

HB

123

<TARGET><BILL>HB 123</BILL><SUBJECT>HB
123</SUBJECT><COMM>SHSS30</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.

¹ 2011 (State of Alaska Health Care Commission 2011 Annual Report)

² 2012 (Truven Health Analytics)

Session (January-April):
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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 26-29) states that the health care facility may include statement with their price list that the undiscounted prices may be higher or lower than the amount the individual will pay for their health care service.

Subsection (e) (p. 2, line 30, p. 3, lines 1-3) 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 (f) (p. 3, lines 4-8) 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

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facility will compile a list of all of the health care services and procedures performed by the provider or facility.

Subsection (g) (p. 3, lines 9-15) 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. The person penalized will be entitled to a hearing conducted by the office of administrative hearings.

Subsection (h) (p. 3, lines 16-31, p. 4, lines 1-21) goes over the definitions for department, health care facility, which excludes the Alaska Pioneers' Home and the Alaska Veterans' Home, an assisted living home, a long-term care nursing facility licensed by the department, a facility operated by an Alaska tribal health organization, and a hospital operated by the United States Department of Veterans Affairs, the United States Department of Defense, or any other federal institution. Health care provider and health care service are also defined, as well as undiscounted 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.

Fiscal Note

State of Alaska
2018 Legislative Session

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

Identifier: **HB123CS(HSS)-DHSS-BVS-3-6-18**
Title: DISCLOSURE OF HEALTH CARE COSTS
Sponsor: SPOHNHOLZ
Requester: Senate 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)

	FY2019	Included in	Out-Year Cost Estimates				
	Appropriation Requested	Governor's FY2019 Request	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
OPERATING EXPENDITURES	FY 2019	FY 2019					
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 (FY2018) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2019) 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/comments:

Refreshed to SLA2018 form, updated bill version designator. No change to content.

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

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2018 LEGISLATIVE SESSION

BILL NO. CSHB123(HSS)

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.

Fiscal Note

State of Alaska
2017 Legislative Session

Bill Version:	CSHB 123(HSS)
Fiscal Note Number:	1
(H) Publish Date:	3/10/2017

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	Included in	Out-Year Cost Estimates				
	Appropriation Requested	Governor's FY2018 Request	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
OPERATING EXPENDITURES	FY 2018	FY 2018					
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

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.

SENATE COMMITTEE REPORT

DATE: 4/10/17

FURTHER: Judiciary

DATE TURNED
IN TO OFFICE: 4/5/18

Health and Social Services Committee considered CS FOR HOUSE BILL NO. 123(HSS)

HB 123-DISCLOSURE OF HEALTH CARE COSTS

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

and recommends:

- be replaced with SCS CS HB 123 (HSS) Same Title Technical Title Change New Title/SCR No. _____
- adopt previous SCS _____ (_____) Same Title Technical Title Change New Title/SCR No. _____
- attached amendment(s)
- adopt _____ Letter of Intent
- further referral to _____ Committee

Dept Abbr.	
ADM	LWF
CED	LAW
COR	LEG
EED	MVA
DEC	DNR
DFG	DPS
GOV	REV
DHS	DOT
AJS	UA

NEW FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #
DHS			✓	2

PREVIOUS FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #

APPROPRIATION - no fiscal note

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	Begich	✓			
	VanDyke	✓			
	Siessel	✓			
CHAIR:	Wilson	✓			

SENATE CONCURRENT RESOLUTION NO.
IN THE LEGISLATURE OF THE STATE OF ALASKA
THIRTIETH LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH AND SOCIAL SERVICES COMMITTEE

Introduced:
Referred:

A RESOLUTION

1 **Suspending Rules 24(c), 35, 41(b), and 42(e), Uniform Rules of the Alaska State**
2 **Legislature, concerning House Bill No. 123, relating to disclosure of health care services**
3 **and price information.**

4 **BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

5 That under Rule 54, Uniform Rules of the Alaska State Legislature, the provisions of
6 Rules 24(c), 35, 41(b), and 42(e), Uniform Rules of the Alaska State Legislature, regarding
7 changes to the title of a bill, are suspended in consideration of House Bill No. 123, relating to
8 disclosure of health care services and price information.

30-LS0380\G
Glover
2/13/18

SENATE CS FOR CS FOR HOUSE BILL NO. 123()

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTIETH LEGISLATURE - SECOND SESSION

BY

Offered:

Referred:

Sponsor(s): REPRESENTATIVES SPOHNHOLZ, Tuck, Drummond, Parish, Gara, Tarr, LeDoux, Wool,
Grenn, Birch, Josephson

A BILL

FOR AN ACT ENTITLED

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

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

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

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

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

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

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

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

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

1 **AS 18.23.400; and**

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

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

5 **Article 4. Health Care Services and Price Information.**

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

12 (1) the procedure code;

13 (2) the undiscounted price;

14 (3) any facility fees; and

15 (4) the payment rate established under AS 47.05 and AS 47.07 for the
16 medical assistance program.

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

21 (1) the procedure code;

22 (2) the undiscounted price;

23 (3) any facility fees; and

24 (4) the payment rate established under AS 47.05 and AS 47.07 for the
25 medical assistance program.

26 (c) If a health care provider performs fewer than 25 health care services in the
27 state or fewer than 50 health care services are performed at a health care facility in the
28 state in the annual reporting period under this section, the health care provider or
29 health care facility shall include in the list required under (a) or (b) of this section all
30 of the health care services performed by the health care provider or at the health care
31 facility.

1 (d) A health care provider who provides health care services at a health care
2 facility in a group practice is not required to compile and publish a list under (a) and
3 (e) of this section if

4 (1) the health care facility where the provider is in a group practice
5 compiles and publishes a list in compliance with (b) and (e) of this section; and

6 (2) the prices and fees that the provider charges are reflected in the list
7 compiled and published by the health care facility.

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

10 (1) by providing the list to the department for entry in the department's
11 database under AS 18.15.360 along with the name and location of the health care
12 provider or health care facility;

13 (2) by posting a copy of the list

14 (A) in a font not smaller than 20 points;

15 (B) in a conspicuous public reception area at the health care
16 provider's office or health care facility where the services are performed;

17 (C) that includes the address for the department's Internet
18 website;

19 (D) that may include a statement explaining that the
20 undiscounted price may be higher or lower than the amount an individual
21 actually pays for the health care services described in the list;

22 (E) that includes a statement substantially similar to the
23 following: "You will be provided with an estimate of the anticipated charges
24 for your nonemergency care upon request. Please do not hesitate to ask for
25 information."; and

26 (F) that lists any health care insurers with which the health care
27 provider or health care facility has a contract to provide health care services as
28 an in-network preferred provider; and

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

31 (f) The department shall annually compile the lists provided under (a) and (b)

1 of this section by health care service and, where relevant, health care provider and
 2 health care facility name and location, post the information on the department's
 3 Internet website, and enter the information in the database maintained under
 4 AS 18.15.360.

5 (g) If a patient who is receiving nonemergency health care services requests an
 6 estimate from a health care provider or health care facility of the reasonably
 7 anticipated charges for treating the patient's specific condition, the health care provider
 8 or health care facility

9 (1) shall provide a good faith estimate before the nonemergency health
 10 care services are provided and not later than 10 business days after receiving the
 11 request;

12 (2) shall provide the estimate in whichever of the following formats
 13 the patient requests: orally, in writing, or by electronic means; if the estimate is
 14 provided orally, the health care provider or health care facility shall keep a record of
 15 the estimate;

16 (3) is not required to disclose the charges for the total anticipated
 17 course of treatment for the patient, but if the estimate does not include charges for the
 18 total anticipated course of treatment, the estimate must include a statement explaining
 19 that the estimate only includes charges for a portion of the total anticipated course of
 20 treatment; and

21 (4) may provide an estimate that includes a reasonable range of
 22 charges for anticipated health care services if the charges for the services will vary
 23 significantly in response to conditions that the health care provider or health care
 24 facility cannot reasonably assess before providing the services.

25 (h) A good faith estimate required under (g)(1) of this section must include

26 (1) a brief description in plain language that an individual with no
 27 medical training can understand of the health care services, products, procedures, and
 28 supplies that are included in the estimate;

29 (2) a notice disclosing the health care provider's or health care facility's
 30 in-network or out-of-network status that is substantially similar to one of the following
 31 forms:

1 (A) "(Name of health care provider or health care facility) is a
2 contracted, in-network preferred provider for ONLY the following plan
3 networks: (list each network or state 'NONE. YOU MAY INCUR OUT-OF-
4 NETWORK CHARGES.');" ;

5 (B) "(Name of health care provider or health care facility) is a
6 contracted, in-network preferred provider for your insurance plan."; or

7 (C) "(Name of health care provider or health care facility) is
8 NOT a contracted, in-network preferred provider for your insurance plan.
9 YOU MAY INCUR OUT-OF-NETWORK CHARGES." ;

10 (3) the procedure code for each health care service included in the
11 estimate;

12 (4) any facility fees, along with an explanation of the facility fees; and

13 (5) the identity, or suspected identity, of any other person that may
14 charge the patient for a service, product, procedure, or supply in connection with the
15 health care services included in the estimate, along with an explanation of whether the
16 charges are included in the estimate.

17 (i) A health care provider or a health care facility that provides a good faith
18 estimate to a patient under (g) and (h) of this section is not liable for damages or other
19 relief if the estimate differs from the amount actually charged to the patient.

20 (j) The requirement for a health care facility to provide a good faith estimate
21 of reasonably anticipated charges for nonemergency health care services under
22 (e)(2)(E), (g), and (h) of this section does not apply to a health care facility that is an
23 emergency department.

24 (k) A health care provider or a health care facility that fails to comply with the
25 requirements of (a) - (e), (g), and (h) of this section is liable for a civil penalty not to
26 exceed \$5,000 for each violation. The department may impose a penalty,

27 (1) for failure to comply with (a) - (e) of this section, of not more than
28 \$100 for each day of noncompliance after March 31; or

29 (2) for failure to provide a good faith estimate under (g) and (h) of this
30 section, of not more than \$100 for each day of noncompliance.

31 (l) A health care provider or health care facility penalized under (k) of this

1 section is entitled to a hearing conducted by the office of administrative hearings
2 under AS 44.64.

3 (m) A municipality may not enact or enforce an ordinance that is inconsistent
4 with or imposes health care price or fee disclosure requirements in addition to the
5 requirements under this section or regulations adopted under this section.

6 (n) In this section,

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

8 (2) "facility fee" means a charge or fee billed by a health care provider
9 or health care facility that is in addition to fees billed for a health care provider's
10 professional services and is intended to cover building, electronic medical records
11 system, billing, and other administrative and operational expenses;

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

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

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

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

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

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

30 (4) "health care insurer" has the meaning given in AS 21.54.500;

31 (5) "health care provider" means an individual licensed, certified, or

1 otherwise authorized or permitted by law to provide health care services in the
2 ordinary course of business or practice of a profession;

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

7 (7) "nonemergency health care service" means a health care service
8 other than a health care service that is immediately necessary to prevent the death or
9 serious impairment of the health of the patient;

10 (8) "patient" means an individual to whom health care services are
11 provided in the state by a health care provider or at a health care facility;

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

17 (10) "undiscounted price" means an amount billed for a service
18 rendered without complications or exceptional circumstances; "undiscounted price"
19 does not include a negotiated discount for an in-network or out-of-network service
20 rendered or the cost paid by a third party for that service.

21 * **Sec. 3.** This Act takes effect January 1, 2019.

SENATE CS FOR CS FOR HOUSE BILL NO. 123(HSS)
IN THE LEGISLATURE OF THE STATE OF ALASKA
THIRTIETH LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): REPRESENTATIVES SPOHNHOLZ, Tuck, Drummond, Parish, Gara, Tarr, LeDoux, Wool, Grenn, Birch, Josephson

SENATOR Begich

A BILL

FOR AN ACT ENTITLED

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

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

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

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

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

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

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

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

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

1 AS 18.23.400; and

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

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

5 **Article 4. Health Care Services and Price Information.**

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

12 (1) the procedure code;

13 (2) the undiscounted price;

14 (3) any facility fees; and

15 (4) the payment rate established under AS 47.05 and AS 47.07 for the
16 medical assistance program.

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

21 (1) the procedure code;

22 (2) the undiscounted price;

23 (3) any facility fees; and

24 (4) the payment rate established under AS 47.05 and AS 47.07 for the
25 medical assistance program.

26 (c) If a health care provider performs fewer than 25 health care services in the
27 state or fewer than 50 health care services are performed at a health care facility in the
28 state in the annual reporting period under this section, the health care provider or
29 health care facility shall include in the list required under (a) or (b) of this section all
30 of the health care services performed by the health care provider or at the health care
31 facility.

1 (d) A health care provider who provides health care services at a health care
2 facility in a group practice is not required to compile and publish a list under (a) and
3 (e) of this section if

4 (1) the health care facility where the provider is in a group practice
5 compiles and publishes a list in compliance with (b) and (e) of this section; and

6 (2) the prices and fees that the provider charges are reflected in the list
7 compiled and published by the health care facility.

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

10 (1) by providing the list to the department for entry in the department's
11 database under AS 18.15.360 along with the name and location of the health care
12 provider or health care facility;

13 (2) by posting a copy of the list

14 (A) in a font not smaller than 20 points;

15 (B) in a conspicuous public reception area at the health care
16 provider's office or health care facility where the services are performed;

17 (C) that includes the address for the department's Internet
18 website;

19 (D) that may include a statement explaining that the
20 undiscounted price may be higher or lower than the amount an individual
21 actually pays for the health care services described in the list;

22 (E) that includes a statement substantially similar to the
23 following: "You will be provided with an estimate of the anticipated charges
24 for your nonemergency care upon request. Please do not hesitate to ask for
25 information."; and

26 (F) that lists any health care insurers with which the health care
27 provider or health care facility has a contract to provide health care services as
28 an in-network preferred provider; and

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

31 (f) The department shall annually compile the lists provided under (a) and (b)

1 of this section by health care service and, where relevant, health care provider and
2 health care facility name and location, post the information on the department's
3 Internet website, and enter the information in the database maintained under
4 AS 18.15.360.

5 (g) If a patient who is receiving nonemergency health care services requests an
6 estimate from a health care provider, health care facility, or health care insurer of the
7 reasonably anticipated charges for treating the patient's specific condition, the health
8 care provider or health care facility, or health care insurer

9 (1) shall provide a good faith estimate before the nonemergency health
10 care services are provided and not later than 10 business days after receiving the
11 request;

12 (2) shall provide the estimate in whichever of the following formats
13 the patient requests: orally, in writing, or by electronic means; if the estimate is
14 provided orally, the health care provider, health care facility, or health care insurer
15 shall keep a record of the estimate;

16 (3) is not required to disclose the charges for the total anticipated
17 course of treatment for the patient, but if the estimate does not include charges for the
18 total anticipated course of treatment, the estimate must include a statement explaining
19 that the estimate only includes charges for a portion of the total anticipated course of
20 treatment; and

21 (4) may provide an estimate that includes a reasonable range of
22 charges for anticipated health care services if the charges for the services will vary
23 significantly in response to conditions that the health care provider, health care
24 facility, or health care insurer cannot reasonably assess before the services are
25 provided.

26 (h) A good faith estimate required under (g)(1) of this section must include

27 (1) a brief description in plain language that an individual with no
28 medical training can understand of the health care services, products, procedures, and
29 supplies that are included in the estimate;

30 (2) a notice disclosing the health care provider's or health care facility's
31 in-network or out-of-network status that is substantially similar to one of the following

1 forms:

2 (A) "(Name of health care provider or health care facility) is a
3 contracted, in-network preferred provider for ONLY the following plan
4 networks: (list each network or state 'NONE. YOU MAY INCUR OUT-OF-
5 NETWORK CHARGES.');" ;

6 (B) "(Name of health care provider or health care facility) is a
7 contracted, in-network preferred provider for your insurance plan."; or

8 (C) "(Name of health care provider or health care facility) is
9 NOT a contracted, in-network preferred provider for your insurance plan.
10 YOU MAY INCUR OUT-OF-NETWORK CHARGES." ;

11 (3) the procedure code for each health care service included in the
12 estimate;

13 (4) any facility fees, along with an explanation of the facility fees; and

14 (5) the identity, or suspected identity, of any other person that may
15 charge the patient for a service, product, procedure, or supply in connection with the
16 health care services included in the estimate, along with an explanation of whether the
17 charges are included in the estimate.

18 (i) A health care provider, health care facility, or health care insurer that
19 provides a good faith estimate to a patient under (g) and (h) of this section is not liable
20 for damages or other relief if the estimate differs from the amount actually charged to
21 the patient.

22 (j) The requirement for a health care facility to provide a good faith estimate
23 of reasonably anticipated charges for nonemergency health care services under
24 (e)(2)(E), (g), and (h) of this section does not apply to a health care facility that is an
25 emergency department.

26 (k) A health care provider or a health care facility that fails to comply with the
27 requirements of (a) - (e), (g), and (h) of this section or a health care insurer that fails to
28 comply with the requirements of (g) and (h) of this section is liable for a civil penalty
29 not to exceed \$10,000 for each violation. The department may impose a penalty,

30 (1) for failure to comply with (a) - (e) of this section, of not more than
31 \$100 for each day of noncompliance after March 31; or

1 (2) for failure to provide a good faith estimate under (g) and (h) of this
2 section, of not more than \$100 for each day of noncompliance.

3 (l) A health care provider, health care facility, or health care insurer penalized
4 under (k) of this section is entitled to a hearing conducted by the office of
5 administrative hearings under AS 44.64.

