured individuals also continue to need price information.

Patients are also becoming increasingly likely to encounter benefit structures that insurers and employers design to channel them to high-value providers. For example, tiered insurance plans specify providers who achieve high quality and low costs, and patients who choose these providers have lower cost-sharing. Employers or insurers may also set a reference price for elective procedures—the amount that an employer or insurer agrees to pay for that service—and if a patient chooses a provider

that charges more than the reference price, the patient must pay the difference. For example, the California Public Employees' Retirement System set a reference price of $30,000 for joint replacement surgery, which saved California $6 million and saved patients $600,000 in two years.[15] These efforts can only succeed if patients have clear price and quality information.

Of course, there will always be emergencies and other situations in which patients need immediate treatments and have little or no control over what hospital or doctor they use. But for the many procedures and treatments that are scheduled in advance, consumers should have access to meaningful, user-friendly information.

Price transparency challenges

Unfortunately, simply publishing health care prices is not as straightforward as listing the prices of other consumer goods and services. There are a number of reasons why these efforts are complicated and some approaches to transparency are far more helpful than others.

Operational challenges

There is not a single price for different health care services. Health care providers set a charge for each item and service, which are essentially the wholesale or "list" prices. They bear little relation to the amount that public and private payers and insured patients pay for health care services. Charges listed in a hospital's chargemaster—the comprehensive list of prices for every item or service—are more than twice as high as the actual prices paid by insurers, and physicians also set extraordinarily high list prices for their services.[16] These list prices have limited use because private insurers negotiate far lower prices with providers. Traditional Medicare also pays significantly lower prices based on formulas set by law. However, providers will still bill the full charge amount in two situations, for treating uninsured patients and out-of-network patients.[17] Low-income uninsured patients are likely to receive some level of discount.[18]

The lower prices insurers pay based on their agreements with different health care providers are still of little help to patients because patients with different insurance benefits and cost-sharing structures will pay a different portion of the medical bill. Even if two patients have the same insurance, they may still pay vastly different amounts for the same procedure performed by the same doctor at the same facility. For example, if an insurance policy has a $1,000 deductible and then 20 percent co-insurance for outpatient procedures, a patient who has only paid $200 of the deductible will pay $800 more for the exact same care than a patient who has already paid the entire annual deductible.

Patients will also pay higher amounts for the exact same procedure if it is performed by out-of-network providers or, in yet another variation, if the patient needs a higher level of care and therefore the procedure occurs in a hospital operating room instead of an outpatient surgery center.

Efforts to present price information in a consumer-friendly format are thwarted by another feature of the current payment system. For each encounter with the health care system, a patient will likely receive more than one bill. For example, patients will usually receive separate bills from a hospital as well as from the doctors who treated the patient.

How each of those bills is generated by health care providers further complicates this issue. Instead of charging one price for an entire episode of care, such as all of the costs associated with a hospital stay to undergo hip replacement surgery, health care providers submit claims to insurers with prices for different codes that describe individual, specific items and services furnished to the patient as part of their care. Hospitals may have charges for 12,000 to 45,000 specific items and services.[19] Depending on the patient's actual treatment, those codes may vary, and providers cannot always accurately predict each needed service in advance, particularly if the patient faces complications.[20]

This payment structure, combined with the need for patient-specific insurance information, makes it very difficult for patients to track down relevant, user-friendly information. Researchers who called more than 100 hospitals for the price of a hip replacement found large variations in responses from the hospitals and in some cases did not receive any response.[21]

Researchers only received complete price information—including both hospital and doctors' costs—from 12 of 20 top-ranked hospitals. Of those 12, 9 were able to give a single, bundled price, but for the remaining 3, researchers needed to have separate discussions with the hospital and doctor before finding the total cost.[22] Overall, only 16 percent of randomly selected hospitals could give a complete, bundled price. Researchers also found that the estimated prices varied from about $10,000 to well over $100,000 at the selected hospitals.[23]

Additional challenges

Price transparency efforts must also navigate other obstacles, including legal barriers that protect industry stakeholders. For example, hospitals' contracts with insurers may contain gag clauses, which prevent the insurers from disclosing negotiated rates. Device manufacturers include similar prohibitions in their contracts with hospitals.[24] And in some states, these prices might be considered trade secrets, which could make some disclosures of this information unlawful.[25]

The health care market has become increasingly consolidated and has very high barriers to entry. Therefore, reforms must also protect against the possibility that these efforts at transparency could raise prices as competitors become aware of each other's prices.[26] The U.S. Department of Justice, or DOJ, and the Federal Trade Commission, or FTC, have raised these concerns, stating in a 1996 joint opinion about price transparency in the health care industry that without appropriate safeguards, price transparency could result in providers colluding to set "mutually acceptable" prices.[27] Industry stakeholders repeatedly cite the possibility of collusion to create a useful straw man argument to oppose transparency.

But there are ways to mitigate any such risk, and this concern should not block necessary reforms. In their 1996 opinion, DOJ and FTC created an antitrust "safety zone," wherein price and cost information:

- Must be managed by a third party
- Must be at least 3 months old
- Must have a data collection with at least five providers contributing, with no individual provider's data accounting for more than 25 percent of the information[28]

These conditions were "intended to ensure that an exchange of price or cost data is not used by competing providers for discussion or coordination of provider prices or costs."[29]

These "safety zone" requirements are nearly two decades old, and since then there are new approaches to increase price transparency that can protect against collusion without the need for DOJ and FTC's strict conditions. For example, insurers could disclose price information only to their enrollees or to employers purchasing insurance for their employees. In both situations, price transparency can lead to selecting higher-value, lower-cost providers, but providers will not be able to directly compare their prices with their competitors. Providers could also publish average prices in highly concentrated areas,[30] although that would be less helpful for patients.

