Submitted by: Chair of the Assembly at the Request of the Mayor
Prepared by: Dept. of Law
For reading: February 14, 2017

Municipal Clerk's Office
Amended and Approved
Date: 2/28/2017

ANCHORAGE, ALASKA
AO No. 2017-26, As Amended

AN ORDINANCE OF THE ANCHORAGE MUNICIPAL ASSEMBLY TO REQUIRE HEALTH CARE PRACTITIONERS AND FACILITIES, UPON REQUEST, TO PROVIDE AN ESTIMATE OF ANTICIPATED HEALTH CARE CHARGES.

WHEREAS, health care consumers, especially those with high-deductible plans, are increasingly seeking information about the costs of health care procedures;

WHEREAS, markets cannot function efficiently without meaningful pricing information;

WHEREAS, citizens have reported difficulty in obtaining information about the costs of health care services;

WHEREAS, health care costs are a significant portion of the Municipal budget;

WHEREAS, in 2016, 28% of employees receiving health insurance through the municipality enrolled in the high-deductible plan;

WHEREAS, the Municipality's health care costs have increased significantly, from an average cost per enrolled employee per month of $1,064.90 in 2005 to approximately $2,347.54 in 2016, with an average annualized rate of increase in plan costs of approximately 7.6%;

WHEREAS, plan costs plus employees' cost shares (in the form of deductibles, coinsurance and co-pays) per enrolled employee per month has increased from approximately $1,750 in 2010 to approximately $2,415 in 2015, for an average annualized rate of increase of approximately 6.9%;

WHEREAS, several jurisdictions, including most recently Florida and Ohio, have adopted health care price transparency laws with the twin aims of empowering health care consumers and possibly reducing health care costs; now, therefore,

THE ANCHORAGE ASSEMBLY ORDAINS:

Section 1. Anchorage Municipal Code title 16 *Health* is hereby amended to add a new chapter 130 *Health Care Transparency* to read as follows:

16.130.010. Estimate of Charges Upon Request

A. *Disclosures by Practitioner.* Upon request by a patient, before providing nonemergency medical services and not later than **10**[~~7~~] business days after receiving the request, a health care practitioner shall provide, in writing or by electronic means, an [~~itemized~~]estimate of reasonably anticipated charges to treat the patient's or prospective patient's specific condition. An estimate need not address an entire

course of treatment, if the fact that the estimate discloses charges for only a portion of the anticipated total course of treatment is disclosed in the estimate. For charges whose magnitude will vary significantly in response to conditions not reasonably knowable prior to the provision of medical services, a reasonable range of charges may be provided.

B. *Disclosures by Facility.* Upon request by a patient, before providing nonemergency medical services and not later than **10**[~~7~~] business days after receiving the request, a health care facility shall provide, in writing or by electronic means, an [~~itemized~~]estimate of reasonably anticipated charges to treat the patient's condition at the facility. An estimate need not address an entire course of treatment, if the fact that the estimate discloses charges for only a portion of the anticipated total course of treatment is disclosed in the estimate. For charges whose magnitude will vary significantly in response to conditions not reasonably knowable prior to the provision of medical services, a reasonable range of charges may be provided.

C. *Required Components of Estimate.* An estimate of reasonably anticipated charges required by this section shall include:

1. *Description of Procedures, Services, Products, Supplies and other Items.* A brief description, in plain language comprehensible to an ordinary layperson, of all procedures, services, products or supplies for which the practitioner or facility intends, or is likely, to charge.

2. *Billing Codes.* For each procedure, service, product, supply or other item that will result in a charge and that corresponds to a standardized billing code, the then-current code for each such procedure, service, product supply or other item. For purposes of this section, a "standardized billing code" includes, but is not necessarily limited to, an International Classification of Diseases (ICD) code, a Current Procedural Terminology (CPT) code published by the American Medical Association, a Current Dental Terminology (CDT) code published by the American Dental Association, or a code used in the Healthcare Common Procedure Coding System (HCPCS).

3. *Facility or Additional Fees.* Any facility or additional fees, along with a brief statement, in plain language comprehensible to an ordinary layperson, describing the fee.