6 (m) A municipality may not enact or enforce an ordinance that is inconsistent
7 with or imposes health care price or fee disclosure requirements in addition to the
8 requirements under this section or regulations adopted under this section.

9 (n) In this section,

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

11 (2) "facility fee" means a charge or fee billed by a health care provider
12 or health care facility that is in addition to fees billed for a health care provider's
13 professional services and is intended to cover building, electronic medical records
14 system, billing, and other administrative and operational expenses;

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

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

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

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

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

31 (4) "health care insurer" has the meaning given in AS 21.54.500;

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

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

8 (7) "nonemergency health care service" means a health care service
 9 other than a health care service that is immediately necessary to prevent the death or
 10 serious impairment of the health of the patient;

11 (8) "patient" means an individual to whom health care services are
 12 provided in the state by a health care provider or at a health care facility;

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

18 (10) "undiscounted price" means an amount billed for a service
 19 rendered without complications or exceptional circumstances; "undiscounted price"
 20 does not include a negotiated discount for an in-network or out-of-network service
 21 rendered or the cost paid by a third party for that service.

22 * **Sec. 3.** AS 21.96 is amended by adding a new section to read:

23 **Sec. 21.96.200. Good faith estimate.** Upon request of a covered person
 24 who is receiving nonemergency health care services, a health care insurer shall
 25 provide a good faith estimate of the amount of the reasonably anticipated charges for
 26 treating the patient's specific condition under AS 18.23.400(g) and (h).

27 * **Sec. 4.** The uncodified law of the State of Alaska is amended by adding a new section to
 28 read:

29 TRANSITION: REGULATIONS. The Department of Health and Social Services may
 30 adopt regulations necessary to implement the changes made by this Act. The regulations take
 31 effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the

1 law implemented by the regulation.

2 * **Sec. 5.** Section 4 of this Act takes effect immediately under AS 01.10.070(c).

3 * **Sec. 6.** Except as provided in sec. 5 if this Act, this Act takes effect January 1, 2019.



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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HB123 Disclosure of Health Care Costs

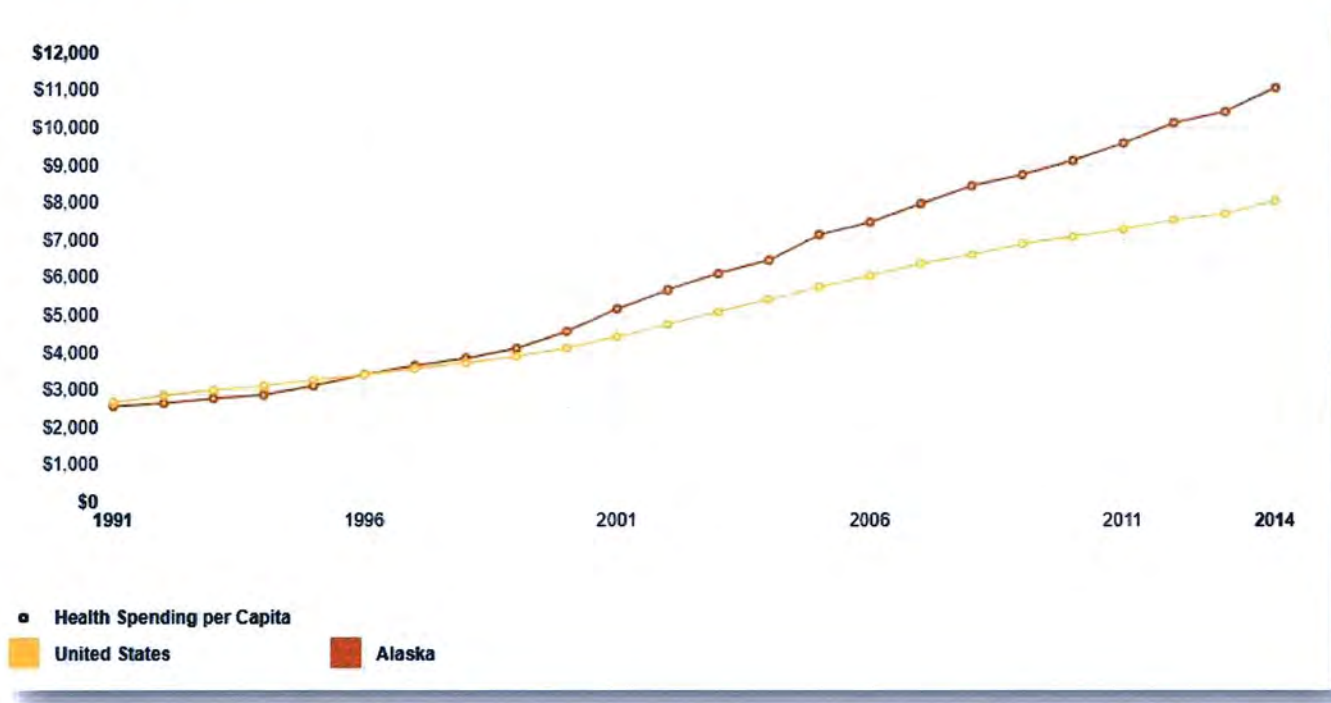
Representative Ivy Spohnholz

District 16

3/15/2018

1

Health Care Expenditures per Capita, 1991-2014



3/15/2018

3

Health care costs: What's happening in Alaska?

Medical specialist costs are 35 to 40% higher in Alaska than in the lower 48; hospital stays are 50% more expensive in Alaska.²

90% of the Anchorage School District's (ASD) budget is labor; employee compensation is the largest cost driver and this is all due to healthcare and group coverage costs.²

2013 study indicated that ASD cost increases have been because of health care; benefits are more than double the national median.¹

Alaska's health care costs are second highest in the nation. Only Washington DC is higher.

Health premiums for families have risen from 10% of the average Alaskan salary to 33% since 2001.¹



“How much does it cost?”

This question is so deeply integrated in the act of buying that consumers rarely have to ask because prices for services are ubiquitous.⁷

This is not so in health care.

Without transparency, consumers can't predict or plan whether their medical bill will be on the high or low end of the price spectrum.

Access to price information is needed to empower consumers to make informed choices about their health care.¹⁰

Transparency is the first step in reducing health care costs.

Price transparency will start the conversation on the cost of health care services.

3/15/2018

Price
Transparency:
Why is this
important?

6

30-LS0380\G

Explanation of Changes & Sectional Analysis

HB123:

Changes from (H)JUD CS v. I to (S)HSS CS v. G

Version I

1. Providers – **25 most common procedures** with **CPT code** and **undiscounted price**.
2. Facilities – **50 most common procedures** with **CPT code** and **undiscounted price**.
3. Price information will **be located in a reception area** and/or **website**.
4. Statement will be provided that explains the **price will be higher or lower than amount actually paid**.
5. **Dept. of Health & Social Services** will **compile** the information and **post** on their website.

Version G adds the following:

1. Providers and facilities will also provide **facility fees** and the **Medicaid payment rate**.
2. Price information will be in **font size no smaller than 20**.
3. **Good Faith Estimate (GFE) upon request including health care services, CPT codes, facility fees, and identity of others that may charge**.
4. In-network and out-of-network information will be displayed (post & GFE).
5. Increase in civil penalties: \$100/day, not to exceed \$5,000.

The Department of Health & Social Services (DHSS) currently collects information and maintains a database related to public health.

AS 18.15.360(a) has been amended to include health care services and price information.

3/15/2018

Section 1

AS 18.15.360(a)

9

- Subsection (a) – Providers will list 25 health care services most commonly performed.
- Subsection (b) – Facilities will list 50 health care services most commonly performed.
- Subsection (c) – if fewer than 25 or 50 health care services are performed, the provider or facility will list all of the health care services performed.
- The lists will include:
 - Procedure code
 - Undiscounted price
 - Medicaid price
 - Facility Fees

3/15/2018

Section 2

Article 4. Health Care Services and Price Information.

Sec. 18.23.400 Disclosure and reporting of health care services and price, and fee information.

10

- Subsection (d) – a provider working in a group practice is not required to post price information.
- Subsection (e) – a health care provider or facility will compile the information under (a) and (b) once a year by January 31st.
 - The list will be given to DHSS.
 - The posting of the price information will be in font size no smaller than 20.
 - “You will be provided with an estimate upon request.”
 - In-Network preferred providers will also be displayed.

3/15/2018

Section 2 (cont.)

Article 4. Health Care Services and Price Information.

Sec. 18.23.400 Disclosure and reporting of health care services and price, and fee information.

11

- Subsection (f) – DHSS will post this information once a year on their website.
- Subsection (g) – Good faith estimate (GFE):
 - A patient can request a GFE for **nonemergency health care services**.
 - No later than 10 days after receiving the request or by date of service is provided (if less than 10 days).
 - Can be received verbally, in writing, or by electronic means.

3/15/2018

Section 2 (cont.)

Article 4. Health Care Services and Price Information.

Sec. 18.23.400 Disclosure and reporting of health care services and price, and fee information.

12

■ Subsection (h) – the estimate must include:

- Description of procedures, services, products, supplies with procedure codes
- Facility fees
- Individualize charges
- Identity of others that my charge
- Prices
- Individual's in-network preferred provider and out-of-network providers.

3/16/2018

Section 2 (cont.)

Article 4. Health Care Services and Price Information.

Sec. 18.23.400 Disclosure and reporting of health care services and price, and fee information.

13

- Subsection (i) – Providers and facilities will not be liable for damages if the estimate is different from the amount charged.
- Subsection (j) – Emergency departments are not required to provide a GFE.
- Subsection (k) – Civil penalty after March 31st is \$100 a day, not to exceed \$5,000. GFE civil penalty after 10 days is \$100 a day, not to exceed \$5,000.
- Subsection (l) – Providers and facilities can challenge their penalties with the office of administrative hearings.

3/15/2018

Section 2 (cont.)

Article 4. Health Care Services and Price Information.

Sec. 18.23.400 Disclosure and reporting of health care services and price, and fee information.

- Subsection (m) – a municipality may not enforce an ordinance that imposes health care price disclosure requirements. Supremacy clause.
- Subsection (n) – department, facility fee, health care facility, health care insurer, health care provider, health care service, nonemergency health care service, patient, third party, and undiscounted price are defined.

3/15/2018

Section 2 (cont.)

Article 4. Health Care Services and Price Information.

Sec. 18.23.400 Disclosure and reporting of health care services and price, and fee information.

15

Effective date will be January 1, 2019.

3/15/2018

Section 3

16

Supporters

Alaska Association of Health Underwriters

Alaska Association of School Business Officials

Alaska Commission on Aging

Alaska Nurses Association

Alaska Permanent Capital Management

Alaska Professional Fire Fighters Association

Allen & Petersen

Bean's Café

Continental Auto Group

Denali Federal Credit Union

Denali Flying Service

Fosselman & Associates

Matanuska Telephone Association

Northrim Benefits Group, LLC

Taku Engineering, LLC

Valley Block & Concrete

3/15/2018

Questions?

3/15/2018

18

State Action on Price Transparency

FLORIDA – [HB 1175](#)

- Health care facilities are required to publish and post 50 most commonly provided services categorized in 3 price levels.
- Minimum size for the posting; 15 sq. ft.
- A price estimate will also be provided upon request.
- Incentive for posting price information: repayment of license fees and CE requirement waived for a certain time period.
- Enrolled during 2016 Legislature.

State Action on Price Transparency

COLORADO – [SB17-065](#)

- A health care provider will post 15 of their most common procedures.
- A health care facility will post 50 most common in-patient services, and the 25 most common out-patient services.
- The patient will be provided with a single document, electronically or by posting on the provider's website of the information, along with the CPT code and description of the health care services written in plain English.
- Enrolled January 1, 2018.

State Action on Price Transparency

NEW HAMPSHIRE & MAINE – A+

- Both New Hampshire and Maine have enacted health care price transparency legislation that is the gold standard.
- All Payer Claims Database – full scope of providers with paid amounts, not charged amounts.
- State price transparency website – easy to understand with information on health care costs, and allows consumers to select facilities for comparison purposes.

Price Transparency Efforts in Alaska

ANCHORAGE MUNICIPALITY

The Municipality of Anchorage enacted their [ordinance](#) for price transparency a year ago.

KETCHIKAN MUNICIPALITY

They're exploring a similar transparency measure that would require healthcare providers to disclose estimated medical costs to patients before they receive treatment.⁹

TABLE A – SUMMARY OF SCORING CRITERIA

	DATA SOURCE	SCOPE OF PROVIDER	SCOPE OF PRICES	SCOPE OF SERVICES	PRESENTATION OF DATA
LOW SCORING	Providers	Only hospitals/ facilities or only clinicians	Charges	Only in-patient, only out-patient, or a limited list of services	Prepared report or by request
HIGHEST SCORING	APCD	Hospitals/facilities and clinicians	Paid amounts	All in-patient and out-patient services	On a public, legislated website, with additional credit for quality of the site

Elements in a high-standard health care price transparency bill

Sources

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10. [How State Leaders Can Begin Undoing Obamacare's Damage, Robert E. Moffit, Ph.D., The Heritage Foundation, Jan. 2018.](#)
11. [Anchorage Municipal Ordinance, AO NO. 2017-26](#)
12. [Health Care Expenditures per Capita by State of Residence, State Health Facts, Health Costs & Budgets, Henry J. Kaiser Family Foundation, 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: House Judiciary v. I to Senate Health & Social Services, v. G

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

Version I contained language for health care providers and facilities to post price information for the most commonly performed services with the undiscounted price. Version G expands that language to include the addition of facility fees and Medicaid payment rates.

In Version I, health care providers and facilities will publish the price information lists by January 31st each year, in addition to sending the information to the Department of Health & Social Services for their database. The price information will be posted in their reception area. Version G still requires this, although, language has been added to require the health care provider and facility to post the information in font size no smaller than 20, in addition to posting a statement that says the following: "You will be provided with an estimate of the anticipated charges for your nonemergency care upon request. Please do not hesitate to ask for information." A list of health care insurers that are in-network with the provider or facility will also be posted.

Civil penalties in Version I were \$50 a day, not to exceed \$2,500. In Version G, they have increased to \$100 a day, not to exceed \$5,000. If a good faith estimate (GFE) is not provided 10 days prior to the date of request, the civil penalties will be \$100 a day, not to exceed \$5,000.

Version G has added definitions for facility fee, health care insurer, and nonemergency health care service.

The following changes have been added to Version G that is not found in Version I:

- A health care provider that works in a group practice is not required to post their price information unless the group practice has already compile and published the information and the fees.
- A patient may request a GFE and the health care provider or facility has 10 days to return the estimate verbally, in writing, or electronically to the patient that made the request. If the request is returned to the patient verbally, the provider or facility must maintain a record of that request.

- The GFE will include: health care services, products, procedures, and supplies, the in-network and out-of-network providers, procedure code, facility fees, and the identity of other agencies that may charge for a service or product in connection to the health care service.
- A health care provider or facility that provides a GFE is not liable for damages if the GFE is different from the amount the patient is charged.
- A municipality may not enforce an ordinance that imposes health care price disclosure requirements.

This completes the changes and additions to HB123 from version I to version G.

**SENATE CS for CS HOUSE BILL 123
COMPARISON SHEET version I to version G**

Statute	Provision	House Bill v. I	Senate Bill v. G	
AS 18.23.400	Disclosure and reporting of health care services and price information	No provision	The GFE will include: health care services, products, procedures, and supplies, the in-network and out-of-network providers, procedure code, facility fees, and the identity of other agencies that may charge for a service or product in connection to the health care service.	h
AS 18.23.400	Disclosure and reporting of health care services and price information	No provision	A health care provider or facility that provides a GFE is not liable for damages if the estimate differs than the amount charged to the patient.	i
AS 18.23.400	Disclosure and reporting of health care services and price information	No provision	A health care facility that is an emergency department is not required to provide a GFE for nonemergency care.	j
AS 18.23.400	Disclosure and reporting of health care services and price information	g A health care provider or facility that fails to comply will be liable for a civil penalty. DHSS may impose a civil penalty of no more than \$50 a day after March 31. The total penalty may not exceed \$2,500.	Change increase to \$100 a day, not to exceed \$5,000; failure to provide a GFE after 10 days or before the service is provided is \$100 day, not to exceed \$5,000.	k
		A health care provider or facility penalized is entitled to a hearing conducted by the office of administrative hearings under AS 44.64.	No change	l
AS 18.23.400	Disclosure and reporting of health care services and price information	No provision	A municipality may not enforce an ordinance that imposes health care price disclosure requirements.	m
AS 18.23.400	Disclosure and reporting of health care services and price information	h Definitions for department, health care facility, health care provider, health care service, recipient, third party, undiscounted price.	Add facility fee, health care insurer, nonemergency health care service.	n
Effective Date		January 1, 2018	January 1, 2019	

**SENATE CS for CS HOUSE BILL 123
COMPARISON SHEET version I to version G**

Statute	Provision		House Bill v. I	Senate Bill v. G	
AS 18.15.360	Data collection	a	DHSS will expand their data collection to include health care services and price information.	No change	a
AS 18.23.400	Disclosure and reporting of health care services and price information	a	A health care provider will annually compile by procedure code the 25 health care services most commonly performed and the undiscounted price.	Add facility fees and the Medicaid payment rate.	a
AS 18.23.400	Disclosure and reporting of health care services and price information	b	A health care facility will annually compile by procedure code the 50 health care services most commonly performed and the undiscounted price.	Add facility fees and the Medicaid payment rate.	b
AS 18.23.400	Disclosure and reporting of health care services and price information	f	Health care providers or facilities performing fewer than 25 or 50 services, respectively, will include a list of all health care services performed by the provider or at the facility.	No change	c
AS 18.23.400	Disclosure and reporting of health care services and price information		No provision	A health care provider who provides services in a group practice is not required to compile and publish a list if the group practice already compiles and publishes a price list, and the prices of the provider are reflected in the list.	d
AS 18.23.400	Disclosure and reporting of health care services and price information	c/d	Health care providers and facilities will publish the lists by January 31st each year, in addition to: providing the list to DHSS for their database in AS 18.15.360(a), post a copy of the list in a public area, and on the provider or facility website if they have one. There will also be a statement explaining that the price may be higher or lower than the amount the individual actually pays.	Add font size no smaller than 20; a written statement, "You will be provided with an estimate of the anticipated charges for your nonemergency care upon request. Please do not hesitate to ask for information;" a list of health care insurers in-network with the provider or facility.	e
AS 18.23.400	Disclosure and reporting of health care services and price information	e	DHSS will compile and annually update the lists provided by the health care providers and facilities, with their names and addresses, and post this information on the department's website, and enter this information into their database maintained under AS 18.15.360.	No change	f
AS 18.23.400	Disclosure and reporting of health care services and price information		No provision	A patient can request a good faith estimate (GFE). The provider or facility has 10 days to provide the estimate or before the services are provided. The GFE will be given verbally, in writing, or electronically. If the GFE is given to the patient verbally, the provider or facility will keep a record of the request. The GFE must include a portion of the total charges or a reasonable range of the anticipated charges.	g



Alaska options for health care reform and administrative improvements to the Affordable Care Act

By Roger Stark, MD, FACS,

Alaska Policy Forum Visiting Scholar and WPC Health Care Policy Analyst

This publication is an abbreviated version of the Policy Brief “Alaska Options for Health Care Reform and administrative improvements to the Affordable Care Act” published by the Alaska Policy Forum. The complete Policy Brief can be found at www.AlaskaPolicyForum.org.