The last hurdle facing policymakers is the public's perception that higher costs mean higher quality. The health care market does not function like the markets for other consumer goods, and quality and price are not necessarily correlated.[31] When consumers review prices, they should also have access to quality information. Information such as mortality rates, complication rates, and average length of stay for common procedures are examples of the types of consumer-friendly quality indicators that should accompany price information.[32]

Current efforts to increase transparency

Despite these numerous challenges, policymakers at the state and federal levels have taken a variety of approaches to shine light on health care prices. Private-sector innovators are also actively engaged in this issue. These efforts vary in their scope and success—some focus on making information available to consumers, while others focus on disclosing more detailed health care data to employers, other health care payers, and health care researchers.

Federal efforts

Federal efforts to increase price transparency are slowly gaining momentum. Prior to the Affordable Care Act, there was some price and quality information available to Medicare beneficiaries. For example, beneficiaries can compare premium prices of prescription drug plans, and over the past decade, Medicare has slowly built its Compare websites, which include Hospital Compare, Physician Compare, and Nursing Home Compare. These websites allow beneficiaries to review quality rankings of hospitals, doctors, and other health care providers.[33]

The Affordable Care Act includes a limited number of new price transparency requirements. Insurers and other health care payers must disclose certain cost and quality information, including information on out-of-network cost-sharing, consumer rights, and claims payment policies.[34] Health care plans must also provide in-network cost-sharing information—including deductibles, copayment, and co-insurance—so that consumers can make informed decisions when selecting health care providers.[35] At a minimum, insurers and other plan sponsors must make this information available through a website while also offering another way for individuals without Internet access to find these materials.[36]

These new requirements offer promise for patients, but the Department of Health and Human Services has yet to focus enough attention on implementing these provisions. The department's regulations restate the language in the law, which is insufficient to ensure that consumers have access to this information.[37] Strong enforcement and more specific guidance on how plans should calculate cost-sharing amounts are also needed to ensure that information is timely, complete, and easy to understand.

HHS has made greater progress toward implementing other transparency initiatives aimed at sharing more technical data. This can help health care purchasers such as insurers and businesses, as well as health care researchers.

The Affordable Care Act's Medicare Data Sharing for Performance Measurement Program now allows the Centers for Medicare & Medicaid Services to disclose Medicare claims to qualified entities, which are public or private organizations that are approved by the secretary of health and human services to use claims data to evaluate provider performance. The groups that have received approval to participate in the program to date are regional and state organizations with significant experience working with large amounts of health care data.[38] These entities will then combine this information with data from other payers to allow them to more accurately evaluate quality and costs as well as to prepare public reports about providers' performance.[39]

Qualified entities must enter into a data-use agreement and pay a fee for the cost of providing the data, and the law places several other limits on the use of the data and how research using these data must be presented.[40] In addition to these limited disclosures of claims data, the ACA also requires hospitals to release and update their standard charges annually.[41]

Separate from the health reform law's requirements, the Centers for Medicare & Medicaid Services is taking additional steps to release Medicare data. In 2013, the agency released charge data for the 100 most common inpatient hospital services and 30 common outpatient hospital services for more than 3,000 hospitals.[42] Not surprisingly, the data showed significant variations between hospitals, even within the same area.[43] More recently, after a federal court lifted an injunction that previously prohibited Medicare from releasing information about the amount it pays to individual doctors, the agency decided to release these data on a case-by-case basis in response to requests for this information.[44]

State efforts

Federal efforts to increase price transparency are moving forward, but more reform is occurring at the state level. Thus far, 31 states have enacted price transparency legislation.[45] These state laws are not consistent, however, and in many states the publicly available information is not user-friendly.[46] For example, there are numerous patient-oriented, state-based websites, but most report only prices of inpatient care and fewer than 15 percent post quality data.[47] In addition, most states list only average prices or, even less helpful, charges.[48]

Massachusetts and New Hampshire, in comparison, have robust, consumer-friendly price transparency initiatives that differ from most other states' efforts in a number of critical ways. New Hampshire's public website displays the median, provider-specific price for a procedure—taking into account negotiated discounts—for each commercial insurer.[49] The website's cost information is organized by service, geographic location, the insurance plan type, and cost-sharing information.[50] This approach is not perfect—it lists only median prices as negotiated by the insurers, not an individual's out-of-pocket costs—but it is still a valuable tool for consumers, providers, and employers.

Massachusetts' law takes a slightly different approach; the state requires insurers and health plan administrators to offer consumers provider-specific estimates of their out-of-pocket costs for specific hospital stays or procedures.[51] These prices, like those posted on New Hampshire's website, include costs of both doctors and health care facilities, instead of discrete services. Importantly, these estimates are binding, unless the patient receives additional, unanticipated services.[52] The law also requires providers to give patients information that their insurer might need to calculate their out-of-pocket costs, and in-network providers must give patients information about how to access the website and toll-free number.

In addition to these consumer-focused requirements, providers must also disclose their estimated charges. And the law includes other initiatives aimed at studying prices and increasing access to quality and cost data—an 18-member commission will study price variation, and all health care organizations must submit annual cost and quality data to the commission. A public website will then list data about the relative costs of different providers.