4. *"Rack" or Individualized Charges.* For each reasonably anticipated charge, the practitioner or facility shall provide either:

   a. the amount that the practitioner or facility would charge a person with no health care insurance, along with a clear indication that the charges being disclosed do not account for any insurance benefits to which the patient or

prospective patient may be entitled and that payment may vary by insurer, or

b. the amount that the practitioner or facility anticipates charging the person requesting the estimate, accounting for any insurance policy held by the person and any status of the person that would affect a charge; for purpose of this section, "status" includes, but is not limited to Alaska Native, American Indian, veteran and indigent status.

5. *Identity of Others That May Charge.* The identity, or suspected identity of any other person, entity or facility that may charge the patient or prospective patient in connection with any procedure, service, product or supply referenced in the estimate, along with an indication of whether the amount of any such charges have been included in the estimate, or would be in addition to the total amount of charges estimated.

6. *Notice to Consult with Insurer.* A notice that the patient or prospective patient may contact his or her health insurer for additional information concerning cost-sharing responsibilities.

7. *Disclosure of In-Network or Out-of-Network Status.* An accurate notice, substantially in one of the following forms:

a. "[Name of health care provider or facility] is a contracted, in-network, preferred provider for ONLY the following plan networks: [list each such network, e.g. Premera Heritage Select, Premera Heritage Plus, etc.; else, list "NONE. YOU MAY INCURE OUT-OF-NETWORK CHARGERS"]",

b. "[Name of health care provider or facility] is a contracted, in-network, preferred provider for your insurance plan.", or

c. "[Name of health care provider or facility] IS NOT a contracted, in-network, preferred provider for your insurance plan. YOU MAY INCUR OUT-OF-NETWORK CHARGES."

D. *Required posting.* Health care practitioners and health care facilities shall conspicuously post a sign in patient registration areas containing at least the following language: "You will be provided with an estimate of the anticipated charges of your care, upon request. Please do not hesitate to ask for information. Anchorage Municipal Code 16.130.010."

E. *Penalties.*

1. Failure to timely provide an estimate required by this section shall result in a daily fine of $100 until the estimate is provided to the patient or prospective patient. The total fine may not

exceed $1000.

2. Failure or to make the posting required by this section shall result in a daily fine of $100 until the failure is cured. The total fine may not exceed $1000.

16.130.900 Definitions.

For purposes of this chapter, the following definitions shall apply:

Emergency medical care means services utilized in responding to the perceived individual needs for immediate medical care in order to prevent loss of life or aggravation of physiological or psychological illness or injury;

Health care practitioner means an acupuncturist licensed under AS 08.06, an audiologist or speech language pathologist licensed under AS 08.11, a behavior analyst licensed under AS 08.15, a person licensed in the state as a chiropractor under AS 08.20,a professional counselor licensed under AS 08.29, a dental hygienist or dental assistant licensed under AS 08.32, a dentist licensed under AS 08.36, a dietitian or nutritionist licensed under AS 08.38, a naturopath licensed under AS 08.45, a hearing aid dealer licensed under AS 08.55, a massage therapist licensed under AS 08.61, a marital or family therapist licensed under AS 08.63, a medical practitioner or osteopath licensed under AS 08.64,a direct-entry midwife certified under AS 08.65, a nurse licensed under AS 08.68, a dispensing optician licensed under AS 08.71, an optometrist licensed under AS 08.72, a pharmacist licensed under AS 08.80, a physical therapist or occupational therapist licensed under AS 08.84, a psychologist or a psychological associate under AS 08.86, a clinical social worker licensed under AS 08.95, a person engaged in the practice of medicine or osteopathy as defined in AS 08.64.380, or a person engaged in any manner in the healing arts who diagnoses, treats, tests, or counsels other persons in relation to human health or disease and uses the letters "M.D.", “D.O.”, or the title "doctor" or "physician" or another title that tends to show that the person is willing or qualified to diagnose, treat, test, or counsel another person.