Policy recommendations

Patients are the most important part of the health care system and they should be in charge of their own health care. There is nothing inherently different about health care as a service than any other economic activity. Health care providers should be paid for their work, and to the extent possible prices for health services should be set, not by government, but by economic efficiency and the natural movement of supply and demand in the market.

These practical steps would put patients in charge of their health coverage without complete repeal of the ACA:

1. Reform the ACA through Administration and incremental legislative actions.
 - promote greater use of 1332 and 1115 waivers.
 - provide patient-centered alternatives, such as health savings accounts and catastrophic health insurance plans, to the essential health benefits in the ACA.
 - extend the use of short-term, limited-duration health insurance plans.
 - allow the purchase of health insurance across state lines.
 - permanently withdraw the cost-sharing reduction subsidies and allow the exchanges to collapse sooner rather than later. Because of adverse selection, the exchanges are currently in a financial death spiral. More taxpayer money will not improve the long-term outlook of the exchanges.
 - repeal the Obamacare taxes.
2. Promote price transparency, so patients become true consumers of health care and know the real cost of the services they are receiving.
3. Change the tax code and allow equal treatment for individuals and families, so they can benefit from the same tax deductions that employers now receive for providing employee health benefits.
4. Enact meaningful reform of Medicaid and Medicare entitlements and make them true, targeted, safety-net programs, as they were originally designed.

Specific measures for Alaska

In addition to administrative changes the Secretary of Health and Human Services can make to the ACA, which are outlined in the complete Policy Brief, Alaska can enact its own health care reform, regardless of federal actions. Here is a sample of policy options available to Alaska policymakers under current federal law:

1. Aggressively pursue 1332 and 1115A waivers

Under these two sections, Alaska can request, and the current Administration can approve, significant changes in the implementation of the ACA without action by Congress.

2. Pass state legislation to limit state contributions to the Medicaid expansion

The Alaska legislature can pass laws that limit the amount of state responsibility for Medicaid expansion costs to 10 percent or to a fixed amount of expansion costs.

3. Repeal Certificate of Need laws

Research now shows that state Certificate of Need laws do not decrease health care costs, but that they do limit patient choices by banning investment and construction of new health care facilities.

4. Expand and promote the use of private association health plans

These plans would allow small private groups and individuals to join together to purchase health insurance in the same way large groups do.

5. Cap or freeze Medicaid enrollment

Medicaid, as originally intended by Congress, should be targeted to help the most vulnerable patients, while encouraging patients with means to gain access to affordable private health insurance coverage.

6. Eliminate or decrease waste, fraud, and abuse in the Medicaid program

A high percent of Medicaid costs do not increase care or access for enrollees. The massive bureaucratic nature of the program makes it a target for cheating and financial crime.

7. Expand and promote telemedicine

While Alaska has made improvements to telemedicine in recent years, there are many opportunities for expansion.

8. Reduce reimbursement rates for Medicaid to those of Medicare

Alaska is one of only two states which reimburses Medicaid at higher rates than Medicare.

9. Protect direct primary care

Alaska should protect direct primary care from state regulatory insurance laws and consider integrating it into the state's Medicaid system.

10. Encourage Price Transparency

Alaska can encourage health care price transparency to create better health care consumers.

11. Implement Right to Shop for state employees

Incentivizing public employees to shop for value in health care can lower state costs and improve patient options

12. Reduce maintenance of certification requirements and licensing laws

To address provider shortages, Alaska should aggressively relax barriers to medical practice which will increase access to health care for patients.

13. Reduce number of Medicaid Optional services

Alaska currently offers many optional Medicaid services that are not available to senior citizens on Medicare. Altering Medicaid to only cover the federal mandatory benefits would reduce costs significantly.



Dr. Roger Stark is a health care policy analyst and a retired physician. He is the author of two books including *The Patient-Centered Solution: Our Health Care Crisis, How It Happened, and How We Can Fix It*. He has also authored numerous in-depth studies on health care policy, including *Health care reform: lowering costs by putting patients in charge*.

Those Indecipherable Medical Bills? They're One Reason Health Care Costs So Much.

Hospitals have learned to manipulate medical codes — often resulting in mind-boggling bills.

By ELISABETH ROSENTHAL MARCH 29, 2017

The catastrophe struck Wanda Wickizer on Christmas Day 2013. A generally healthy, energetic 51-year-old, she suddenly found herself vomiting all day, racked with debilitating headaches. When her alarmed teenage son called an ambulance, the paramedics thought that she had food poisoning and didn't take her to the emergency room. Later, when she became confused and groggy at 3 a.m., her boyfriend raced her to Sentara Norfolk General Hospital in coastal Virginia, where a scan showed she was suffering from a subarachnoid hemorrhage. A vessel had burst, and blood was leaking into the narrow space between the skull and the brain.

During a subarachnoid hemorrhage, if the pressure in the head isn't relieved, blood accumulates in that narrow space and can push the brain down toward the neck. Vital nerves that control breathing and vision are compressed. Death is imminent. Wickizer was whisked by helicopter ambulance to the University of Virginia Medical Center in Charlottesville, 160 miles away, for an emergency procedure to halt the bleeding.

After spending days in a semi-comatose state, Wickizer slowly recovered and left the hospital three weeks after the hemorrhage, grateful to be alive. But soon after she returned home to her two teenage children, she found herself confronted with a

different kind of catastrophe. Wickizer had had health insurance for most of her adult life: Her husband, who died in 2006, worked for the city of Norfolk, which insured their family while he was alive and for three years beyond. After his death, Wickizer worked in a series of low-wage jobs, but none provided health insurance. A minor pre-existing condition — she was taking Lexapro, a common medicine for depression — meant that her only insurance option was to be funneled into the “high-risk pool” (a type of costly insurance option that was essentially rendered obsolete by the Affordable Care Act and now figures in some of the G.O.P. plans to replace it). She would need to pay more than \$800 per month for a policy with a \$5,000 deductible, and her medical procedures would then be reimbursed at 80 percent. She felt she couldn’t afford that. In 2011, she decided to temporarily stop working to tend to her children, which qualified them for Medicaid; with trepidation, she left herself uninsured.

And so in early 2014, without an insurer or employer or government agency to run interference between her and the hospital, she began receiving bills: \$16,000 from Sentara Norfolk (not including the scan or the E.R. doctor), \$50,000 for the air ambulance. By the end of January, there was also one for \$24,000 from the University of Virginia Physicians’ Group: charges for some of the doctors at the medical center. “I thought, O.K., that’s not so bad,” Wickizer recalls. A month later, a bill for \$54,000 arrived from the same physicians’ group, which included further charges and late fees. Then a separate bill came just for the hospital’s charges, containing a demand for \$356,884.42 but little in the way of comprehensible explanation.

In other countries, when patients recover from a terrifying brain bleed — or, for that matter, when they battle cancer, or heal from a serious accident, or face down any other life-threatening health condition — they are allowed to spend their days focusing on getting better. Only in America do medical treatment and recovery coexist with a peculiar national dread: the struggle to figure out from the mounting pile of bills what portion of the fantastical charges you actually must pay. It is the sickness that eventually afflicts most every American.

What’s less understood is the extent to which our current medical-billing system itself is responsible for the high prices patients are charged. There are, of course,

many factors that have led to the United States' record-breaking \$3 trillion health care bill: runaway drug prices, excessive testing and sky-high charges for even the most basic medical interventions. But all of those individual price increases have been enabled — indeed, aided and abetted — by the complex system of billing and coding that underlies bills like those sent to Wickizer. That system, with its lines of alphanumeric codes and arcane medical abbreviations, has given birth to a gigantic new industry of consultants, armies of back-room experts whom medical providers and insurance companies deploy against each other in an endless war over which medical procedures were undertaken and how much to pay for them. Caught in the crossfire are Americans like Wanda Wickizer, left with huge bills and indecipherable explanations in languages they cannot possibly understand.

Disease-classification systems originated during an outbreak of the bubonic plague in 17th-century London — epidemiologic constructs to classify and track causes of death and prevent the spread of infections among populations that spoke different languages. In the 1890s, the French physician and statistician Jacques Bertillon further systematized death reporting by introducing the Bertillon Classification of Causes of Death, the first medical-coding system, which was adopted and modified in many countries. It became an official global effort, which was periodically revised by an international commission. During the first half of the 20th century, the number of entries naturally increased with improved understanding of science, and many countries began tabulating not just causes of deaths but also the incidence of diseases.

In the 1940s, the World Health Organization took over stewardship of Bertillon's system and renamed it to reflect a new, broader focus: the International Statistical Classification of Diseases, Injuries and Causes of Death (ICD). The codes became an invaluable tool, a common language for epidemiologists and statisticians to track the world's afflictions. But over the last several decades in the United States, codes gradually took on a bedrock financial function as the basis for medical billing. In 1979, the government decided to use what by then were called ICD-9 codes — which specify the patient's diagnosis — in adjudicating Medicare and Medicaid claims, with some modifications added specifically for that purpose; the United States version was called ICD-9-CM. (The country has recently moved to a new iteration, ICD-10-CM.) For its beneficiaries, Medicare pays a fixed fee for inpatient

hospitalization based primarily on the ICD-CM code, which is translated into a DRG (diagnosis-related group) code — which is the immediate basis for reimbursement.

Other insurers followed in making codes the basis for billing. Coding systems begot new coding systems, because few hospitals wanted to be paid according to Medicare's relatively low DRG standards. And because strategic coding meant increased payment, that begot coding specialists and coding courses and coding degrees. There are now different increasingly complex coding languages that define payment for different kinds of services: CPT codes, for office visits delivered by doctors, as well as HCPCS, ICD-PCS-CM and DRG, for charges that are incurred in the hospital. There are tens of thousands of codes in each lexicon that have become increasingly specific. For example, there are different codes for in-office earwax removal depending on the method used (irrigation or instruments), different codes for delivering different vaccinations and a code for each injection delivered in the hospital. Different insurers also use different coding systems. While Medicare would have most likely considered Wickizer's brain bleed as DRG 021, if billed to a commercial insurer, it could result in more than a dozen ICD codes and hundreds of HCPCS entries.

Seemingly subtle choices about which code to use can have large financial consequences. If after reviewing a hospital chart of, say, a patient who has just had a problem with his heart, a hospital coder indicates the diagnosis code for "heart failure" (ICD-9-CM Code 428) instead of the one for "acute systolic heart failure" (Code 428.21), the difference could mean thousands of dollars. "In order to code for the more lucrative code, you have to know how it is defined and make sure the care described in the chart meets the criterion, the definition, for that higher number," says one experienced coder in Florida, who helped with Wickizer's case and declined to be identified because she works for another major hospital. In order to code for "acute systolic heart failure," the patient's chart ought to include supporting documentation, for example, that the heart was pumping out less than 25 percent of its blood with each beat and that he was given an echocardiogram and a diuretic to lower blood pressure. Submitting a bill using the higher code without meeting criteria could constitute fraud.

Each billing decision, then, can be seen as a battle of coder versus coder. The coders who work for hospitals and doctors strive to bring in as much revenue as possible from each service, while coders employed by insurers try to deny claims as overreaching. Coders who audit Medicare charts look for abuse to reclaim money or fraud that needs to be punished with fines. Hospital coders teach doctors — and doctors pay to take courses — to learn how they can “upcode” their charts to a more lucrative level with minimal effort. In a doctor’s office, a Level 3 visit (paid, say, at \$175) might be legally transformed into a Level 4 (say, \$225) by performing one extra maneuver, like weighing the patient or listening to the lungs, whether the patient’s illness required that or not.

While most hospitals and insurers set their own rates for each level of care, adding a step when interacting with a patient can also bring windfalls. E.R. doctors, for example, learned that insurers might accept a higher-reimbursed code for the examination and treatment of a patient with a finger fracture (usually 99282) if — in addition to needed interventions — a narcotic painkiller was also prescribed (a plausible bump up to 99283), indicating a more serious condition.

Toward the end of the 20th century and into the next, as strategic coding increased, a new industry thrived. For-profit colleges offered medical-coding degrees, and internships soon followed. Because alphanumeric coding languages are as distinct from one another as Chinese is from Russian, different degree tracks are necessary, along with distinct professional organizations that offer their own particular professional exams, certifications and licensing. Hospital systems and insurers — which have become huge, Hydra-like enterprises — now all employ roomfuls of coding-program graduates to perform these tasks. Membership in the American Academy of Professional Coders has risen to more than 170,000 today from roughly 70,000 in 2008.

Individual doctors have complained bitterly about the increasing complexity of coding and the expensive necessity of hiring their own professional coders and billers — or paying a billing consultant. But they have received little support from the medical establishment, which has largely ignored the protests. And perhaps for good reason: The American Medical Association owns the copyright to CPT, the code used by doctors. It publishes coding books and dictionaries. It also creates new codes

when doctors want to charge for a new procedure. It levies a licensing fee on billing companies for using CPT codes on bills. Royalties for CPT codes, along with revenues from other products, are the association's biggest single source of income.

Patients with good health insurance are often blissfully unaware and mostly unaffected by the jockeying that goes on over how to code their bills. But uninsured patients like Wickizer, or (increasingly) those with high deductibles, are stuck with no insurer to argue on their behalf. Her experience with the University of Virginia Medical Center is not unique: Studies have shown that hospitals charge patients who are uninsured or self-pay 2.5 times more than they charge those covered by health insurance (who are billed negotiated rates) and three times more than the amount allowed by Medicare. That gap has grown considerably since the 1980s.

When Wickizer arrived home from the hospital in January 2014, she had trouble concentrating and finding words; she spoke deliberately, slowly. She remembers nothing before February, she says, but relied on help from her parents, who live nearby, and her boyfriend, who is retired from the Navy. She did her best to address the onslaught of bills that began appearing in her mailbox.

First, she took stock of her finances. She paid the rent for the Norfolk apartment that she and her children lived in by renting out a townhouse that she and her deceased husband had bought in Virginia Beach; after paying property tax, insurance and maintenance on the townhouse, she just broke even. She also received about \$2,000 a month in Social Security survivor benefits because of her husband's death. In addition, she had about \$100,000 from her husband's life insurance in a retirement account, which she was also hoping would help pay for her children's college. With medical bills totaling nearly \$500,000 and no health insurance, the numbers didn't add up. "My dad said: 'They'll never expect you to pay that,'" Wickizer told me. "But they did."

As a sign of good faith, she quickly paid \$1,500 to the hospital and \$1,000 to the doctors and sought to make sense of the bills. Patients today are told to be good medical consumers, but they are asked to write checks for thousands of dollars — in this case hundreds of thousands — with little explanation of what they're for. Wickizer did what she would have done with a credit-card statement: She contacted

the hospital and requested an itemized bill. Her idea was that if she could understand how much she was being charged for each procedure, she could compare the fees with the reimbursements that Medicare or another insurer would pay for those services and begin some kind of negotiation.

A month later, on March 19, the hospital finally sent a list of charges, using medical abbreviations and terminology but not revealing the all-important alphanumeric codes. Despite being 60 pages long, the tally seemed incomplete, leaving out doctor's charges and including other fees that seemed incidental, like charges for catheters, wires and oxygen. Room charges were vastly different on different days.

Nearly simultaneously, she received a one-page bill for the hospital portion of her care, broken down only into the broadest categories, including \$111,162 in room charges, \$34,755.75 for pharmacy, \$19,653 for labs, \$8,640 for the operating room, \$8,325 for anesthesia, \$1,143 for the recovery room, \$44,524 for medical supplies and \$40,489 for radiology services, totaling \$356,884.42. The bill informed her that the medical center was prepared to offer her its standard 20 percent discount for patients who are uninsured, leaving a "what you owe now" fee of \$285,507.58. It noted that the hospital could offer some additional financial assistance, but only if her household of three had assets of less than \$3,100 ("such as bank or retirement accounts"), which disqualified Wickizer and very likely most Americans who have ever held a job.