Massachusetts and New Hampshire are also two of a growing number of states that combine data from all payers into an all-payer claims database.[53] All-payer claims databases generally collect medical claims, pharmacy claims, and dental claims, as well as additional information about the provider and patient demographics from most public payers—including Medicare and Medicaid—and private payers.[54] These collections are large enough to allow policymakers and health care payers to consider quality, utilization, and cost trends across the health care system, a significant change from the fragmented data sets that these groups have typically relied upon in the past. Although the raw data in these collections are not immediately understandable to patients, their contents allow health care payers and policymakers to evaluate cost and quality, which ultimately benefit patients.[55]

Legislation

Pending federal legislation would expand federal initiatives and require states to do more to encourage transparency. The bipartisan Medicare Data Access for Transparency and Accountability Act would require the secretary of health and human services to disclose all Medicare claims and payment data in a searchable format.[56]

The bipartisan SGR[57] Repeal and Medicare Provider Payment Modernization Act includes a section that would expand access to Medicare claims data by requiring the secretary to include utilization and payment data for physicians and other health care professionals on Medicare's Physician Compare website.[58] This information would be searchable and include the number of services provided, as well as provider-submitted charges and payments.[59]

This legislation would also modify the Medicare Data Sharing for Performance Measurement Program's qualified entity program in a number of ways, most importantly by allowing entities to provide or sell nonpublic analyses and claims data to third parties, including providers, insurers, and in certain cases, to self-insured employers. And the proposal would also allow qualified clinical data registries to access claims data.[60]

Other proposals would require greater transparency by hospitals, other health care providers, and insurers, although the specifics vary. For example, the Health Care Price Transparency Promotion Act would require states to have in place laws that compel hospitals to disclose the price of certain procedures and compel insurers to provide enrollees with information about their estimated out-of-pocket costs for those services. But this proposal explicitly allows insurers to charge patients with higher cost-sharing after the fact and includes only limited hospital-based services.[61]

The Hospital Price Transparency and Disclosure Act requires reporting by hospitals and ambulatory surgery centers to HHS on the frequency of certain procedures and the average charges for both insured and uninsured patients. The secretary would then post this information online along with quality data.[62] This link between cost and quality is very helpful, although a patient's specific costs will vary from the posted averages.

Private initiatives

With only piecemeal, targeted federal and state price transparency efforts in place, some private businesses have tried to fill this gap. A few insurers—in part due to interest from employers—have set up websites for their customers to compare prices between different providers.[63] For example, both Aetna and Anthem offer their members price information that reflects the insurers' negotiated discounts with providers. These insurers hope that publishing this information will encourage patients to seek out higher value providers.[64]

New businesses are also entering this space. For example, Castlight Health of San Francisco uses claims and other data to create pricing information for their employer-customers, including customized information about the employers' benefits, provider network, and cost-sharing requirements.[65] Employees can then log on to the website to find personalized information about their costs.[66] Other companies offer consumers more general cost information such as average prices for insured patients for different procedures, tests, and medications in a particular area.[67]

Businesses are also tackling secrecy in other parts of the health care system. One example is MedPassage, which allows hospitals to shop for medical devices without allowing the device companies access to their competitors' information.[68] The company estimates that hospitals have saved between 30 percent to 60 percent by comparing prices.[69]

Recommendations to improve price transparency

These public and private efforts should serve as a starting point for additional reforms. For patient-level transparency, the focus must be on making price information more accessible and understandable for patients. The three keys to patient-level price transparency are:

- Providing full-episode costs with patient-specific, out-of-pocket costs
- Offering a guarantee of the price so the estimate is meaningful
- Including quality data

Policymakers must also develop ways to educate patients about how to use this information and to combat patient assumptions that higher costs necessarily mean higher quality. Combining quality and price data to inform patients of overall value should help these efforts. Unless public perception changes, price information will not necessarily drive consumers toward lower-cost, higher-value providers.

Setting standards for making sure that patients can easily shop for and compare insurance plans and providers based on value is critical, but it is not sufficient to lower costs. Transparency at other points in the health care system is also necessary.

Administrative actions to increase transparency

As a starting point, there are reforms the Department of Health and Human Services can adopt without any changes to existing law.

First, HHS must focus greater resources on implementing the Affordable Care Act requirement that insurers provide cost-sharing information, including the amount that the individual would pay for a specific item and service by in-network providers. HHS should do the following:

- Require information be presented in such a way that patients can view their out-of-pocket costs for an entire episode of care.
- Require standardized definitions for an episode of care and other terms necessary for consumers to understand their out-of-pocket costs for easier comparisons.
- Require easy access to information about provider networks and covered medications to make cost-sharing information meaningful.

Second, HHS should encourage the development of statewide, all-payer claims databases. Analyses of the information included in these systems can inform states' provider network decisions and payment rates, and hopefully will result in policies that drive consumers towards higher-value providers. State regulators can also use this data to assist in rate review to keep premiums lower.

The Center for Medicare & Medicaid Innovation should offer states grants to help build databases that include Medicare data. This funding should be contingent upon states agreeing to use this information in their efforts to reform their payment and delivery systems and to improve price transparency, and to test whether these efforts can help lower Medicare and Medicaid costs and improve quality. States using these funds should also collect data in a consistent and timely manner to help lower administrative costs for those using these systems.

Legislative actions to increase transparency

Parallel to these administrative actions, federal and state legislators should establish the following minimum requirements for price transparency:

- The Affordable Care Act's cost-sharing disclosure requirements should be modified so that the plan's quoted costs for episodes of care are guaranteed, unless the patient receives additional, unanticipated services.
- Insurers' provider directories should include rankings of higher-value providers to encourage patients to seek out their services.
- Hospitals and other institutional health care providers should provide uninsured and out-of-network patients with episode-based costs, which would also be guaranteed. Providers should also give consumers instructions on how to access relevant quality information.

Federal law should also authorize greater dissemination of Medicare claims information. The price transparency sections of the SGR Repeal and Medicare Provider Payment Modernization Act legislation are a promising start.