Health care facility means a private, municipal, state, or federal hospital, psychiatric hospital, independent diagnostic testing facility, primary care outpatient facility; residential psychiatric treatment center, tuberculosis hospital, skilled nursing facility, kidney disease treatment center (including freestanding hemodialysis units), intermediate care facility, ambulatory surgical facility, a private, municipal, or state facility employing one or more public health nurses, and a long-term care facility; for purposes of this chapter, the term includes the offices or private physicians and dentists, whether in individual or group practice; the term excludes the Alaska Pioneers' Home and the Alaska Veterans' Home administered by the Department of Health and Social Services under AS 47.55.

Nonemergency medical services means the provision of medical care and transportation of the sick and injured, other than emergency medical care.

Section 2. Anchorage Municipal Code section 14.60.030 is hereby amended to

read as follows (*the remainder of the section is not affected and therefore not set out)*:

14.60.030 Fine Schedule

The fine schedule under this chapter is as follows:

Code Section	Offense	Penalty / fine
* * *	* * *	* * *
16.130.010	Failure to Provide Health Care Estimate	$100/day; not to exceed $1000
16.130.010	Failure to Post Sign	$100/day; not to exceed $1000
* * *	* * *	* * *

(AO No. 93-167(S-1), § 1, 4-13-94; AO No. 94-108, § 1, 10-5-94; AO No. 94-134, § 2, 9-8-94; AO No. 95-42, § 2, 3-23-95; AO No. 95-67(S), § 9, 7-1-95; AO No. 95-102, § 1, 4-26-95; AO No. 95-118, § 3, 9-1-95; AO No. 95-163(S), § 21, 8-8-95; AO No. 95-195(S-1), 1-1-96; AO No. 96-51(S-1), § 2, 8-1-96; AO No. 96-96(S-1), § 2, 2-1-97; AO No. 96-126(S), § 3, 10-1-96; AO No. 96-137(S), § 9, 1-2-97; AO No. 97-88, § 3, 6-3-97; AO No. 97-107, § 3, 11-17-97; AO No. 97-133(S), § 1, 11-11-97; AO No. 98-27(S-1), § 2, 11-11-97; AO No. 98-160, § 2, 12-8-98; AO No. 99-13(S), 2-9-99; AO No. 99-91(S), § 4, 7-13-99; AO No. 2000-64, § 1, 4-18-00; AO No. 2000-116(S), § 4, 7-18-00; AO No. 2000-127(S), § 2, 10-14-00; AO No. 2000-129(S), § 26, 11-21-00; AO No. 2001-48, § 1, 3-13-01; AO No. 2001-74(S), § 2, 4-17-01; AO No. 2001-4, § 2, 2-6-01; AO No. 2001-145(S-1), § 11, 12-11-01; AO No. 2003-68, § 1, 9-30-03; AO No. 2003-97, § 4, 9-30-03; AO No. 2003-117, § 2, 1-28-03; AO No. 2003-130, § 8, 10-7-03; AO No. 2003-152S, § 10, 1-1-04; AO No. 2004-1, § 2, 1-1-03; AO No. 2004-99, § 2, 6-22-04; AO No. 2004-100(S-1), § 6, 1-1-05; AO No. 2004-171, § 1, 1-11-05; AO No. 2005-160, § 9, 11-1-05; AO No. 2005-84(S), § 3, 1-1-06; AO No. 2005-185(S), § 35, 2-28-06; AO No. 2005-124(S-1A), § 33, 4-18-06; AO No. 2006-39, § 6, 4-11-06; AO No. 2006-54, § 1, 5-2-06; AO No. 2006-80, § 1, 6-6-06; AO No. 2007-50, § 4, 4-10-07; AO No. 2007-60, § 4, 11-1-07; AO No. 2007-70, § 3, 5-15-07; AO No. 2008-84(S), § 5, 7-15-08; AO No. 2009-61, § 3, 7-7-09; AO No. 2009-82, § 5, 7-7-09; AO No. 2009-40(S), § 3, 7-21-09; AO No. 2009-112, § 4, 10-13-09; AO No. 2009-122, § 2, 12-17-09; AO-2010-35(S), § 7, 5-11-10; AO No. 2010-39, § 2, 5-11-10; AO No. 2010-87(S), § 3, 12-7-10; AO No. 2011-46, § 4, 4-12-11; AO No. 2011-59, § 10, 5-24-11; AO No. 2011-106(S), § 3, 11-8-11; AO No. 2011-112, § 4, 11-22-11, eff. 12-22-11; AO No. 2012-10, § 1, 1-31-12; AO No. 2012-77, § 29, 8-7-12; AO No. 2013-109(S-1), § 5, 12-3-13; AO No. 2013-130(S-1), § 1, 1-14-14; AO No. 2014-42, § 31, 6-21-14; AO No. 2014-85, § 4, 8-5-14; AO No. 2014-110(S), § 2, 9-9-14; AO No. 2014-137(S), § 3, 11-18-14; Ord. No. 2015-23(S), § 20, 3-24-15; AO No. 2015-48, § 16, 5-14-15; AO No. 2015-54, § 1, 5-26-15; AO No. 2015-65, § 4, 6-9-15; AO No. 2015-111(S-1), § 2, 1-1-16; AO No. 2016-16(S), § 4, 2-9-16; AO No. 2016-76(S), § 7, 7-12-16 ; AO No. 2016-81(S), § 4, 8-25-16 ; AO No. 2016-83(S), § 9, 7-26-16); AO No. 2016-82 , § 3, 8-9-16; AO No. 2016-116 , § 2, 10-