Next, she did her best to find out what Medicare or another insurer would have paid for her hospitalization, hoping to offer the hospital that amount from her retirement account. To understand the Medicare codes, she had to learn a bit of coding language. Would her hospitalization count as Medicare DRG 020 or 021? She estimated that in 2013, her subarachnoid hemorrhage (most likely coded, she determined, as "intracranial hemorrhage or cerebral infarction disorders, DRG 021, with procedures and major comorbidities or complications"), would have been reimbursed by Medicare for about \$80,000. Had a member of the armed services experienced the same condition, Tricare, the military insurer, might have paid closer to \$70,000. But to know how much a commercial insurer would have paid, she would have to figure out what HCPCS codes the hospital used to calculate her bill,

and the hospital did not send those. Hospitals tend to treat their billing strategies — codes and their master price list, called a charge master — as trade secrets vital to their business. State laws and judges tend to respect that as proprietary information.

When the billers called insisting on payment of the full \$285,507.58, Wickizer explained, “I don’t have this kind of money.” She offered the hospital and its doctors the \$100,000 in her retirement account. They declined and suggested that she sign up for a payment plan of \$5,000 a month to the hospital — and a second \$5,000 plan for the physicians’ group. It was an untenable amount.

In October 2014, a sheriff affixed a summons to Wickizer’s front door, saying that the university was suing her for nonpayment. Eric Swensen, a spokesman for the University of Virginia, declined to answer questions about the case, citing patient privacy, as governed by HIPAA rules. But he noted that the university provides \$270 million worth of free care to patients who meet its criterion for assistance and sets up interest-free payment plans for those who don’t.

After receiving the summons, Wickizer resorted to a technique followed by many a frustrated customer: She went on Facebook, posted her story and solicited advice. (The Facebook group *Paying Till It Hurts*, where she posted her story, was created in 2014 in connection with a New York Times series that I wrote with the same name.) A handful of experts — patient advocates, billing professionals, lawyers and a coder — volunteered their help pro bono to try to get more information from the medical center and translate the coding that yielded the unaffordable figure. (One notable aspect of our commercialized health system is that for every person who is pushing to profit, there is another who is doing his or her best to protect patients.)

In vetting Wickizer’s bill, the experts encountered roadblocks from the medical center at every turn in a contentious battle that lasted for over a year. Multiple legal requests to review Wickizer’s chart and complete bill — with its coding elucidated — were refused. Nora Johnson, a retired hospital bill-compliance auditor from West Virginia who volunteered to help Wickizer, noted that not revealing the billing codes constituted a violation of federal law. No insurer would have paid the bills without seeing them, allowing at least a rational attempt at negotiation. As Wickizer’s team

wrote to the University of Virginia in one of their letters: “No Codes = No Pay.” The University of Virginia Physicians’ Group, which independently charged Wickizer \$54,000, eventually turned over its billing codes. Wickizer’s experts were able to use the bill fragments they had received in discovery, supplemented by those codes, to get a better idea of what medical procedures Wickizer received during her three-week hospitalization. From there, they tried to extrapolate how the hospital had, perhaps, coded her case. By examining the cost reports the University of Virginia hospital must file with Medicare, which indicate the amount it spends delivering certain types of care, Christine Kraft, another medical-billing expert, estimated that even by its own calculations, the medical center spent less than \$60,000 treating Wickizer.

The stealth battle between hospitals and insurers over bills for each hospitalization, office visit, test, piece of equipment and procedure is costly for us all. Twenty-five percent of United States hospital spending — the single most expensive sector in our health care system — is related to administrative costs, “including salaries for staff who handle coding and billing,” according to a study by the Commonwealth Fund. That compares with 16 percent in England and 12 percent in Canada.

That discrepancy comes, in part, from the prolonged negotiations over payment and the huge number of coders, billers and collectors who have to be compensated: Their salaries and loans from those years of training in obscure languages are folded into those high charges and rising premiums. In addition, as is often the case in warfare, the big conventional army can be at a disadvantage: The insurance companies and government seem to be always one step behind the latest guerrilla tactics of providers’ coders.

For years, creative coding has been winning over what the government calls “correct coding,” meaning coding that gives providers their due, but without exaggeration. Indeed, each attempt by the government to control questionable coding to enhance providers’ revenue has seemed to only fuel more attempts. In 1996, for example, Medicare’s National Correct Coding Initiative made it clear that certain codes couldn’t appear on the same bill because they were inherently part of the same procedure. As a rule, an anesthesiologist could not, for example, separately

bill for anesthesia and checking your oxygen level during your surgery. But the government created Modifier 59 — a code that could be appended to other codes to allow doctors to take exceptions to that rule in unusual cases. Modifier 59 could be used to allow for two payments in certain situations, such as when an oncology nurse needed to insert two separate IVs for two different purposes — one to administer chemotherapy, say, and another hours later because the patient seemed dehydrated. Such cases were expected to be exceedingly rare.

But just as entrepreneurial corporate tax lawyers search each new tax code for economic advantage, entrepreneurial coders and billers find loopholes to exploit at the edge of the law. An investigation by the Health and Human Services Office of the Inspector General in 2005 found many instances of Modifier 59 abuse. Forty percent of code pairs billed with Modifier 59 in 2003 were not legitimate, resulting in \$59 million in overpayment. Similarly, when Medicare announced that it would pay only a set fee for the first hour and a half of a chemotherapy infusion — and a bonus for time thereafter — a raft of infusions clocked in at 91 minutes.

Like nearly every area of medicine, coding science has advanced — though not to the patient's benefit. Commercial computer “encoder” programs maximize income from coding and make helpful suggestions (“That could be billed for Level 3,” or “Did you forget Code 54150,” indicating a circumcision on a bill for a male newborn). Today many medical centers have coders specializing in particular disciplines — joint replacement or ophthalmology or interventional radiology, for example. Advanced coding consultants advise lesser coders. The Business of Spine, a Texas-based consulting firm with a partner office in Long Island, advises spine surgeons' billers about what coding Medicare and commercial insurers will tolerate, what's legal and not, to maximize revenue. The evolution of this mammoth growth enterprise means bigger bills for everyone — whether through increasing premiums and deductibles on insurance policies or, as in Wickizer's situation, depleting the savings earmarked for children's college.

Like many medical centers, the University of Virginia Health System has turned at least some of its billing and debt collection over to professionals, third-party contractors who have no pretense of the charitable mission espoused by the University of Virginia, founded by Thomas Jefferson in 1819 to educate leaders in

public service. The collectors are often paid a percentage of the money they recover. They tend not to care whether a procedure was coded well or poorly. Their task is usually to go after the total sum the hospital says it is owed.

In Wickizer's case, the hospital brought in a law firm that specialized in debt collection, then called Daniel & Hetzel and based in Winchester, Va. For a year and a half, Wickizer's team of experts dissected the bills and negotiated with the hospital and its representatives at the law firm over its charges and coding strategies — just as insurers do behind the scenes on patients' behalf. The experts laid out their logic for what might constitute reasonable payment in a detailed report based on what they could discover about Wickizer's care: how it could be coded and what other hospitals and insurers would have paid. They helped her local lawyer, Kelly Roberts, write motions for discovery and legal letters and made offers of payment between \$65,000 and \$80,000, which they calculated should provide the hospital a profit on the services rendered to Wickizer.

But the hospital did not accept any of the offers. In a letter, Peter Hetzel, an attorney at the firm, said his client would accept only just over \$225,000, saying the University of Virginia Medical Center was “the victim here.” He noted, too, that the small rental property that Wickizer owned — appraised at \$90,200 in 2014 — was considered fair game for the hospital to seize as payment. Swensen, the spokesman for the university, said that it decides on a case-by-case basis whether or not to report nonpayment to credit agencies or to pursue civil cases against patients in court. He added: “If we obtain a lien on real estate, we do not seek to sell the property if it is the patient's primary residence.”

In February 2016, Wickizer received a letter from the state of Virginia saying that the medical center would be dunning money from any tax refund she might get. At one point, in exasperation, Wickizer wrote to her group of experts: “More than likely I am going to have to declare bankruptcy by the time this is all said and done, and I just would like to have everything settled. I want to pay them what I have and what is fair.”

By then, Wickizer was recovering physically and had married her boyfriend. But she was still struggling with stress from the uncertainty of the mammoth bills

hanging over her. With court dates scheduled and postponed, motions filed and denied, she and her pro bono lawyer from Chicago, Tom Osran, along with her local lawyer were finally scheduled to face off in court with the University of Virginia Medical Center on April 29, 2016. The day before trial, after Osran was preparing to book his plane ticket to Virginia, and after I called the hospital inquiring about attending the court session, the case was dismissed. The terms of the settlement are sealed.

Nearly a year later, Wickizer remains exhausted by the ordeal. Her speech, which was hesitant when I first spoke with her more than two years ago, sounds fluid now, and she is funny and thoughtful, though she says she still occasionally needs to search to find the right word, a form of a condition known as aphasia. Now working part-time as a clerk in a small store, she would like to go back to her previous work as a bookkeeper, she told me when we spoke in March. But she has failed to secure a job; she worries that her barely noticeable speech problems make her job interviews less than optimal. Or perhaps, she frets, the problem is her credit rating, which (unknown to her at the time) dropped more than 200 points after the doctors who cared for her reported her unpaid bills to credit agencies. That black mark will remain until 2021, even though her legal case is resolved and she now has military health insurance through her husband. And, she notes with a sigh of resignation, "I'm the kind of person who's always tried to do everything right."

Elisabeth Rosenthal is editor in chief of Kaiser Health News and a former senior writer at The Times.

Adapted from "An American Sickness: How Healthcare Became Big Business and How You Can Take It Back," to be published this month by Penguin Press.

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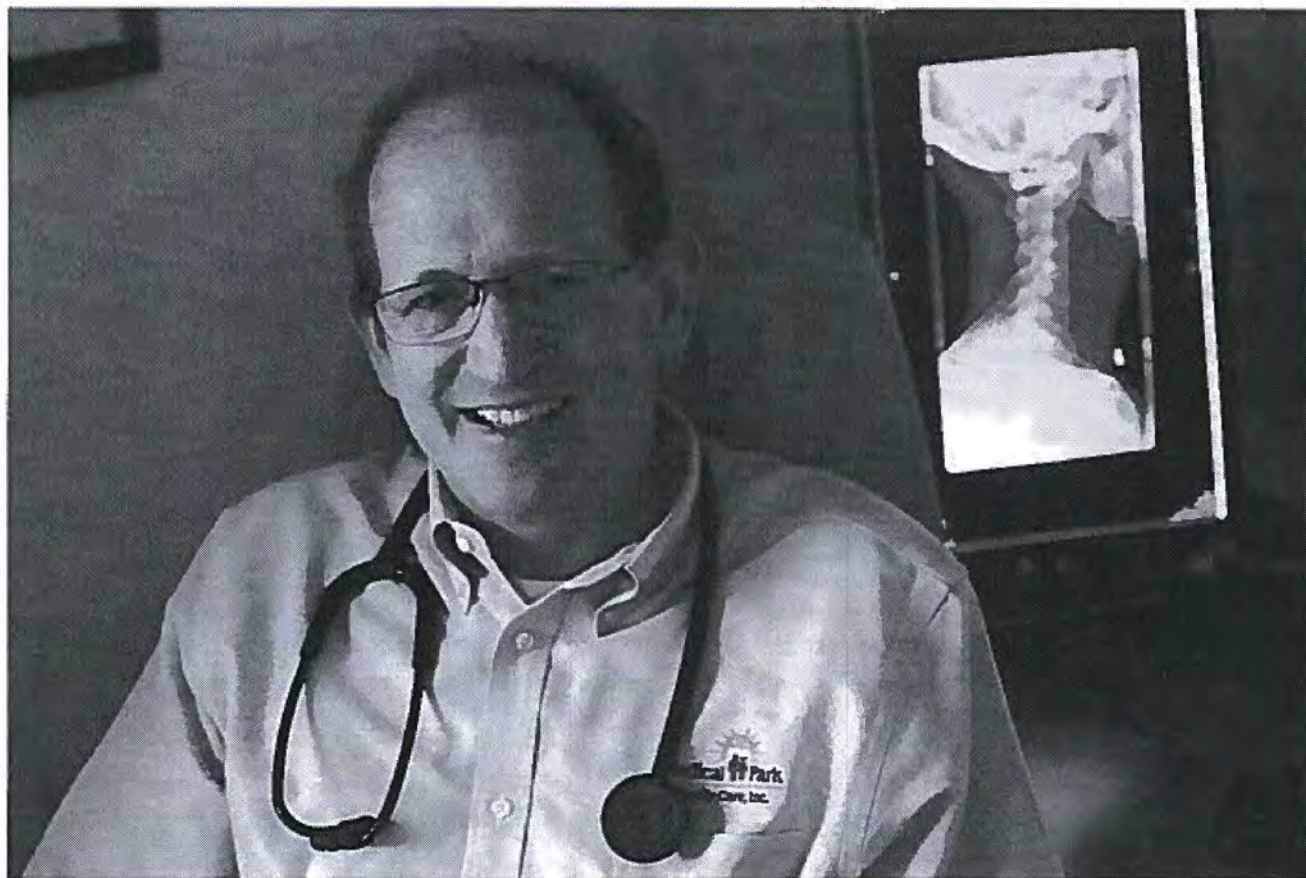
A version of this article appears in print on April 2, 2017, on Page MM43 of the Sunday Magazine with the headline: The Code Rush.

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

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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.



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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

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

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

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

Article Title	Subjects	Summary	News Source	URL
Same surgery, different price: Patient gets \$15,000 bill second time	anecdotal 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 insurance's 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

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

Article Title	Subjects	Summary	News Source	URL
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, led 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

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

Article Title	Subjects	Summary	News Source	URL
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

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

Article Title	Subjects	Summary	News Source	URL
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.html
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 stitches 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

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

Article Title	Subjects	Summary	News Source	URL
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	<p>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.</p> <p>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.</p>	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

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

Article Title	Subjects	Summary	News Source	URL
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. Okcopy.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

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

Article Title	Subjects	Summary	News Source	URL
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 create 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

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

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/XhpiSnKQtwc4RhxP6mTfrK/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/r7ylsshRg7eXBUXlb15oI/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

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

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, Merrill Gozner	http://www.modernhealthcare.com/article/20130511/MAGAZINE/305119987

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

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

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

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

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

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-healthcare-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-disclosure-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 Carolina 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

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

Article Title	Subjects	Summary	News Source	URL
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

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

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.

WHITE PAPER

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

BOBBI COLUNI, SENIOR DIRECTOR, CONSUMER INNOVATIONS

FEBRUARY 2012

Office of Rep. Ivy Spohnholz



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TABLE OF CONTENTS

INTRODUCTION	1
EXPLORING THE RADICAL VARIATION IN HEALTHCARE PRICING	1
Service Sites Impact Costs.....	2
Price Variation for an Illinois-based Employer.....	3
Reducing U.S. Healthcare Costs by \$36 Billion.....	3
CONSUMER ENGAGEMENT AS A STRATEGY TO REDUCE WASTEFUL SPENDING	4
The Need for Price Transparency.....	4
Price Versus Quality.....	5
Consumer Cost Sharing.....	5
BEST PRACTICES FOR IMPLEMENTING PRICE TRANSPARENCY SOLUTIONS	6
Ensure Consumers Have a Vested Interest.....	6
Provide Price and Quality Information.....	6
Calculate Out-of-Pocket Costs and Show Benefit Application.....	6
Show Total Costs and Components.....	7
Highlight Ways to Save Money.....	8
Educate and Raise Consumer Awareness.....	9
Engage Consumers to Manage Conditions and Control Costs.....	10
Promote Savings Potential.....	11
CONCLUSION	12
REFERENCES	13

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



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.

Office of Rep. Ivy Spohnholz



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March 23, 2017

Representative Ivy Spohnholz
State Capital room 421
Juneau, AK 99801

Representative Spohnholz:

I am writing you today in support of HB 123 the medical pricing disclosure bill. HB 123 is a good first step in tackling the high prices Alaskans pay for health care. It will start to allow those seeking medical treatment to begin to act like rational consumers because of the increased pricing information it will make available. As an elected union official I have worked on healthcare for over a decade now. I understand the strain it places on individuals and the strain the high cost places on employers who provide coverage. As a large employer going through difficult financial times the State of Alaska has a real vested interest in bringing the cost of health care down in our state.

If I told you we were going to eat out at a different kind restaurant and order a simple hamburger, you might be interested in trying something new. But then you learn there are no prices on the menu. You order anyways because you must eat in order to maintain your energy to lead a productive life. The meal is good and you are overall satisfied with what you ate and the service. Then something unusual happens, you receive several bills for the meal. The hostess, busser, cook, server, facility and the dishwashers all issue separate bills. On top of that some of the bills are several times higher than what you are used to paying. By the time you pay all of them you have paid six times what a hamburger costs in other locations. Had you been armed with the pricing information of this particular restaurant you would have acted as a rational consumer and made an alternative choice. If enough consumers made rational choices the practice of charging six times what a hamburger costs in other areas would have to stop or their business would fail.