Including price and utilization information on Medicare's Compare websites in a consumer-friendly, searchable format is an important change. Once this information is included in all of the Compare websites, the websites' star rating systems should include an overall "value" score for each health care provider, calculated using both quality and price data.

The Medicare Data Sharing for Performance Measurement Program's qualified entity program should also be dramatically expanded to allow more researchers, policymakers, providers, insurers, and self-insured employers access to the detailed, granular levels of data—such as provider-level procedure codes and diagnosis codes—that would not be helpful to include in Medicare's Compare websites or other consumer-focused websites. Restrictions on how researchers may analyze this data, including the requirement that Medicare claims data be aggregated with other claims data, should be lifted to allow for greater research flexibility.[70]

Lastly, federal law should also increase price transparency in the device industry. As MedPassage and similar models show, it is possible to design a system that allows for comparison shopping between products without revealing prices to competitors. Device manufacturers should submit their average prices for implantable devices—in addition to other devices selected by the secretary of health and human services—to the Centers for Medicare & Medicaid Services or a third-party contractor. Hospitals and physicians could then view this information through a restricted website. Website users would agree to keep this information confidential and not disclose prices to outside parties.

Past legislation would have required similar disclosures, but the Centers for Medicare & Medicaid Services would have then publicly posted the information. Keeping the information confidential would address the industry's claims about possible collusion. Federal law should also prohibit device manufacturers from restricting how hospitals may share device prices with physicians who practice in their facilities.

Conclusion

The past year has brought increased focus on the role that excessive prices play in keeping our nation's health care costs so high. The Obama administration should respond by taking specific, meaningful steps to increase price transparency, starting with more vigorous implementation of the Affordable Care Act's transparency provisions. Moreover, growing bipartisan interest in increasing price transparency presents an uncommon opportunity to adopt additional consumer-friendly reforms that will lower health care prices. The proposals in this report outline specific steps that both the Obama administration and lawmakers can take that will advance price transparency and increase value throughout the health care system.

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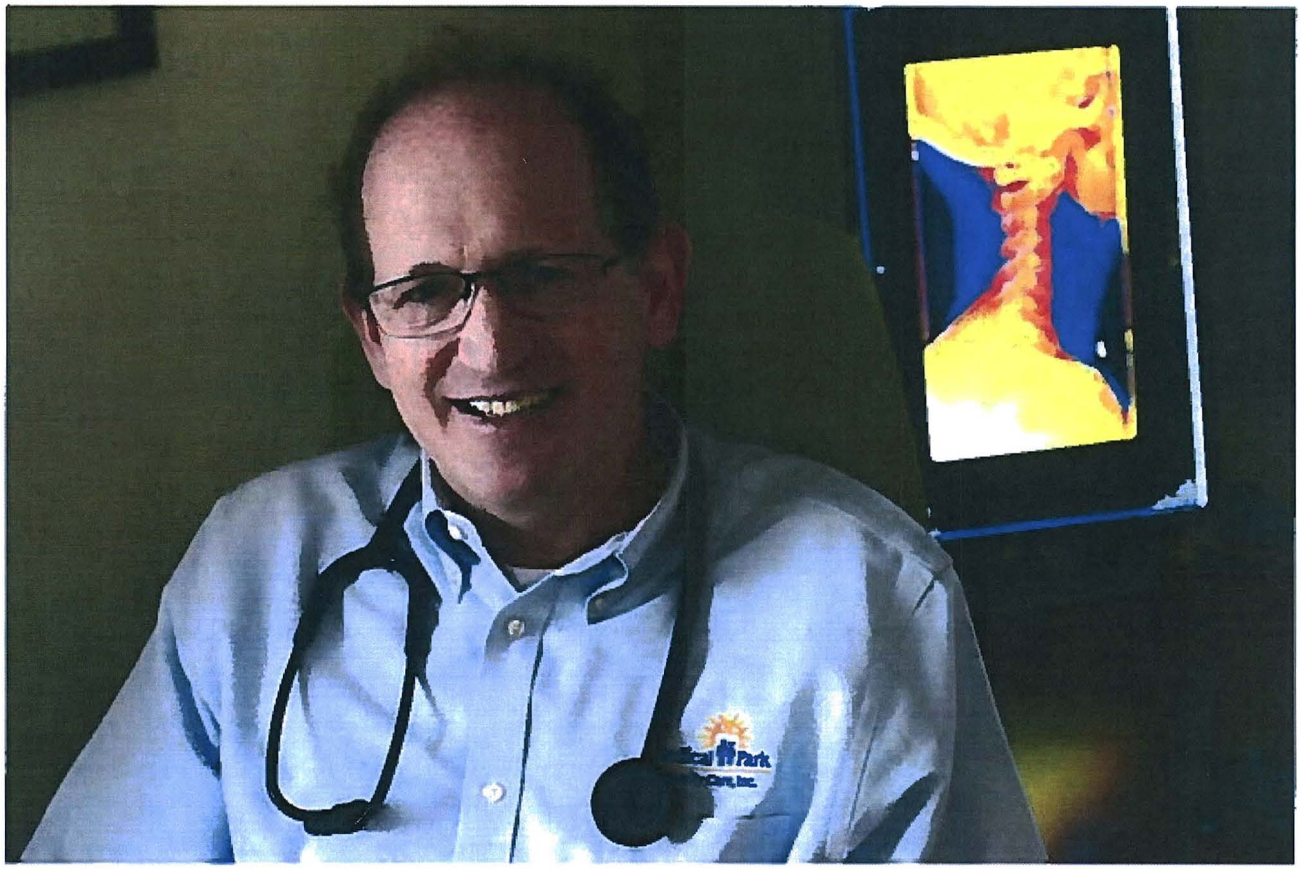
70 The administration's fiscal year 2015 budget would remove some of these restrictions. See U.S. Department of Health and Human Services, "Fiscal Year 2015 Budget in Brief" (2014), available at http://www.hhs.gov/budget/fy2015/fy-2015-budget-in-brief.pdf.

Office of Rep. Ivy Spohnholz

Opinions

A doctor's quest to remain human inside an insane medical system

Author: Charles Wohlforth Updated: August 15, 2016 Published August 13, 2016



Dr. Noah Laufer is president of Medical Park Family Care, Inc. (Erik Hill / Alaska Dispatch News)

When I wrote about Alaska's extreme health care costs last week, I received more than two dozen emails from readers with their own horror stories about encounters with the system's weirdness. Many of them were doctors.

"For a patient, it's a couple of times a year. For us it's all the time," said Dr. T. Noah Laufer, president of Medical Park Family Care.

Besides taking care of patients, his real love, Laufer runs a small business with more than 70 employees. A business that never knows how much it will be paid for the services it provides.

[How health care costs are bleeding Alaska dry]

Other small businesses set prices, sell services based on those prices and then collect those fees. But for doctors such as Laufer, each patient visit is just the beginning of a huge paperwork exercise, often with a back-and-forth war of attrition with health insurance employees that ends with an arbitrary amount of payment.

"They make their money off us with a million and one petty ways to deny payment," Laufer said. And this daily battlefield has gone digital. "We use computers to meet their deliberate befuddling techniques," he said.

Medicare, for the elderly, pays the least. Medical Park Family Care still sees patients after they turn 65 but won't take elders as new patients because the clinic loses money on each visit. Medicaid usually pays break-even fees, Laufer said. Private insurance pays the most, although each company pays a different amount.

As for people who have to pay on their own, Laufer said the doctors try to work something out. They have long-term relationships with their family practice patients and try to be aware of their financial issues.

But generally in our system, those who don't have insurance are charged the highest prices, as much as 10 times what a hospital or medical practice would receive from an insurance company or the government. A doctor (not Laufer) told me prices usually are set to exceed the maximum amount they could hope to get from insurance, knowing each charge will be marked down.

This is a key flaw in our health care system. It's not just that the prices are unknown. The prices are fantasies. A crazy tangle of laws, programs and companies determines different payment for each person for each procedure according to an invisible logic that no one understands. The linkage of cost to price is gone.

The forces that make markets work — supply and demand, competition and price transparency — don't exist here. For doctors with their own practices, it's a strange world in which to work. You can't make a normal business plan. Laufer doesn't know the percentage of bills that are paid. He just hopes the numbers magically work out at the end of the month.

The clinic can't afford health insurance for its own employees. Like many other small businesses, it self-insures, with a policy for catastrophes, and has sometimes faced massive losses for major illnesses of its workers.

Laufer emphasized that he doesn't want anyone to feel sorry for him. He loves being a doctor and makes an upper-middle-class income. But he chose his career because he loves caring for people, and the system threatens that.

The clinic's doctors could work for a big company. Laufer said a hospital has expressed interest in taking over. A typical family practice doctor steers some $20 million worth of business a year through his or her decisions, a rich source of billings for a hospital. But the doctors don't want to work for a big company. They like working for their patients.

"It's not about economics," Laufer said. "It's being able to have autonomy and do what's right."

Laufer grew up in the practice he now runs, in a brown concrete block building among the birch trees at Lake Otis Parkway and Northern Lights Boulevard in Anchorage. His father was one of the original doctors there in the early 1970s. As a boy, Laufer went into exam rooms and watched doctors helping people.

He especially remembers being 6 or 7 years old and accompanying his father on a house call to an old man who was dying — and who did die. But he died well because Laufer's father was there.

Laufer met his wife, Michelle, in medical school, and together they accumulated $480,000 in student loans, which they paid off only after Noah was 48 years old. The money came partly from patients at Medical Park transferred from doctors who had once treated him like a son — patients the older doctors didn't want to give to anyone else before retiring.

Family practice doctors make among the lowest incomes of any specialty. Laufer's office shows evidence of that, with old, unmatched carpet and well-worn furniture, not at all like the granite counter tops and frosted glass I saw at an orthopedics office.

But the satisfaction makes up for it. Laufer knows 85 percent of his patients well. He tries to know their whole families. He said his success or failure can't be judged without looking at the health of the generation that follows the patients he cares for.

The best medical visits happen when a provider sizes you up by how you look — he or she knows you that well. And tells you you'll be OK. Most of the time, people get better without medicine. Laufer and his colleagues like sending patients home without a prescription, even though there's no money in it.

They're a dying breed. The health care system is a voracious money machine made of huge companies and massive bureaucracies.

Human beings left alone have caring impulses. Laufer and his colleagues are trying to give their lives to the sick and, while making comfortable incomes, not get rich. We've built a system that is making that close to impossible.

Whatever the solution is, we need to return to the roots of why we care for one another. I'll keep that in mind as I search for answers over my future columns on health care.

The views expressed here are the writer's and are not necessarily endorsed by Alaska Dispatch News, which welcomes a broad range of viewpoints. To submit a piece for consideration, email

commentary@alaskadispatch.com. Send submissions shorter than 200 words to letters@alaskadispatch.com or click here to submit via any web browser.

About this Author

Charles Wohlforth

Charles Wohlforth's column appears three times weekly. A lifelong Anchorage resident, he is the author of more than 10 books, and hosts radio shows on Alaska Public Media. More at wohlforth.com.