The above scenario is similar to how health care works in Alaska. We lack the information to make rational choices and the problem is compounded by our geographic isolation. Many fire fighters and their families in Alaska are covered by a health trust out of Washington State. We pay 30% more for similar coverage and last year we spent a nearly a million dollars more than we put into the trust. None of this is related to higher usage. If we don't correct this we will see another round massive premium increases or be dropped by the trust altogether.

Since we have been in the trust we have had our eyes opened to the price differences across many states. It is not uncommon for a procedure in Alaska to cost significantly more than Washington State. We are talking ACL repair, shoulder surgery, breast cancer treatment costing 3 or 4 times what the same treatment costs in Washington State. It should be noted that we are not saying Washington State is the cheapest, it is just the information we have available by comparing claims.

I don't need to explain to you that all Alaskans share in the burden of high priced health care. I commend you in taking on this very important issue. I believe this legislation is the first step of many that need to be taken to help lower the cost of health care and empower individuals to act as rational consumers. I look forward to helping see medical pricing transparency become the norm in the State of Alaska.

A handwritten signature in black ink that reads "Thomas A. Wescott".

Thomas A Wescott
President Alaska Professional Fire Fighters



March 20, 2017

We are writing on behalf of the Alaska Nurses Association in strong support of HB 123: "An Act relating to disclosure of health care services and price information." This bill will empower Alaskans to make informed decisions about their healthcare options in our state.

Supporting efforts for healthcare cost transparency is a long-standing priority of the Alaska Nurses Association. We believe that patients should have reliable, accurate information about healthcare procedures and services so that they can make informed decisions about their healthcare. House Bill 123 would give patients more control over their healthcare spending and help to drive down Alaska's high healthcare costs.

Price transparency is a cost-lowering tool. Without access to healthcare pricing information, patients have little ability to make an informed consumer choice. When armed with pricing information, patients have the ability to make those choices, and long-term, the ability to influence the cost of healthcare services.

In a recent report, the U.S. Government Accountability Office asked dozens of healthcare providers about their price for a knee replacement. The estimates given ranged from \$33,000 to \$101,000. Without HB 123, patients will face a difficult choosing the most cost-effective, high-quality option for their healthcare.

HB 123 will require healthcare providers to publish healthcare price information in public spaces and on their websites and to submit that pricing information to the Department of Health and Social Services. Individual providers would be required to disclose the total undiscounted costs of their 25 most common services, while larger facilities would be required to disclose the same information for their 50 most common services.

While much more remains to be done to lower healthcare costs for Alaskans, HB 123 is a necessary step in the right direction. Alaskans deserve to be informed decision-makers in their healthcare.

The Alaska Nurses Association certainly appreciates your support on behalf of women and families in our state.

Sincerely,

Arlene Briscoe, RN-BC
Legislative Chair
Alaska Nurses Association

Jane Erickson, RN, CCRN
President, Board of Directors
Alaska Nurses Association

The Alaska Nurses Association strongly endorses HB 123, empowering patients to take financial control of their healthcare and choose high-quality, cost-effective care.



THE STATE
of **ALASKA**
GOVERNOR BILL WALKER

Department of
Health and Social Services

ALASKA COMMISSION ON AGING

P.O. Box 110693
Juneau, Alaska 99811-0693
Main: 907.465.3250
Fax: 907.465.1398

March 10, 2017

Representative Ivy Spohnholz
Alaska State Capitol, Room 421
Juneau, AK 99801-1182

Subject: Support for CSHB 123, Disclosure of Health Care Costs

Dear Representative Spohnholz:

The Alaska Commission on Aging (ACoA) is pleased to offer our support for CSHB 123, a bill authored by you and co-sponsored by Representatives Chris Tuck, Harriet Drummond, Justin Parish, Les Gara, and Geran Tarr, that would require health care providers to publicly disclose medical care price information.

The aging of Alaska's population presents unique challenges for our health care delivery system. Older Alaskans are particularly vulnerable to increases in medical costs as many live on fixed incomes. From the standpoint of older citizens, having access to health care price information will allow patients to make informed decisions regarding their health care *before* they receive services as well as to encourage meaningful conversations between patients and their health care providers. We especially appreciate CS subsection added under Article 4, Sec. 18.23.400 (d) which provides health care providers with the flexibility to add a disclaimer on their postings stating that the "un-discounted price" listed may be different than the actual amount paid by patients depending on their insurance provider, eligibility for sliding scale fee services, and other factors.

The *need to improve transparency of medical health care pricing* was a priority issue identified by seniors and other public members participating in the Medicaid Redesign community forums conducted by the Commission at senior centers. Seniors and other public member participants viewed this item as a key factor that could lead to improved quality and more affordable health care services. We believe that HB 123 addresses this concern head-on in a manner that is compliance manageable for health care providers.

The Commission supports CSHB 123 and appreciates your leadership on this legislation. We believe that HB 123 will benefit health care consumers of all ages regardless of where they live. Seniors, more than any other age group, are consumers of health care. Recognizing that there may be other enhancements made to this bill down the road, the Commission supports CSHB 123 as a first step to promote greater consumer awareness about the cost of health care. For further information about our position, please contact Denise Daniello, ACoA's executive director (465-4879).

Sincerely,

Handwritten signature of David A. Blacketer in black ink.

David A. Blacketer
Chair, Alaska Commission on Aging

Sincerely,

Handwritten signature of Denise Daniello in black ink.

Denise Daniello
ACoA Executive Director

Cc: Representative Chris Tuck
Representative Harriet Drummond

Representative Les Gara
Representative Geran Tarr

Representative Justin Parish

[REDACTED]

From: Ashley Snodgrass [REDACTED]
Sent: Friday, March 10, 2017 3:20 PM
To: Bernice Nisbett
Subject: I Support Transparency - HB 123

Hello Bernice,

I'm writing to voice my support for the legislation regarding transparency Representative Spohnholz is proposing – HB 123. I support this legislation because this will allow patients to be educated consumers of healthcare, by knowing costs before committing to a service. In no other industry would a customer purchase a good or service without knowing the cost they must pay. This information barrier serves to hurt consumers by veiling and mystifying the costs of services the service doctors provide.

I appreciate Representative Spohnholz for introducing this legislation and supporting this change that needs to be made.

Thank you,

Ashley Snodgrass

Rep. Ivy Spohnholz

From: AMY LUJAN [REDACTED]
Sent: Thursday, March 09, 2017 5:03 PM
To: Rep. Ivy Spohnholz
Subject: Support for HB123

Representative Spohnholz and Members of the House HSS Committee,

My name is Amy Lujan, and I am Executive Director for the Alaska Association of School Business Officials (ALASBO), which represents K-12 school business staff from across the state.

I am writing in support of HB123. As you're well aware, health insurance costs are a major issue for all Alaskans. Alaskan school district staff work hard to provide health insurance to their employees that is attractive as part of the overall compensation package they provide. The overall package must be competitive nationwide in order to attract the best staff to our state.

Unfortunately, the complexity of our health care system makes it hard for even those covered by insurance to make responsible choices with regard to providers. The complexity is not unique to Alaska, but it's often compounded by the limited number of providers and high costs.

It's very discouraging to hear stories of insured individuals being saddled with medical debt, in part because the information they received from the provider was confusing. Sometimes the bad financial outcome is attributed to "bad insurance", even though the situation could have been avoided.

I am hopeful that the proposals in HB123 will help improve transparency so that school district employees and other Alaskans can make more informed decisions about their health care and avoid unnecessary medical debt.

Thank you for your consideration of this bill and the opportunity to provide testimony.

Amy Lujan
Executive Director
Alaska Association of School Business Officials (ALASBO)
3145 Pioneer Avenue
Juneau, AK 99801
907-723-7415
www.alasbo.org

[REDACTED]

From: Teena Applegate [REDACTED]
Sent: Thursday, March 09, 2017 4:46 PM
To: Bernice Nisbett
Subject: Support: Transparency Legislation

Hi Bernice:

I just wanted to provide my support of the Transparency Legislation. I see it as a necessary step needed in order to contain costs for Alaskans. If not contain at least allow Alaskans to be aware of what their costs of their healthcare will be. It seems a reasonable ask for any Alaskan.

Best Regards,

Teena

Teena Applegate | Employee Benefits Consultant | tapplegate@northrimbenefits.com

Northrim Benefits Group, LLC | 3111 C Street STE 500 | Anchorage AK 99503 | P: 907-263-1401 | C: 907-317-7577 | F: 907-279-6818 | www.northrimbenefits.com | Like us on [Facebook](#)

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[REDACTED]

From: Joshua Weinstein [REDACTED]
Sent: Thursday, March 09, 2017 1:33 PM
To: Bernice Nisbett
Subject: HB 123 - Support

Hi Bernice,

I'm an employee benefits consultant overseeing a firm that works with hundreds of Alaskan employers. We advise those employers on the health benefits programs they provide to their valuable employees. The lack of transparency in healthcare pricing, particularly in our state, is a driver for the rising costs of those services. I support Representative Spohnholz's bill, HB 123, as a mechanism that creates transparency regarding the pricing of healthcare services delivered in our state. From this clarity, a more competitive marketplace can be born and evolve.

Thank you for the opportunity to share my thoughts.

Joshua Weinstein, DIA
President/Employee Benefits Consultant

Certified PPACA and Self-Funding Professional
Northrim Benefits Group, LLC
3111 C Street, Suite 500
Anchorage, AK 99503
907-263-1401 Phone
907-279-6818 Fax
907-830-2658 Cell
jweinstein@northrimbenefits.com

www.northrimbenefits.com

[Schedule an appointment with me. \(Click here.\)](#)

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[REDACTED]

From: Albert Fogle [REDACTED]
Sent: Thursday, March 09, 2017 11:35 AM
To: Bernice Nisbett
Subject: HB 123

Hello Bernice,

I want to contact you to let you know that as an Employee Benefits Consultant who represents thousands of employees and residents of Alaska, I am in support of HB 123 and for that matter any legislation that brings more power to the consumer in a marketplace.

Alaska has a healthcare cost crisis and it's getting worse because the providers and facilities have control of the pricing of medical services and does not share that information with the consumer until after a service and/or procedure is completed. Then weeks pass and when a medical bill finally arrives in the mail, there is no way to "put the toothpaste back in the container", we have already completed the service/procedure and have to pay for the service without know a price for a service.

HB 123 will help residents of Alaska start to understand more about the cost of the medical goods and services they're purchasing, or that their insurance company will be purchasing for them and will be able to good consumers and good stewards of their and the insurance company's money.

Working in the Private Sector, we typically don't seek government interference or regulation, but in this case it's important the legislator and governor step in to help create a more effective market. I have all too often in my 7+ years in the health insurance industry and as a consumer of healthcare, I have seen the providers and facilities refuse to produce a cost estimate for services and unwillingness to work with the consumer to help find the prices for services.

Please use this testimony to help make your cause for medical transparency in the marketplace to protect the CONSUMER!

Please let me know if you have any questions or concerns,



*

Schedule a meeting with me, just click this link!!

Albert Fogle | Employee Benefits Consultant | Northrim Benefits Group

Certified PPACA Professional

3111 C Street, Suite 500 Anchorage, Alaska 99503

907-263-1401 phone | 907-279-6818 fax | afogle@northrimbenefits.com

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March 9, 2017

Representative Ivy Spohnholz, Chair
House Health and Social Services Committee
Alaska House of Representatives
State Capitol Building, Room 421
Juneau, Alaska 99801

Representative Spohnholz,

Bean's Cafe supports HB 123 and urges its passage. Bean's Cafe is an employer with 35 employees in Alaska.

The current cost of healthcare in Alaska is making it difficult for our employees to afford their portion of healthcare coverage. We are second chance employer and many of our staff come from homelessness or the correctional system. These are truly some of the most vulnerable people who are trying every day to make a living. Combined with high housing costs in Anchorage many are forced to make difficult decisions about health care coverage.

In addition, the increased cost as an employer may significantly impact our operations. As the economy tightens in Alaska we, like many other non-profits, are seeing declines in donations and increased need for services. To put it in perspective, our portion of employer provided health coverage increased \$45.49 per month. We were able to keep it at this level by increasing percentage paid by employees and raising our deductible from \$500 to \$2000.

If each of our employees signed up for coverage through our plan, our increased cost in 2017 for medical insurance would be \$19,105.80. *For this same amount of money we could provide weekend food for 166 hungry children for an entire school year.*

Our support for HB 123 is based on three considerations - market transparency, information availability and appropriate role of government.

Market Transparency - When buyers and sellers interact to exchange goods and services, a determined price and *the communication* of that price is essential for a functional market. Part of the reason Alaska's health care market is so dysfunctional is that prices for medical goods and services are not communicated during the process leading to an agreement, leaving buyers unable to substitute or seek a lower price. This situation is not because consumers of medical goods and services have failed to request, even demand, this information.

We are aware there are challenges to developing a transparent market. There are differentiations in price structures and services offered which make true comparisons

difficult. In some cases consumers may even opt for higher priced services, believing they are higher quality. However, generally we believe that when consumers have the information they need to make informed market decisions they will seek the best, lowest price, ultimately establishing a more competitive market. Over time, we believe this will lead to lower prices for services for Alaskans.

Information Availability - HB 123 is quite limited in scope. It requires medical providers to make known the prices for only the top 25 most common procedures they perform, and medical facilities only the 50 most common services they provide. This information is readily available, in some cases already disclosed in reports, and with facilities it is established on their chargemaster. The bill does not compel anyone to produce or generate anything that is not already known and used internally.

Alaska's medical providers and facilities are needed in our community. We don't want to see them burdened or forced to direct their attention away from patients. Based on our expertise, we are convinced that they can easily meet the requirements of HB 123.

Role of government - As businesspeople, the irony of supporting government intervention in a market is not lost on us, and we are understandably hesitant to do so. However, the market is so distorted that we fear unless something changes, it will fail.

Ideally, HB 123 would be unnecessary. We would much rather see consumers of health services and facilities already have the information they need to compare prices, and after considering other information about providers and facilities, make an informed market decision. We look forward to a time when, after providers and facilities become more accustomed to providing the transparency necessary for a functional market, and consumers expect and demand such information, HB 123 would be unnecessary and could be repealed. However, in light of the health care crises gripping Alaskans, we believe it is appropriate, and necessary, for the legislature to pass HB 123 to help balance the market.

For these reasons, Bean's Cafe urges the 30th Alaska Legislature to pass HB 123 this year. Please call on us for any information that may help you do so.

Sincerely,



Lisa Sauder
Executive Director
Bean's Cafe, Inc.
PO BOX 100940
Anchorage, AK 99510
907-350-3818

[REDACTED]

From: Tiffany Stock [REDACTED]
Sent: Thursday, March 09, 2017 10:57 AM
To: Bernice Nisbett
Subject: Support of HB 123

Hi Bernice,

I just wanted to send an email showing that I fully support what HB 123 is trying to accomplish.

Transparency around the cost of healthcare services is imperative for creating a more informed consumer, encouraging competition amongst facilities and providers and aiding in creating lower cost healthcare.

I had a situation where my daughter needed surgery due to a broken thumb. The provider would not give me any estimate on the surgery and the facility gave me a quote of \$12,000-\$36,000 – both of these made it very scary to have a procedure done having no idea what my financial obligation would be.

Thank you for your attention.

Sincerely,

Tiffany

Tiffany Stock | Vice President, Sales & Marketing | Employee Benefits Consultant | Certified PPACA and Self-funding Professional | tstock@northrimbenefits.com

Northrim Benefits Group, LLC | 3111 C Street, Suite 500 | Anchorage, AK 99503 | P: 907-263-1401 | F: 907-279-6818 | www.northrimbenefits.com | Like us on [Facebook](#)

[REDACTED]

From: Rep. Ivy Spohnholz
Sent: Wednesday, March 08, 2017 7:11 PM
To: Bernice Nisbett
Subject: FW: Support of HB 123

FYI

Thanks!

Ivy

From: Marshall Pickering [REDACTED]
Sent: Wednesday, March 08, 2017 2:15 PM
To: Rep. Ivy Spohnholz <Rep.Ivy.Spohnholz@akleg.gov>
Subject: Support of HB 123

Hello Rep. Spohnholz,

My name is Marshall Pickering and I am a member of AAHU (the association of health underwriters) and I believe you came by one of our meetings back in 2016 when we had the Legislative panel with other reps in Anchorage. I wanted to send you an email in support of HB 123. Transparency is extremely important for consumers in regards to healthcare and hope that my testimony can help get the support that it needs to help get this bill passed. I work in the health insurance industry and have seen how the lack of transparency from providers puts low income and normal citizens at risk of being over charged for services, or even recommended to get services done that might not be medically necessary. I myself have been a victim of this as well a couple years ago, so I know it firsthand.

Thank you,

Marshall Pickering



March 8, 2017

Representative Ivy Spohnholz, Chair
House Health and Social Services Committee
Alaska House of Representatives
State Capitol Building, Room 421
Juneau, Alaska 99801

Representative Spohnholz,

Matanuska Telephone Association supports HB 123 and urges its passage. MTA is an employer with 284 employees in Alaska. Many with families, all of which are, at one time or another, a consumer of healthcare services.

The rising cost of healthcare in Alaska is making it difficult to provide reasonable compensation, including benefits. The costs escalation is not sustainable. The ability to identify cost drivers starts with the price of the product.

MTA's support for HB 123 is based on three considerations – market transparency, information availability and appropriate role of government.

Market Transparency - When buyers and sellers interact to exchange goods and services, a determined price and *the communication* of that price is essential for a functional market. Part of the reason Alaska's health care market is so dysfunctional is that prices for medical goods and services are not communicated during the process leading to an agreement, leaving buyers unable to substitute or seek a lower price. This situation is not because consumers of medical goods and services have failed to request, even demand, this information.