97 Comments

WHITE PAPER

SAVE $36 BILLION IN U.S. HEALTHCARE SPENDING THROUGH PRICE TRANSPARENCY

BOBBI COLUNI, SENIOR DIRECTOR, CONSUMER INNOVATIONS

FEBRUARY 2012

THOMSON REUTERS™

TABLE OF CONTENTS

INTRODUCTION

Healthcare in the United States is a $2 trillion industry that accounts for 17 percent of the Gross Domestic Product (GDP).[1] Healthcare spending continues to increase at a rate of nearly 10 percent annually. By 2020, experts estimate that it will grow to consume 21 percent of GDP.[2]

Finding ways to better manage healthcare spending is critical to the nation's financial future and its ability to remain competitive. Recent changes to healthcare benefits, including the opportunity for consumers to exercise more choice in selecting providers and treatments, have the potential to help reduce costs. Yet despite the choices available, consumers often lack information vital to making informed decisions about their healthcare.

Price transparency is one area where information is especially lacking. Studies show that healthcare costs for the same procedure in the same market can vary by more than 100 percent. Providing consumers with clear, comparative information on the cost of services is key to further engaging them in the decision-making process and, ultimately, reducing healthcare costs.

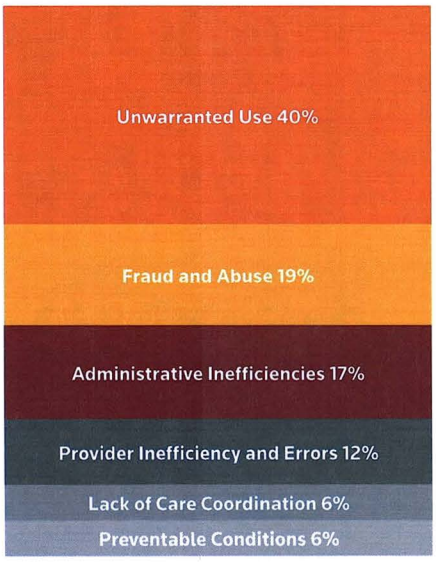
This white paper explores how reducing price variation for the 108 million Americans with employer-sponsored insurance could save the nation as much as $36 billion per year.[3] It also draws on Thomson Reuters research findings and respected literature in the field to identify key issues surrounding price transparency and offers eight best practices for implementing successful price transparency initiatives.

EXPLORING THE RADICAL VARIATION IN HEALTHCARE PRICING

Much has been written about healthcare waste in the United States. The facts, as outlined in the chart below, tell a powerful story. The bottom line is, if the United States does not better control healthcare expenditures, system waste could reach $1.6 trillion by 2020 — doubling in just 10 years.[4]

FIGURE 1: The High Cost of Healthcare Waste

	Cost in Billions
1. Unwarranted Use	$250-325
2. Fraud and Abuse	$125-175
3. Administrative Inefficiencies	$100-150
4. Provider Inefficiency and Errors	$75-100
5. Lack of Care Coordination	$25-50
6. Preventable Conditions	$25-50
	$600-850



Source: Where Can $700 Billion in Waste Be Cut Annually From the U.S. Healthcare System?, Thomson Reuters, 2009

One specific factor driving the high cost of healthcare is the significant price variation — sometimes more than 100 percent — for the same healthcare services in the same geographic market. This topic has been well-documented. An annual survey of healthcare costs in Massachusetts found that prices paid for the same hospital and professional services vary significantly and cited a three- to six-fold price difference. The most striking finding was that if prices for hospital inpatient and professional services were narrowed to the range spanning prices in the 20th to 80th percentile, the potential savings were more than $265 million.[5]

The chart below clearly illustrates the broad range of prices paid for different services in the Detroit metropolitan area. Broad variances such as these reinforce the importance of providing consumers with access to pricing information specific to their benefits and location, so they can make informed decisions about their care.

FIGURE 2: Shopping Comes to Healthcare

What people are paying

Here are six examples of the cost of procedures at area hospitals. The **typical maximum** is what the hospital gets from cash-paying customers or ones with smaller insurance companies. The **typical minimum** is the discounted price the area's largest insurers pay. Price may vary widely for many reasons, including labor costs, volume of free care, new technology and other factors.

Hospital (grouped by affiliation)	Typical minimum cost	Typical maximum cost
MRI OF THE SPINE		
St. John Providence Health Detroit-Warren-Southfield	$905	$1,106
Beaumont Hospitals Grosse Pointe-Royal Oak-Troy	$905	$1,106
Henry Ford Hospital Detroit	$1,509	$1,710
Henry Ford Hospital Warren	$1,106	$1,308
Henry Ford Hospital Macomb	$1,308	$1,509
Children's Hospital of Mich.	$1,106	$1,308
Harper/Hutzel Women's Hosp.	$1,106	$1,308
Karmanos Cancer Institute	$1,509	$1,710
Sinai-Grace Hospital	$905	$1,106
SCREENING COLONOSCOPY		
St. John Providence Health Detroit-Macomb-Southfield	$860	$1,051
Beaumont Hospitals Grosse Pointe-Royal Oak-Troy	$860	$1,051
Henry Ford Hospital Detroit	$1,433	$1,625
Henry Ford Hospital Warren	$1,051	$1,242
Henry Ford Hospital Macomb	$1,051	$1,242
Harper/Hutzel Women's Hosp.	$860	$1,051
Karmanos Cancer Institute	$1,051	$1,242
Sinai-Grace Hospital	$860	$1,051
NASAL/SINUS ENDOSCOPY/SURGERY		
St. John Providence Health Detroit-St. Clair Shores-Southfield	$1,757	$2,147
Beaumont Hospitals Grosse Pointe-Royal Oak-Troy	$1,757	$2,147
Henry Ford Hospital Detroit	$2,928	$3,318
Children's Hospital of Mich.	$2,147	$2,537
LEFT HEART CATHERIZATION		
St. John Hospital Detroit	$3,107	$3,672
St. John Providence Health Macomb-Southfield	$3,672	$4,237
Beaumont Hospital Royal Oak	$3,107	$3,672
Beaumont Hospital Troy	$2,542	$3,107
Henry Ford Hospital Detroit	$2,542	$3,107
Henry Ford Hospital Warren	$1,977	$2,542
Henry Ford Hospital Macomb	$2,542	$3,107
Harper/Hutzel Women's Hosp.	$3,107	$3,672
Sinai-Grace Hospital	$2,542	$3,107
BREAST LUMPECTOMY		
St. John Hospital Detroit	$1,727	$2,110
St. John Providence Health Warren-St. Clair Shores-Southfield	$1,343	$1,727
Beaumont Hospitals Royal Oak-Troy	$1,343	$1,727
Henry Ford Hospitals Detroit	$2,494	$2,878
Harper/Hutzel Women's Hosp.	$1,727	$2,110
Karmanos Cancer Institute	$2,110	$2,494
C-SECTION DELIVERY		
St. John Providence Health Detroit-Warren-Southfield	$9,619	$11,757
Beaumont Hospitals Grosse Pt.	$11,757	$13,894
Beaumont Hospitals Royal Oak-Troy	$7,481	$9,619
Henry Ford Hospital Detroit	$11,757	$13,894
Henry Ford Hospital Macomb	$7,481	$9,619
Sinai-Grace Hospital	$13,894	$16,032

Source: *Detroit Free Press*, March 4, 2011

Service Sites Impact Costs

When it comes to outpatient procedures, the location where services are rendered — physician's office, ambulatory care facility, or hospital outpatient facility — can dramatically impact the cost. The total cost of procedures performed in a physician's office or an ambulatory care facility is typically much lower than those accrued in a hospital outpatient site.

The degree to which services are delivered in office settings varies geographically. Recent data from a large New York health insurer show that 85 percent of colonoscopies (about 26,000 procedures) for metro New York consumers were performed in physicians' offices. The cost for these procedures averaged $450 each, with no additional facility fee. In contrast, a Chicago insurer found that 78 percent of its colonoscopy procedures were performed in hospital outpatient facilities. While the average physician fee for this service was just $330, the facility charge for each procedure ranged from $2,000 to $6,000.[6] Thus even though the professional fee was $120 more expensive in New York, the total cost for Chicago consumers was dramatically higher due to the facility component of the charge.

Fiscal Note

State of Alaska
2017 Legislative Session

Bill Version: HB 123
Fiscal Note Number:
() Publish Date:

Identifier: HB123-DHSS-BVS-2-24-17
Title: DISCLOSURE OF HEALTH CARE COSTS
Sponsor: SPOHNHOLZ
Requester: (H) HSS

Department: Department of Health and Social Services
Appropriation: Public Health
Allocation: Bureau of Vital Statistics
OMB Component Number: 961

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2018 Appropriation Requested	Included in Governor's FY2018 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2018**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Fund Source (Operating Only)

None							
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Positions

Full-time							
Part-time							
Temporary							

Change in Revenues

None							
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimated SUPPLEMENTAL (FY2017) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2018) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? Yes
If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/19

Why this fiscal note differs from previous version:

Not applicable; initial version.

Prepared By: Jay C. Butler, MD, Chief Medical Officer/Director Phone: (907)269-6680
Division: Public Health Date: 02/23/2017 12:00 PM
Approved By: Shawnda O'Brien, Asst. Commissioner Date: 02/24/17
Agency: Health and Social Services

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2017 LEGISLATIVE SESSION

BILL NO. HB123

Analysis

House Bill 123 requires healthcare providers and facilities to compile an annual list of the undiscounted price of the most common healthcare procedures and diagnosis codes performed in person or by telehealth. The reporting entities are required to report these annual lists to the Department of Health and Social Services and post them in their offices and on their websites. The Department is required to compile these reports in a database, and post them on its website. Failure to comply is a civil penalty of $50 to $2,500 applied per day of late reporting. These changes would be effective January 1, 2018.

The Health Analytics and Vital Records Section of the department would be responsible for implementing the health care services and price information bill. The department would have to build and staff a new database to compile the provider (and possibly the facility) lists and create a webpage to post the information. If the intent is for a simple webpage despository of the facilities' and providers' lists in PDF format, then the cost of the website and the staff time to post the lists can be absorbed by the section, and does not require an appropriation. Estimated staff time to maintain and post the lists would be negligible, and could be absorbed within current resources. This is on the understanding that the department is not being asked to collect, analyze, or otherwise maintain data and information contained in these lists, and that the lists would be posted as-is when received from the facility or provider.

Additionally, the department would need regulations to establish reporting guidelines, and prescribe the format and submission process. This will ensure file compatibility and uniformity in order to streamline the posting process and minimize administrative burden on the reporting entities and the department. Regulations are expected to be in place July 1, 2019.

30-LS0380\T
Glover
3/9/17

CS FOR HOUSE BILL NO. 123( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTIETH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES SPOHNHOLZ, Tuck, Drummond, Parish, Gara, Tarr

A BILL

FOR AN ACT ENTITLED

"An Act relating to disclosure of health care services and price information; and providing for an effective date."