We are aware there are challenges to developing a transparent market. There are differentiations in price structures and services offered which make true comparisons difficult. In some cases, consumers may even opt for higher priced services, believing they are higher quality. However, generally we believe that when consumers have the information they need to make informed market decisions they will seek the best, lowest price, ultimately establishing a more competitive market. Over time, we believe this will lead to lower prices for services for Alaskans.

Information Availability - HB 123 is quite limited in scope. It requires medical providers to make known the prices for only the top 25 most common procedures they perform, and medical facilities for only the 50 most common services they

provide. This information is readily available, in some cases already disclosed in reports, and with facilities it is established on their chargemaster. The bill does not compel anyone to produce or generate anything that is not already known and used internally.

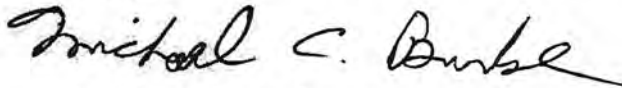
Alaska's medical providers and facilities are needed in our community. We don't want to see them burdened or forced to direct their attention away from patients.

Role of government - As businesspeople, the irony of supporting government intervention in a market is not lost on us, and we are understandably hesitant to do so. However, the market is so distorted that we fear unless something changes, it will fail.

Ideally, HB 123 would be unnecessary. We would much rather see consumers of health services and facilities already have the information they need to compare prices, and after considering other information about providers and facilities, make an informed market decision. We look forward to a time when, after providers and facilities become more accustomed to providing the transparency necessary for a functional market, and consumers expect and demand such information, HB 123 would be unnecessary and could be repealed. However, in light of the health care crises gripping Alaskans, we believe it is appropriate, and necessary, for the legislature to pass HB 123 to help balance the market.

For these reasons, MTA urges the 30th Alaska Legislature to pass HB 123 this year.

Sincerely,



Michael C. Burke, CEO
Matanuska Telephone Association

[REDACTED]

From: Barbara Bonner [REDACTED]
Sent: Wednesday, March 08, 2017 11:02 AM
To: Rep. Ivy Spohnholz; Bernice Nisbett
Subject: HB 123

I would like to express support for HB 123. In the same way that I can check prices at the supermarket before I buy, I would like to be able to check prices for medical procedures. I have actually had to call around trying to figure out the cheapest option for having a dental procedure done, and I know how time-consuming it can be. It would be much more convenient to be able to access some kind of chart online to be able to compare prices. In addition to the dental issue, I called around trying to check prices for a medical visit and although I had to code for the visit, the doctor's office would not give me a price because I was not a patient.

Please make medical and dental prices transparent!

[REDACTED]

From: Denali Flying Service [REDACTED]
Sent: Wednesday, March 08, 2017 6:02 PM
To: Bernice Nisbett
Subject: HB 123

March 7, 2017

Representative Ivy Spohnholz, Chair

House Health and Social Services Committee

Alaska House of Representatives

State Capitol Building, Room 421

Juneau, Alaska 99801

Representative Spohnholz,

Denali Flying Service supports HB 123 and urges its passage. Denali Flying Service is a small business in Alaska. We are consumer of healthcare services.

The rising costs of healthcare in Alaska is making it difficult to provide reasonable compensation including benefits. The costs escalation is not sustainable. The ability to identify cost drivers, starts with the price of the product.

Denali Flying Service support for HB 123 is based on three considerations – market transparency, information availability and appropriate role of government.

Market Transparency - When buyers and sellers interact to exchange goods and services, a determined price and *the communication* of that price is essential for a functional market. Part of the reason Alaska's health care market is so dysfunctional is that prices for medical goods and services are not communicated during the process leading to an agreement, leaving buyers unable to substitute or seek a lower price. This situation is not because consumers of medical goods and services have failed to request, even demand, this information.

We are aware there are challenges to developing a transparent market. There are differentiations in price structures and services offered which make true comparisons difficult. In some cases consumers may even opt for higher priced services, believing they are higher quality. However, generally we believe that when consumers have the information they need to make informed market decisions they will seek the best, lowest price, ultimately establishing a more competitive market. Over time, we believe this will lead to lower prices for services for Alaskans.

Information Availability - HB 123 is quite limited in scope. It requires medical providers to make known the prices for only the top 25 most common procedures they perform, and medical facilities only the 50 most common services they provide. This information is readily available, in some cases already disclosed in reports, and with facilities it is established on their chargemaster. The bill does not compel anyone to produce or generate anything that is not already known and used internally.

Alaska's medical providers and facilities are needed in our community. We don't want to see them burdened or forced to direct their attention away from patients. Based on our expertise, we are convinced that they can easily meet the requirements of HB 123.

Role of government - As businesspeople, the irony of supporting government intervention in a market is not lost on us, and we are understandably hesitant to do so. However, the market is so distorted that we fear unless something changes, it will fail.

Ideally, HB 123 would be unnecessary. We would much rather see consumers of health services and facilities already have the information they need to compare prices, and after considering other information about providers and facilities, make an informed market decision. We look forward to a time when, after providers and facilities become more accustomed to providing the transparency necessary for a functional market, and consumers expect and demand such information, HB 123 would be unnecessary and could be repealed. However, in light of the health care crises gripping Alaskans, we believe it is appropriate, and necessary, for the legislature to pass HB 123 to help balance the market.

For these reasons, Denali Flying Service urges the 30th Alaska Legislature to pass HB 123 this year. Please call on us for any information that may help you do so.

Sincerely,

Barry Stanley

Denali Flying Service



March 7, 2017

Representative Ivy Spohnholz, Chair
House Health and Social Services Committee
Alaska House of Representatives
State Capitol Building, Room 421
Juneau, Alaska 99801

Representative Spohnholz,

Fosselman and Associates, CPAs, a Palmer firm with 8 employees, supports HB 123 and urges its passage.

The rising costs of healthcare in Alaska is making it difficult to provide reasonable compensation including benefits. The costs escalation is not sustainable. Our current plan is being canceled. The premium increase for a replacement plan is 21.7% higher while in-network deductibles and out of pocket maximums are also increasing.

Plans with high deductibles and high out of pocket maximums place the onus of cost control on the employee. This is an impossible task when the prices for health care are difficult, if not impossible, to obtain in advance. Obtaining cost information from multiple providers and facilities is even more problematic. The benefits of consumer driven healthcare will never be realized without price information being readily available to the healthcare consumer.

In my work as a CPA, I am seeing more couples every year who were able to retire before age 65 establish residences in other states simply to be able to afford health insurance. Our current system is, in effect, creating a growing number of healthcare exiles. If current cost trends continue I expect this phenomenon to become more prevalent over time.

For these reasons, Fosselman and Associates, CPAs urges the 30th Alaska Legislature to pass HB 123 this year. Please call on us for any information that may help you do so.

Sincerely,

Catherine Fosselman

March 7, 2017

Representative Ivy Spohnholz, Chair
House Health and Social Services Committee
Alaska House of Representatives
State Capitol Building, Room 421
Juneau, Alaska 99801

Representative Spohnholz,

I support HB 123 and urges its passage. I have been in the insurance & employee benefits field for over 30 years and work with many employers in Alaska and their employees and families, all of whom are at one time or another a consumer of healthcare services.

The rising costs of healthcare in Alaska is making it difficult for individuals and families to receive and pay for care. The cost escalation is not sustainable.

Employers are making difficult decisions and increasing deductible and out of pocket amounts in the plans they offer employees and in many cases increasing the employee share of the premiums as well. Deductibles of \$2000 or more for individuals and \$4,000 or more for families have become commonplace in Alaska. In addition, families are asked to pay \$1500 or more for monthly premiums in many cases.

In order to assist employees in accessing affordable healthcare services we have been educating them on how to be a good consumer. However in order for that to happen the consumer must have the ability to access the information they need to make an informed decision. The Alaska consumer is able to research options on treatment, facilities, physicians and surgeons, and necessary testing options both in state and out of state. They are then able to discuss the options with their physician however in many cases consumers have no way to access cost information when receiving care in Alaska. Without this information the consumer is not able to make an informed decision and therefore has no idea what the financial obligation is for their treatment. Healthcare is the only type of service that functions this way.

As consumers we can shop options based on cost and quality for all other goods and services. We need to make that same information available for healthcare services.

The Municipality of Anchorage recently passed a transparency law that will help consumers here access information to shop to healthcare services. But the consumers in other areas of the state need to have the same access to information.

As cited in the Municipal Ordinance, many other states such as California, Texas, Minnesota and Ohio have passed price transparency laws that allow consumers to access cost information before consuming health services. Alaskans deserve to have access to cost information as well.

Much like the taxi industry is being changed by Uber and Airb&b is transforming the lodging industry I believe it's time for the healthcare industry to evolve and provide consumers with information they are demanding in a new and more timely way.

However with that said, Alaska's medical providers and facilities are needed in our community. We don't want to see them burdened or forced to direct their attention away from patients. The information required to be provided under HB 123 is information the hospitals and medical providers have ready access to and is limited to the most common services and procedures so it should not present a burden to them to provide.

For these reasons, I urge the 30th Alaska Legislature to pass HB 123 this year.

Sincerely,

Terry Allard, CEBS

Rep. Ivy Spohnholz

From: Michelle Ridgway [REDACTED]
Sent: Monday, March 06, 2017 9:11 AM
To: Rep. Ivy Spohnholz
Subject: Medical Cost Disclosure Bill

Dear Representative Spohnholz (and/or Staff):

I am THRILLED that you are putting cost transparency in the spotlight. I have thusfar only heard the KTOO radio report, and have tasked myself with reading the bill. Let me know if testimony is needed.

Briefly, I have had several experiences in which I have diligently researched treatment / procedure costs for friends, associates, family members and myself before making healthcare decisions in Alaska. I was apalled by Alaskan providers' inability and lack of willingness to provide cost estimates for most procedures. Many costs are controlled by Hospital corporations, and other entities out of State, and several community providers had no idea of the costs nor how to obtain the information. Further, I was shocked to learn of the 4.5 - 7.5 multiplier for same procedures in Alaskan coastal communities vs, say, Portland or Seattle (by the SAME corporate hospital!).

If you need public testimony with factual data exposing the cost opacity and implications to Alaskan's lives and productivity caused by this "hide the cost" practice, I will adust my work schedule, saddle up and go to the hill to testify. I am from Auke Bay.

If testimony is needed, please have a staffer email me today and let me know what time, room number and whether written or verbal testimony or both are preferred.

A pdf version of the bill would be handy as well.

Experiences in obtaining (or trying to obtain) specific cost data:

Kidney blockage removal in Juneau (cost was 4.2 x the estimate provided)

Shoulder injected MRI procedure in Kodiak (cost 5.5. X cost for same procedure in Portland or Seattle, but hospital would not / could not disclose that fact - I had to get data from Providence through 10 + calls to billing rabbit warren in Portland).

Simple eye procedure cost in Anchorage - 6 X cost range depending upon which price provider thought they could get. 7 phone calls to obtain actual cost.

Michelle Ridgway, 48-year Alaska Resident
(907) 957-2277



March 5, 2017

Representative Ivy Spohnholz, Chair
House Health and Social Services Committee
Alaska House of Representatives
State Capitol Building, Room 421
Juneau, Alaska 99801

Representative Spohnholz,

Denali Federal Credit Union (Denali), a financial cooperative owned by its 72,000 members, supports HB 123 and urges its passage. Denali has more than 325 employees currently residing in the state of Alaska. We also serve more than 700 sponsor groups and nearly 1,000 member businesses, all of which are consumers of healthcare services.

The rising cost of healthcare in Alaska is the greatest challenge we face when designing a competitive compensation and benefit program for our employees. Denali has attempted to combat unsustainable healthcare cost increases with creative alternatives that include self-funded insurance plans, out-of-state medical travel benefits, a Teledoc program, a high deductible health plan option, and others. Despite all of these efforts healthcare benefit costs continue to skyrocket for Denali. Increasing healthcare costs limit the number of staff we can hire and the range of services we can provide to our members.

The effect on our employees is also dramatic and extends beyond annual rate increases paid by employees. To reduce the monthly cost of health insurance, 37.9% of our employees have selected a high deductible plan. We offer a Health Savings Account to help mitigate deductible and co-insurance costs, but the inability to easily obtain cost information impedes their ability manage their healthcare costs. Comparing costs between providers and facilities is nearly impossible. Thus, our employees are taking on additional risk through higher deductibles, but do not have the tools readily available to manage costs effectively.

In light of the health care crises all Alaskans face, we believe it is necessary for the legislature to pass HB 123 to help our employees, members and sponsor groups manage the cost of healthcare. Denali Federal Credit Union urges the 30th Alaska Legislature to pass HB 123 this year.

Sincerely,

Dale Fosselman
Chief Corporate Development Officer

DENALI FEDERAL CREDIT UNION

[REDACTED]

From: Meghan Kennedy-Brown <[REDACTED]>
Sent: Sunday, March 05, 2017 3:16 PM
To: Bernice Nisbett; Rep. Ivy Spohnholz
Subject: HB123

I appreciate what you're doing with this bill and fully support it's passage. I believe that affordable care will be achieved through transparent pricing , not through the insurance companies.

Thank you,

Meghan

Rep. Ivy Spohnholz

From: Marnie Hartill [REDACTED]
Sent: Sunday, March 05, 2017 3:15 PM
To: Rep. Ivy Spohnholz; Rep. Bryce Edgmon; Rep. Sam Kito; Rep. Geran Tarr; Rep. David Eastman; Rep. Jennifer Johnston; Rep. Colleen Sullivan-Leonard; Rep. Matt Claman; Rep. Dan Saddler
Subject: Supporting HB 123

Dear Members of the House Health and Social Services Committee,

I am writing to you in strong support of HB 123.

I intend to testify on Thursday, but I will be between two meetings at 3pm in which I will be driving across town. In case that you might miss me, here is my written testimony:

Thank you for allowing me to testify on HB 123: concerning Health Care Transparency.

I speak to you today as an individual.

I could tell you about my personal frustrations a few years ago-- hopping from one chiropractor to another and to another until learning what the prices were: one charging the same code and price for a 15 minute massage therapy session as the other that provided a 60 minute massage therapy session. I could tell you about my referral for a mammogram that charged me \$900 without my being informed beforehand; later the whole amount was waived. I could tell you about the \$3000 MRI that I had to get, but again, I didn't know I was going to be paying for it for the next two years. I was not given the chance to shop around, but sent to one place. Later I learned that I could have gone to another imaging center that charged far less. I could tell you about my former husband who was in a car wreck and experienced knee surgery but there was a monopoly in town called OPA that over charged him what was fair and customary, made mistakes in his surgery, and then held him in a physical therapy loop that continued to take advantage of the insurance claim of the other party that struck his motorcycle.

As a public school teacher and active leader in the Anchorage Education Association, I have had many moments of advocacy for members who sought my help when seeking health care benefits through our health trust. In my experience and research, I have seen a rising cost of health care due to lack of transparency law. We also have struggled with the 80th percentile clause in the insurance regulations.

Moreover, I want to ask you to consult a resource that I developed this winter. I found that it was difficult to explain to my peers what the 80th percentile regulation was about, and what health cost transparency law would mean for Alaska.

So I developed a white paper.

You can see it too at bit.ly/80thpercent

I fought hard to get two New Business Items passed in our NEA- Alaska Delegate Assembly annual meeting this January. These two items passed and are backed by the thousands of teachers and education professionals in the state of Alaska. The two items support legislation for Health Care Transparency and advocate for removal of the 80thpercentile language.

I want you to know that this Transparency Law would reduce one of the largest cost drivers of our state budget. The cost of health care drives up health premiums, which drive up local school bargaining agreements, which drive up school district deficits, which drive further into our state fiscal situation. See this article from 2014 showing a graph that illustrates this problem:
<http://www.akbizmag.com/Alaska-Business-Monthly/December-2014/Alaskans-Like-to-Eat-Their-Cake-Up-to-a-Point/>

Last year, I was offended when Senator Cathy Giessel issued a newsletter that presented a bar graph showing the cost of public education increasing over the last several years while achievement allegedly dropped. What her bar graph failed to show was the astronomical percent of those public education costs which were Health care premiums and benefits packages in our state. If the legislature can get a hold on our medical care regulations and level the playing field, we can see fairness in health care charges for all Alaskans.

I am aware that many medical providers such as OPA are paying far more for lobbyists to reach out to you than I can match. But I thank you for your time, and hearing me out as a solitary concerned citizen.

Let me be clear, this is not a time for medical providers to be pointing fingers at insurance providers. No. We need to look closely at ALL variables in our health care system (not just insurance) and realize that the medical providers can be accountable too.

We are all accountable for our state fiscal crisis.

Sincerely,

Marnie Hartill
1553 A Street #323
Anchorage, AK 99501
(907)-744-6641



March 2, 2017

Representative Ivy Spohnholz, Chair
House Health and Social Services Committee
Alaska House of Representatives
State Capitol Building, Room 421
Juneau, Alaska 99801

Representative Spohnholz,

The Alaska Association of Health Underwriters (AAHU) supports HB 123 and urges its passage. AAHU is an association of nearly 100 licensed health insurance agents, brokers, consultants and benefit professionals who work with private and public employers and organizations throughout Alaska.

In our work with private companies, local governments, school districts, and others, we have witnessed the effect on Alaskans when employers can't afford, or are forced to limit, health insurance for their employees and dependents because of the high cost of medical services.