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

*** Section 1.** AS 18.15.360(a) is amended to read:

(a) The department is authorized to collect, analyze, and maintain databases of information related to

(1) risk factors identified for conditions of public health importance;

(2) morbidity and mortality rates for conditions of public health importance;

(3) community indicators relevant to conditions of public health importance;

(4) longitudinal data on traumatic or acquired brain injury from the registry established under AS 47.80.500(c)(1); [AND]

(5) **health care services and price information collected under**

AS 18.23.400; and

(6) any other data needed to accomplish or further the mission or goals of public health or provide essential public health services and functions.

*** Sec. 2.** AS 18.23 is amended by adding a new section to read:

Article 4. Health Care Services and Price Information.

Sec. 18.23.400. Disclosure and reporting of health care services and price information. (a) A health care provider shall annually compile a list, by procedure code, including a brief description, in plain language that an individual with no medical training can understand, of the 25 health care services most commonly performed by the provider in the state in the previous calendar year and the undiscounted price charged for each of those health care services.

(b) A health care facility in the state shall annually compile a list, by procedure code, including a brief description, in plain language that an individual with no medical training can understand, of the 50 health care services most commonly performed at the facility in the previous calendar year and the undiscounted price charged for each of those health care services.

(c) A health care provider and health care facility shall publish the lists compiled under (a) and (b) of this section by January 31 each year

(1) by providing the list to the department for entry in the department's database under AS 18.15.360;

(2) by posting a copy of the list in a conspicuous public reception area at the health care provider's office or health care facility where the services are performed; and

(3) if the health care provider or facility has an Internet website, by posting the list on the website.

(d) A health care provider or health care facility may include a statement with a list published under (c) of this section explaining that the undiscounted price may be higher or lower than the amount an individual actually pays for the health care services described in the list.

(e) The department shall compile and annually update the lists provided under (a) and (b) of this section by health care service and, where relevant, provider and

health care facility name and location, and post the information on the department's Internet website and enter the information in the database maintained under AS 18.15.360.

(f) If a health care provider performs fewer than 25 health care services in the state or fewer than 50 health care services are performed at a health care facility in the state in the annual reporting period under this section, the provider or facility shall provide a list of all of the health care services performed by the provider or at the facility.

(g) A health care provider or health care facility that fails to comply with the requirements of this section is liable for a civil penalty. The department may impose a civil penalty of not more than $50 for each day after March 31 that a health care provider or health care facility fails to provide and post information as required under (c) of this section. The total penalty may not exceed $2,500. A person penalized under this subsection is entitled to a hearing conducted by the office of administrative hearings under AS 44.64.

(h) In this section,

(1) "department" means the Department of Health and Social Services;

(2) "health care facility" means a private, municipal, or state hospital, psychiatric hospital, independent diagnostic testing facility, residential psychiatric treatment center as defined in AS 47.32.900, kidney disease treatment center (including freestanding hemodialysis units), the offices of private physicians or dentists whether in individual or group practice; ambulatory surgical center as defined in AS 47.32.900, free-standing birth center as defined in AS 47.32.900, and rural health clinic as defined in AS 47.32.900; "health care facility" does not include

(A) the Alaska Pioneers' Home and the Alaska Veterans' Home administered by the department under AS 47.55;

(B) an assisted living home as defined in AS 47.33.990;

(C) a nursing facility licensed by the department to provide long-term care;

(D) a facility operated by an Alaska tribal health organization; and

(E) a hospital operated by the United States Department of Veterans Affairs or the United States Department of Defense, or any other federally operated hospital or institution;

(3) "health care provider" means an individual licensed, certified, or otherwise authorized or permitted by law to provide health care services in the ordinary course of business or practice of a profession;

(4) "health care service" means a service or procedure provided in person or remotely by telemedicine or other means by a health care provider or at a health care facility for the purpose of or incidental to the care, prevention, or treatment of a physical or mental illness or injury;

(5) "recipient" means an individual to whom health care services are provided in the state by a health care provider or at a health care facility;

(6) "third party" means a public or private entity, association, or organization that provides, by contract, agreement, or other arrangement, insurance, payment, price discount, or other benefit for all or a portion of the cost of health care services provided to a recipient; "third party" does not include a member of the recipient's immediate family;

(7) "undiscounted price" means the charges billed for services rendered without complications or exceptional circumstances; "undiscounted price" does not include a negotiated discount for in-network, out-of-network, or self-insured services rendered or the costs paid by a third party for those services.

*** Sec. 3.** This Act takes effect January 1, 2018.

Representative Ivy Spohnholz

House Health & Social Services Committee Chair

Serving House District 16: College Gate, Russian Jack, Nunaka Valley, & Reflection Lake
Committee Member: Education, Energy, Military & Veterans Affairs, Legislative Budget & Audit

Committee Substitute - Explanation of Changes

House Bill 123: Version O to Version T

"An Act relating to disclosure of health care services and price information; and providing for an effective date."

Section 2, subsections (a) and (b) states that health care facilities and providers will compile a list by **procedure code**.

We've also changed "including a brief and easily understandable description," to "**in plain language that an individual with no medical training can understand.**"

Line 23 we added "**and**" after "performed;"

Subsection (d) states that the health care provider or facility may add a disclaimer explaining that what the consumer pays may be higher or lower than the amount listed.

Subsection (g) states that if the individual is fined and wants to appeal, the individual is entitled to a hearing conducted by the office of administrative hearings.

In Subsection (h), the definition of health care facility does not include federal health a facility operated by an Alaska tribal health organization or a hospital operated by the United States Department of Veterans Affairs or the United States Department of Defense, or any other federally operated hospital or facility.

Subsection (h), number (7) – undiscounted price is defined.

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