Our support for HB 123 is based on three considerations – market transparency, information availability, and appropriate role of government.

Market Transparency - When buyers and sellers interact to exchange goods and services, a determined price and *the communication* of that price is essential for a functional market. Part of the reason Alaska's health care market is so dysfunctional is that prices for medical goods and services are often not communicated prior to treatment. Therefore there is no agreement or understanding of price, leaving buyers unable to substitute or seek a lower price. In many cases, the outcome is not because consumers of medical goods and services have failed to request, even demand, this information.

We are aware there are challenges to developing a transparent market. There are differentiations in price structures and services offered which make true comparisons difficult. In some cases consumers may even opt for higher priced services, believing they are higher quality. However, generally we believe that when consumers have the information they need to make informed market decisions they will seek the best, lowest price, ultimately establishing a more competitive market. Over time, we believe this will lead to lower prices for services for Alaskans.

Information Availability - HB 123 is quite limited in scope. It requires medical providers to make known the prices for only the top 25 most common procedures they perform, and medical facilities only the 50 most common services they provide. This information is readily available, in some cases already disclosed in reports. For facilities it is established on their chargemaster. The bill does not compel anyone to produce or generate anything that is not already known and used internally.



Alaska Chapter Mission Statement

AAHU is a state chapter of the National Association of Health Underwriters. We provide professional development, promote high ethical standards of our members, advocate responsible legislation and proactively educate Alaskans on health and financial security needs.

President
Albert Fogle

Immediate Past-President
Jolene Bryant

President Elect
Hyo Jin Woo

Vice President
Tiffany Stock

Secretary
Johnna Golden

Treasurer
Rhonda Kitter

Executive Director
Kate Gootee



**Alaska Chapter
Mission Statement**

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Kate Gootee

Alaska's medical providers and facilities are our partners in providing health care for our clients. We don't want to see them burdened or forced to direct their attention away from patients. Based on our expertise, we are convinced that they can meet the requirements of HB 123.

Role of government - As businesspeople, the irony of supporting government intervention in a market is not lost on us, and we are understandably hesitant to do so. However, the market is so distorted that we fear unless something changes, it will fail.

Ideally, HB 123 would be unnecessary. We would much rather see consumers of health services and facilities already have the information they need to compare prices, and after considering other information about providers and facilities, make an informed market decision. We look forward to a time when, after providers and facilities become more accustomed to providing the transparency necessary for a functional market, and consumers expect and demand such information, HB 123 would be unnecessary and could be repealed. However, in light of the health care crises gripping Alaskans, we believe it is appropriate, and necessary, for the legislature to pass HB 123 to help balance the market.

For these reasons, AAHU urges the 30th Alaska Legislature to pass HB 123 this year. Please call on us for any information that may help you do so.

Sincerely,


AAHU President



ALASKA PERMANENT
CAPITAL MANAGEMENT[®]
Registered Investment Adviser

March 1, 2017

Representative Ivy Spohnholz, Chair
House Health and Social Services Committee
Alaska House of Representatives
State Capitol Building, Room 421
Juneau, Alaska 99801

Representative Spohnholz,

Alaska Permanent Capital Management Company supports HB 123 and urges its passage. Alaska Permanent Capital Management Company is an employer with 20 employees in Alaska. Many with families, all of which are at one time or another a consumer of healthcare services.

The rising costs of healthcare in Alaska is making it difficult to provide reasonable compensation including benefits. The costs escalation is not sustainable. The ability to identify cost drivers, starts with the price of the product.

Alaska Permanent Capital Management Company's support for HB 123 is based on three considerations – market transparency, information availability and appropriate role of government.

Market Transparency - When buyers and sellers interact to exchange goods and services, a determined price and *the communication* of that price is essential for a functional market. Part of the reason Alaska's health care market is so dysfunctional is that prices for medical goods and services are not communicated during the process leading to an agreement, leaving buyers unable to substitute or seek a lower price. This situation is not because consumers of medical goods and services have failed to request, even demand, this information.

We are aware there are challenges to developing a transparent market. There are differentiations in price structures and services offered which make true comparisons difficult. In some cases consumers may even opt for higher priced services, believing they are higher quality. However, generally we believe that when consumers have the information they need to make informed market decisions they will seek the best, lowest price, ultimately establishing a more competitive market. Over time, we believe this will lead to lower prices for services for Alaskans.

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Alaska's medical providers and facilities are needed in our community. We don't want to see them burdened or forced to direct their attention away from patients.

Role of government - As businesspeople, the irony of supporting government intervention in a market is not lost on us, and we are understandably hesitant to do so. However, the market is so distorted that we fear unless something changes, it will fail.

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For these reasons, Alaska Permanent Capital Management Company urges the 30th Alaska Legislature to pass HB 123 this year.

Sincerely,



Evan Rose
CEO

February 28, 2017

Representative Ivy Spohnholz, Chair
House Health and Social Services Committee
Alaska House of Representatives
State Capitol Building, Room 421
Juneau, Alaska 99801

Representative Spohnholz,

I support HB 123 and urges its passage. I own and manage businesses in Alaska and would like to see the cost of healthcare and insurance in Alaska be more affordable.

The rising costs of healthcare in Alaska is making it difficult to provide reasonable compensation including benefits. The costs escalation is not sustainable. The ability to identify cost drivers, starts with the price of the product.

I support market transparency, information availability and appropriate role of government.

Market Transparency - When buyers and sellers interact to exchange goods and services, a determined price and *the communication* of that price is essential for a functional market. Part of the reason Alaska's health care market is so dysfunctional is that prices for medical goods and services are not communicated during the process leading to an agreement, leaving buyers unable to substitute or seek a lower price. This situation is not because consumers of medical goods and services have failed to request, even demand, this information.

We are aware there are challenges to developing a transparent market. There are differentiations in price structures and services offered which make true comparisons difficult. In some cases consumers may even opt for higher priced services, believing they are higher quality. However, generally we believe that when consumers have the information they need to make informed market decisions they will seek the best, lowest price, ultimately establishing a more competitive market. Over time, we believe this will lead to lower prices for services for Alaskans.

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For these reasons, I urge the 30th Alaska Legislature to pass HB 123 this year.

Sincerely,

/S/

Bhree Roumagoux

Taku Engineering, LLC
205 East Benson Blvd, Suite 201
Tel 907.562.147
billmott@takuengineering.com
takuengineering.com



FEBRUARY 28, 2017

Representative Ivy Spohnholz, Chair

House Health and Social Services Committee
Alaska House of Representative
State Capitol Building, Room 421
Juneau, Alaska 99801

Representative Spohnholz,

Taku Engineering, LLC supports HB 123 and urges its passage. Taku Engineering is an employer with 18 employees in Alaska. Many with families, all of which are at one time or another a consumer of healthcare services.

The rising cost of healthcare in Alaska is making it difficult to provide reasonable compensation including benefits. The costs escalation is not sustainable. The ability to identify cost drivers, starts with the price of the product.

Taku Engineering's support for HB 123 is based on three considerations - market transparency, information availability and appropriate role of government.

Market Transparency - When buyers and sellers interact to exchange goods and services, a determined price and the *communication* of that price is essential for a functional market. Part of the reason Alaska's health care market is so dysfunctional is that prices for medical goods and services are not communicated during the process leading to an agreement, leaving buyers unable to substitute or seek a lower price. This situation is not because consumers of medical goods and services have failed to request, even demand, this information.

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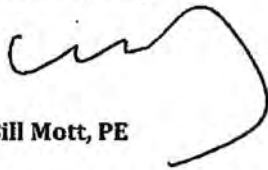
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For these reasons, Taku Engineering, LLC urges the 30th Alaska Legislature to pass HB 123 this year.

Warm regards,

A handwritten signature in black ink, appearing to read 'Bill Mott', written over a large, stylized, handwritten flourish or scribble.

Bill Mott, PE

OWNER



allen & petersen
cooking & appliance center

February 28, 2017

Representative Ivy Spohnholz, Chair
House Health and Social Services Committee
Alaska House of Representatives
State Capitol Building, Room 421
Juneau, Alaska 99801

Representative Spohnholz,

Allen & Petersen Cooking & Appliance Center supports HB 123 and urges its passage. Allen & Petersen Cooking & Appliance Center is an employer with 40 employees in Alaska. Many with families, all of which are at one time or another a consumer of healthcare services.

The rising costs of healthcare in Alaska is making it difficult to provide reasonable compensation including benefits. The costs escalation is not sustainable. The ability to identify cost drivers, starts with the price of the product.

Allen & Petersen Cooking & Appliance Center support for HB 123 is based on three considerations – market transparency, information availability and appropriate role of government.

Market Transparency - When buyers and sellers interact to exchange goods and services, a determined price and *the communication* of that price is essential for a functional market. Part of the reason Alaska's health care market is so dysfunctional is that prices for medical goods and services are not communicated during the process leading to an agreement, leaving buyers unable to substitute or seek a lower price. This situation is not because consumers of medical goods and services have failed to request, even demand, this information.

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Kyle D. Mirka
Owner
Allen & Petersen
3002 Seward Hwy
Anchorage, AK 99503
OFF (907) 276-0239
CEL (907) 230-7432
FAX (907) 276-7689



allen & petersen
cooking & appliance center

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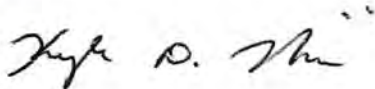
Alaska's medical providers and facilities are needed in our community. We don't want to see them burdened or forced to direct their attention away from patients.

Role of government - As businesspeople, the irony of supporting government intervention in a market is not lost on us, and we are understandably hesitant to do so. However, the market is so distorted that we fear unless something changes, it will fail.

Ideally, HB 123 would be unnecessary. We would much rather see consumers of health services and facilities already have the information they need to compare prices, and after considering other information about providers and facilities, make an informed market decision. We look forward to a time when, after providers and facilities become more accustomed to providing the transparency necessary for a functional market, and consumers expect and demand such information, HB 123 would be unnecessary and could be repealed. However, in light of the health care crises gripping Alaskans, we believe it is appropriate, and necessary, for the legislature to pass HB 123 to help balance the market.

For these reasons, Allen & Petersen Cooking & Appliance Center urges the 30th Alaska Legislature to pass HB 123 this year.

Sincerely,



Kyle D. Mirka
Owner
Allen & Petersen
3002 Seward Hwy
Anchorage, AK 99503
OFF (907) 276-0239
CEL (907) 230-7432
FAX (907) 276-7689



4492 E. Fairview Loop
Wasilla, AK 99654
907-376-4784 Voice
907-376-7596 Fax

February 28, 2017

Representative Ivy Spohnholz, Chair
House Health and Social Services Committee
Alaska House of Representatives
State Capitol Building, Room 421
Juneau, Alaska 99801

Representative Spohnholz,

Valley Block & Concrete supports HB 123 and urges its passage. Valley Block & Concrete is an employer with 42 employees in Alaska. Many with families, all of which are at one time or another a consumer of healthcare services.

The rising costs of healthcare in Alaska is making it difficult to provide reasonable compensation including benefits. The costs escalation is not sustainable. The ability to identify cost drivers, starts with the price of the product.

Valley Block & Concrete's support for HB 123 is based on three considerations – market transparency, information availability and appropriate role of government.

Market Transparency - When buyers and sellers interact to exchange goods and services, a determined price and *the communication* of that price is essential for a functional market. Part of the reason Alaska's health care market is so dysfunctional is that prices for medical goods and services are not communicated during the process leading to an agreement, leaving buyers unable to substitute or seek a lower price. This situation is not because consumers of medical goods and services have failed to request, even demand, this information.

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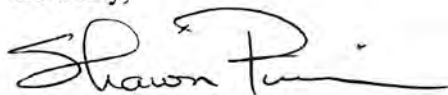
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For these reasons, Valley Block & Concrete urges the 30th Alaska Legislature to pass HB 123 this year.

Sincerely,

A handwritten signature in black ink, appearing to read "Shawn Purviance". The signature is fluid and cursive, with a large initial "S" and "P".

Shawn Purviance
Operations Manager
Valley Block & Concrete



February 28, 2017

Representative Ivy Spohnholz, Chair
House Health and Social Services Committee
Alaska House of Representatives
State Capitol Building, Room 421
Juneau, Alaska 99801

Representative Spohnholz,

Continental Auto Group supports HB 123 and urges its passage. Continental Auto Group is an employer with 250 employees in Alaska. Many with families, all of which are at one time or another a consumer of healthcare services.

The rising cost of healthcare in Alaska is making it difficult to provide reasonable compensation including benefits. The costs escalation is not sustainable. The ability to identify cost drivers starts with the price of the product.

Continental Auto Group support for HB 123 is based on three considerations – market transparency, information availability and appropriate role of government.

Market Transparency - When buyers and sellers interact to exchange goods and services, a determined price and *the communication* of that price is essential for a functional market. Part of the reason Alaska's health care market is so dysfunctional is that prices for medical goods and services are not communicated during the process leading to an agreement, leaving buyers unable to substitute or seek a lower price. This situation is not because consumers of medical goods and services have failed to request, even demand this information.

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For these reasons, Continental Auto Group urges the 30th Alaska Legislature to pass HB 123 this year.

Sincerely,



Marten Martensen

Owner/Dealer

Continental Auto Group

Rep. Ivy Spohnholz

From: akhouse@belfast.servershost.net on behalf of Elizabeth Krome
<akhouse@belfast.servershost.net>
Sent: Tuesday, February 21, 2017 8:02 PM
To: Rep. Ivy Spohnholz
Subject: HB 123

From: Elizabeth Krome [REDACTED]
Subject: HB 123

Message Body:

I so appreciate this bill and fully support it. It is important that the public be aware of the cost for medical care. Only with education of consumers can change come about. Thank you.

E. C. Krome
3642 N. Sams Dr.
Wasilla, AK. 99654

--

This e-mail was sent from a contact form on Representative Ivy Spohnholz (http://akhouse.org/rep_gruenberg)

Rep. Ivy Spohnholz

From: Michael Humphrey [REDACTED]
Sent: Tuesday, February 21, 2017 10:23 AM
To: Rep. Ivy Spohnholz
Subject: HB 123

Representative Ivy Spohnholz

Wanted to let you know that I am in full support of HB123. I agree that we need to "empowers consumers to make informed decisions about their health care options by ensuring accessible information on medical pricing."

If i can be of help, please call on me.

Mike Humphrey - Retired UA Systemwide Director of Benefits

Jody Simpson

From: Marnie Hartill <marniehartill@gmail.com>
Sent: Sunday, April 23, 2017 11:04 AM
To: Sen. David Wilson
Cc: Sen. Natasha Von Imhof; Sen. Cathy Giessel; Sen. Peter Micciche; Sen. Tom Begich
Subject: Support HB 123

Dear Senator David Wilson, and the members of the Senate Health and Social Services Committee,

I am writing to you asking for your support of HB 123, relating to transparency of common health care charges billed by providers. Right now, many Alaskans such as myself are looking to adjust our health care plans to a higher deductible plan with a lower premium. As you know, the cost of premiums is defined by the regional market. Unfortunately, we have some monopolies in our health care market which are currently taking advantage of everyday Alaskans.

Currently, I can fly to Seattle to receive (for example) knee surgery for less than 1/4 the cost billed here in Anchorage for the same surgery. If we can regulate these abuses and get the market under control, the health care insurance premiums will decrease.

Specialists do need to be fairly compensated for their services, but Alaskans deserve to know how much they will be billed for procedures within a common range. Many states have already adopted this type of legislation and it has benefited the citizens and improved the health care system. Patients have rights to know what they will be billed before selecting a provider.

I want to tell you that I am grateful for your support of HB 123. It is a step in the right direction to positively impact conditions in the health care market in Alaska.

Sincerely,

Marnie Hartill
1553 A Street #323
Anchorage, AK 99501

907-744-6641

[REDACTED]

I am hoping to be able to testify at the HB 123 hearing on Friday, but in case I cannot I wanted to offer written testimony.

[REDACTED]

As a consumer and as an employer it is long overdue that price transparency become available in the medical sector. There are really no other services that any of us would engage in without some idea as to the cost of those services – from an hourly rate of a legal representative or accountant to a full estimate for work on our automobiles.

I would also encourage the requirement to disclose the insurance carriers a provider and/or facility and/or services are under contract with as an in-network preferred provider/facility/service.

I had a personal experience with this phenomenon when I asked the wrong question “Do you take “X” insurance”. Well, of course they did as I was covered under a co-pay policy for the physician that covered both in and out of network providers. What I did not understand was that by not having all the facts, not only was the provider not in-network but the facility services were not in-network. So the other services and/or tests would be billed outside of my network agreements, at much higher rates than an in-network facility and with the additional 20% out of pocket over the in-network facility.

For this visit I had brought test results from an in-network provider, so it did not even occur to me that the facility would order in-house tests if they were not in-network. Well they did, I got the bill and was floored. I contacted the in-network provider and was given the procedure cost difference, it was significant. I then contacted the new provider and when I asked how they could charge so much more – the over-priced facility answer was “because we can!” That was not the response I expected.

This demonstrates that the lack of transparency not only leaves the consumer feeling completely helpless, there is no incentive for providers or facilities to consider basic customer service niceties or concessions. In other business sectors that first phone call, or certainly the two letters that followed, would likely have brought forth some form of concession and the staff in the accounting department would have been trained to better handle such a situation. But all that was offered was no response at all.

ECI

Mary Knopf, ASID, IIDA, LEED AP BD+C, ALEP
PRINCIPAL | INTERIOR DESIGNER

3909 Arctic Boulevard, Suite 103
Anchorage, Alaska 99503
907.565.5014 d | 907.561.5543 o | 907-240-8964 c
www.ecialaska.com



March 14, 2018

Transparency

Representative Ivy Spohnholz, Chair
House Health and Social Services Committee
Alaska House of Representatives
State Capitol Building, Room 421
Juneau, Alaska 99801

Representative Spohnholz,

SolstenXP Inc. supports HB 123 and urges its passage. SolstenXP Inc. and its affiliate companies employ over one hundred employees in Alaska. Many of these people have families, all of which are consumers of healthcare services.

Rising healthcare costs in Alaska make it difficult to provide competitive compensation and benefits compared with out of state organizations. The local healthcare cost escalation is not sustainable. The ability to identify cost drivers starts with the price of the product.

Medical expenses should be known by the consumer, up front, before purchase, like any other product or service.

SolstenXP Inc. urges the 30th Alaska Legislature to pass HB 123 this year.

Sincerely,

A handwritten signature in black ink, appearing to read "T.S. Redmond II".

Thomas S. Redmond II
Director of Human Resources
SolstenXP Inc.

Cc: Senator David Wilson, Chair
Senate Health and Social Services
State Capital Building, Room 115
Juneau, AK 99801

Senator David Wilson, Chair
Senator Natasha von Imhof, Vice Chair
Senator Cathy Giessel
Senator Peter Micciche
Senator Tom Begich

March 15, 2018

Honorable Senators:

Healthcare consumers are increasingly seeking information about the costs of healthcare procedures. Timely, transparent disclosure of healthcare costs is essential to protecting the interests of consumers and allowing markets to function efficiently. Healthcare is currently the only industry in which consumers receive a service without being able to understand the price in advance or in a predictable manner.

Many residents in our Alaskan communities have experienced difficulties in obtaining information about the costs of healthcare services in a timely and consistent fashion. These difficulties foment a culture of mistrust and create uncertainty, billing disputes, and an increased tendency to seek medical services outside of Alaska – none of which are in the best interest of our homegrown practitioners or the health of our state as a whole.

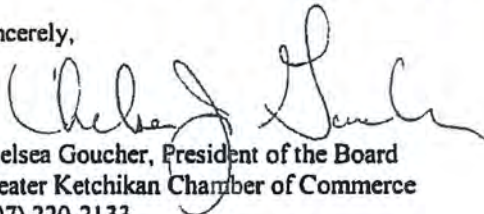
The Municipality of Anchorage has taken a proactive approach to mitigate these issues by adopting a municipal ordinance. The City of Ketchikan is currently considering a similar ordinance and is in the process of gathering public comment. These local actions prove that, across the state, there is a very real appetite to write pricing transparency standards into law.

These comments are respectfully submitted on behalf of the Board of Directors of the Greater Ketchikan Chamber of Commerce. Representing over 200 member businesses in southern southeast Alaska, we advocate for a sound business climate and work to promote a superb quality of life for our local residents. Supporting a statewide law that would alleviate many of the problems associated with opaque pricing practices in the healthcare industry is something that fits our mission perfectly.

We believe that House Bill 123, version G's requirements are reasonable and can be easily met by any reputable practitioner. While we will continue to advocate for improved healthcare transparency here in Ketchikan via municipal ordinance, we fully support this bill and understand that it would preempt local municipal code. We believe this bill in particular strikes a sound balance of protecting consumers while not placing an undue administrative burden on providers; in fact, we believe it's passage will bolster their competitive position. House Bill 123 will support community livability and resident satisfaction, helping to make Alaska a more attractive place to live, work, and do business.

Alaska deserves a standard set of requirements which are the same for all providers. The best way to achieve that would be for the Alaska State Legislature to take action to adopt House Bill 123, version G. Please consider seriously passing this piece of legislation through committee at the earliest time possible and, ultimately, passing it into law. Thank you.

Sincerely,



Chelsea Goucher, President of the Board
Greater Ketchikan Chamber of Commerce
(907) 220-2133



THE STATE
of ALASKA

GOVERNOR BILL WALKER

Department of Health and Social Services

ALASKA COMMISSION ON AGING

P.O. Box 110693
Juneau, Alaska 99811-0693
Main: 907.465.3250
Fax: 907.465.1398

March 15, 2018

Senator David Wilson
Senate Health and Social Services Committee
Alaska State Capitol, Room 115
Juneau, AK 99801-1182

Subject: Support for CSHB 123, Disclosure of Health Care Costs and Price Information

Dear Chair Wilson:

The Alaska Commission on Aging ("the Commission") is pleased to offer support for CSHB 123, a bill authored by Representative Spohnholz that would require health care practitioners and facilities to publicly disclose medical care price information. The Commission supports price transparency as a means to promote increased consumer awareness and greater efficiency in Alaska's health care delivery system.

The Alaska Commission on Aging is a Governor-appointed board within the Department of Health and Social Services that is responsible for planning services for seniors, educating Alaskans about senior issues, and making recommendations directly to elected officials regarding policy and budget items that affect Alaska's seniors.

The aging of Alaska's population presents unique challenges for our state's health care delivery system. Such factors include the increasing numbers of people living with chronic disease and health conditions, their need for health care services to treat those conditions, workforce shortages, and the price of health care. According to the Alaska Medicare Information Office, there were 86,130 Alaskans on Medicare in 2017 with the majority of them being age 65 and older. People who are eligible for Medicare include individuals age 65 and older who have contributed to Medicare through employment; younger people with permanent disabilities who receive Social Security Disability Income payments for at least 24 months; and persons with End Stage Renal Disease. Alaska's population of people age 65 and older number 82,686 citizens in 2017 representing approximately 11.2% of the state's total population (Alaska Department of Labor, January 2018). Older Alaskans are particularly vulnerable to increases in medical costs as many live on fixed incomes. From the perspective of an older person, having access to health care price information allows patients to make informed decisions regarding their health care *before* they receive services and encourages meaningful conversations with their health care providers.

The need to improve transparency of medical health care pricing was a priority issue identified by seniors and other public members participating in the Medicaid Redesign community forums conducted by the Commission at senior centers in 2015. These participants identified medical price disclosure as a key factor that could lead to improved quality and more affordable health care. We believe that CSHB 123 addresses this concern head-on in a manner that is compliance manageable for health care providers.

In particular, we appreciate the addition of the *Good Faith Estimate* requirement under Article 4, Sec. 18.23.400 (g)(1) in the CS (version G) that allows the patient the right to request a cost estimate from their provider for a non-emergency health care procedure, before services are provided, that includes a reasonable breakdown of the anticipated charges sent within ten business days from receiving the request. Similar to consumers shopping for a home or other major expenditure, patients having medical price information are in a better position to make cost-benefit decisions about their health care and plan their personal budgets accordingly.

The Commission agrees in concept with the proposed legislation but is concerned about an important aspect of its implementation that affects older Alaskans. Although CSHB 123 requires health care price disclosures for undiscounted health care costs, as well as payment rates for Medicaid, there is no mention of requirements for disclosing Medicare medical costs either in the annual listing of health care costs publicly posted by health care practitioners and health care facilities or in the Good Faith Estimate given to patients by their providers. Seniors, more than any other age group, are consumers of health care. The majority of them are insured by Medicare. Even in situations where a person holds dual eligibility for Medicare and Medicaid, Medicare is the primary insurer. Without having knowledge of the Medicare costs for services provided by the Good Faith Estimate, we are concerned that Medicare beneficiaries will not fully benefit from this legislation. To address this need to know, we respectfully recommend disclosing Medicare costs for health care services in the Good Faith Estimate for Medicare patients. In this way, health care cost information can be made more transparent and of benefit to patients.

The Commission supports CSHB 123 and views this legislation as a positive step forward in promoting greater consumer awareness about health care costs to improve the efficiency of Alaska's health care delivery system. We appreciate your thoughtful consideration of this legislation and our proposed recommendations.

Sincerely,



David A. Blacketer
Chair, Alaska Commission on Aging

Sincerely,



Denise Daniello
ACoA Executive Director

Cc: Senator Natasha von Imhof, Vice Chair
Senator Cathy Giessel
Senator Peter Micciche
Senator Tom Begich
Representative Ivy Spohnholz

House Bill 123: DISCLOSURE HEALTH CARE COSTS

Amendment No. 1 --- 30-LS0380 \ G.3

Specifically, the amendment does the following:

- **Page 5, Line 26: changes the amount of the civil penalty per-violation cap from \$5000 to \$10,000.**
- **Page 6, Line 25: Includes tribal facilities under the definition of “health care facility.”**
 - **This means tribal facilities would need to comply with the bill’s requirements.**

AMENDMENT # 1

OFFERED IN THE SENATE

BY SENATOR WILSON

TO: SCS CSHB 123(), Draft Version "G"

1 Page 5, line 26:

2 Delete "\$5,000"

3 Insert "\$10,000"

4

5 Page 6, line 25:

6 Delete all material.

7

8 Reletter the following subparagraph accordingly.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

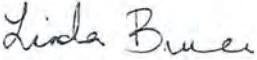
State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

March 30, 2018

SUBJECT: Tribal health facilities
(SCS CSHB 123(); Work Order No. 30-LS0380\G.3)

TO: Senator David Wilson
Attn: Gary Zepp

FROM: Linda M. Bruce 
Legislative Counsel

Attached to this memorandum is the amendment that you requested to remove tribal health organizations from the definition of "health facility." This memorandum is a follow-up to a phone conversation I had with Senator Wilson regarding this issue. In the limited time available to respond to your question I am not able to research the matter in depth. However, note that requiring a tribal health organization to report health care services, price, and fee information may violate the Supremacy Clause of the United States Constitution, which provides that "federal laws are supreme." (U.S. Const. art. VI, cl. 2.) As the Alaska Supreme Court has explained

There are three major types of federal preemption of state law: "express," "field," and "conflict" preemption. Express preemption occurs when Congress explicitly declares an intent to preempt state law in a particular area. . . . Field preemption is the term used when the federal law governing a particular area is so comprehensive and so complete that Congress is said to have completely occupied a field, leaving no room for state law. We "will not infer an intent to occupy the field where Congress has left some room for state involvement." . . . Conflict preemption occurs when a state law and a federal law are in conflict, either because compliance with both state and federal law is impossible or because the state law "stands as an obstacle to accomplishment and execution of the full purposes and objectives of Congress." . . .¹

It appears that Congress has neither expressly or implicitly indicated that federal law preempts state regulation of tribal facilities in all matters. However, requiring a tribal health organization to disclose price information may be subject to conflict preemption. The Alaska Attorney General has previously found that state licensure requirements were

¹ *Allen v. State*, 203 P.3d 1155, 1160 - 1161 (Alaska 2009) (citations and footnotes omitted).

Senator David Wilson
March 30, 2018
Page 2

subject to conflict preemption for dental health aides employed in Native Health Clinics² and pharmacists working for tribal health programs.³

My research has not revealed any judicial decision which has addressed a factual situation similar to what we discussed. Health care facilities that operate under a contract or compact with the federal Indian Health Service are subject to the Indian Self-Determination and Education Assistance Act, 25 U.S.C. sec. 450, et. seq. On its face, that Act is not in conflict with the provisions of the bill concerning price disclosures. Therefore, as we discussed, I am not aware of any specific statute or regulation that specifically preempts a state from requiring that a tribal health organization report health care services, price, and fee information. However, I am not an expert in tribal law. You may wish to consult an attorney with expertise in this area to determine if your amendment could cause liability for the state.

If I may be of further assistance, please advise.

LMB:mlp
18-205.mlp

Attachment

² 2005 Inf. Op. Att'y Gen. (Sept. 8; 663-05-0152) (see attached).

³ 2012 Op. Att'y Gen. (April 17, AN2009102500) (see attached).

House Bill 123: DISCLOSURE HEALTH CARE COSTS

Amendment No. 2 --- 30-LS0380 \ G.5

- **Requested by the Department**
- **Adds a new Section 3 to allow the department to adopt regulations necessary to implement the changes made by the Act.**

Specifically, the amendment does the following:

- **Page 7, following Line 20: inserts new section containing transition language for the adoption of regulations by the Department**
- **Adds a new section 4, which states Section 3 takes effect immediately.**
- **Page 7, Line 21, provides for both the new immediate effective date of Section 4, as well as the original January 1, 2019, effective date for the rest of the bill.**
- **Renumbers the bill sections accordingly**

AMENDMENT #2

OFFERED IN THE SENATE

BY SENATOR WILSON

TO: SCS CSHB 123(), Draft Version "G"

1 Page 7, following line 20:

2 Insert new bill sections to read:

3 **** Sec. 3.** The uncodified law of the State of Alaska is amended by adding a new section to
4 read:

5 TRANSITION: REGULATIONS. The Department of Health and Social Services may
6 adopt regulations necessary to implement the changes made by this Act. The regulations take
7 effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the
8 law implemented by the regulation.

9 *** Sec. 4.** Section 3 of this Act takes effect immediately under AS 01.10.070(c)."
10

11 Renumber the following bill section accordingly.
12

13 Page 7, line 21:

14 Delete "This"

15 Insert "Except as provided in sec. 4 of this Act, this"

House Bill 123: DISCLOSURE HEALTH CARE COSTS

Amendment No. 3 30-LS0380 \ G.6

- Amendment No. 3 adds “health care insurers” to the entities that shall provide good faith estimates to patients who request them for non-emergency health care services.

Specifically, the amendment does the following:

- Page 1, Line 1: Adds “relating to health care insurers” to the title of the bill.
- Beginning on Page 4, Line 6, various subsections under Section 2 (g): deletes “or facility” and inserts “ , health care facility, or health care insurer”
- Page 5, Line 25, following “section”: Inserts “health care insurer” to ensure that insurers will be held liable for civil penalties for not complying with the bill. (Version G currently says not-to-exceed \$5000, but your other amendment raises that to \$10,000, if adopted.)
- Page 7, following Line 20, adds a new Section 3, that adds “a health care insurer” to those who shall provide a good faith estimate.
- Renumbers the bill sections accordingly

AMENDMENT #3

OFFERED IN THE SENATE

BY SENATOR WILSON

TO: SCS CSHB 123(), Draft Version "G"

- 1 Page 1, line 1, following "**information;**":
2 Insert "**relating to health care insurers;**"
3
4 Page 4, line 6:
5 Delete "or health care facility"
6 Insert ", health care facility, or health care insurer"
7
8 Page 4, line 8:
9 Delete "or health care facility"
10 Insert ", health care facility, or health care insurer"
11
12 Page 4, line 14:
13 Delete "or health care facility"
14 Insert ", health care facility, or health care insurer"
15
16 Page 4, lines 23 - 24:
17 Delete "or health care facility"
18 Insert ", health care facility, or health care insurer"
19
20 Page 5, line 17:
21 Delete "or health care facility"
22 Insert ", health care facility, or health care insurer"
23

1 Page 5, line 25, following "section":

2 Insert "or a health care insurer that fails to comply with the requirements of (g) and (h)
3 of this section"

4

5 Page 5, line 31:

6 Delete "or health care facility"

7 Insert ", health care facility, or health care insurer"

8

9 Page 7, following line 20:

10 Insert a new bill section to read:

11 "* **Sec. 3.** AS 21.96 is amended by adding a new section to read:

12 **Sec. 21.96.200. Good faith estimate.** Upon request of a covered person who is
13 receiving nonemergency health care services, a health care insurer shall provide a
14 good faith estimate of the amount of the reasonably anticipated charges for treating the
15 patient's specific condition under AS 18.23.400(g) and (h)."

16

17 Renumber the following bill section accordingly.



**FRESENIUS
MEDICAL CARE**

RECEIVED APR 03 2018

April 3, 2018

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

Subject: HB123, relating to disclosure of health care costs

Dear Senator Wilson:

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

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

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

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

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



FRESENIUS MEDICAL CARE

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

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

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

Thank you for considering this request.

Sincerely

Wendy Funk Schrag

Wendy Funk Schrag, LMSW, ACSW
Vice President State Government Affairs
316.841.5245
Wendy.schrag@fmc-na.com

Jody Simpson

From: Dale Fosselman <fossels@me.com>
Sent: Friday, March 16, 2018 2:17 PM
To: Senate Health and Social Services
Subject: Support for HB123

Members of the Senate Health and Social Services Committee

I am writing to urge passage of HB 123. The primary driver of Alaska's egregious cost of healthcare is the underlying cost of care. Today, it is nearly impossible to be an informed consumer because, at the most fundamental level, providers and facilities do not readily provide cost estimates to their current patients. Prospective patients comparing costs face even greater challenges.

Recently I researched costs for the ACA Silver Plan on the Kaiser Family Foundation website to find an apples to apples comparison of costs and benefits. The annual cost is \$15,499 in Seattle and \$34,027 in Wasilla. According to the website, my out of pocket maximum is \$14,700 so we are by no means looking at a lucrative plan on the benefits side of the equation. The \$18,528 annual cost differential has real consequences for Alaska businesses and families.

Alaska firms are at cost disadvantage to competitors in the Lower 48 and the high cost of health insurance is an all too real impediment to hiring new employees.

For families, the impact can also be disruptive. I have several retired or semi-retired friends who have established residency in the Lower 48 simply because of the differential in the cost of healthcare. This outmigration has a multiplier effect on the Alaska economy as their spending moves south with them.

Passage of HB 123 will help address the issue of unsustainable healthcare costs in Alaska, but it is only a first step. It is an important step, however, and I urge the Committee to pass HB 123

Thank you

Dale Fosselman

Wasilla