18-16; AO No. 2016-115(S) , § 2, 11-15-16; AO No. 2016-124(S) , § 11, 12-20-16).

Section 3. This ordinance shall be effective 60 days after passage and approval by the Assembly.

PASSED AND APPROVED by the Anchorage Assembly this 28th day of February, 2017.

Chair

ATTEST:

Municipal Clerk

MUNICIPALITY OF ANCHORAGE
Summary of Economic Effects -- General Government

AO Number: 2017-26

Title: AN ORDINANCE OF THE ANCHORAGE MUNICIPAL ASSEMBLY TO REQUIRE HEALTH CARE PRACTITIONERS AND FACILITIES, UPON REQUEST, TO MAKE A GOOD FAITH DISCLOSURE OF ANTICIPATED HEALTH CARE CHARGES

Sponsor: MAYOR
Preparing Agency: Department of Law
Others Impacted: DHHS, Code Enforcement

CHANGES IN EXPENDITURES AND REVENUES:	(In Thousands of Dollars)				
	FY16	FY17	FY18	FY19	FY20
Operating Expenditures					
1000 Personal Services					
2000 Non-Labor					
3900 Contributions					
4000 Debt Service					
TOTAL DIRECT COSTS:	$ -	$ -	$ -	$ -	$ -
Add: 6000 Charges from Others					
Less: 7000 Charges to Others					
FUNCTION COST:	$ -	$ -	$ -	$ -	$ -
REVENUES:					
CAPITAL:					
POSITIONS: FT/PT and Temp					

PUBLIC SECTOR ECONOMIC EFFECTS:

Enforcement functions related to the ordinance will be absorbed by current personnel and handled with existing resources. The amount of revenue received from fines is expected to be marginal.

PRIVATE SECTOR ECONOMIC EFFECTS:

It is anticipated that physicians and facilities subject to the ordinance may incur some compliance costs. These are difficult to estimate and not expected to be significant.

Prepared by: *Department of Law* Telephone: 907-343-4545

MUNICIPALITY OF ANCHORAGE

Assembly Memorandum

No. AM 110- 2017

Meeting Date: February 14, 2017

From: **MAYOR**

Subject: **AN ORDINANCE OF THE ANCHORAGE MUNICIPAL ASSEMBLY TO REQUIRE HEALTH CARE PRACTITIONERS AND FACILITIES, UPON REQUEST, TO PROVIDE AN ESTIMATE OF ANTICIPATED HEALTH CARE CHARGES.**

The proposed ordinance would enact a health-care price transparency law to empower health-care consumers.

It builds on the prior efforts of a growing number of jurisdictions that have adopted similar laws, including, most recently Florida and Ohio.[1]

As many commenters have noted, the health care "market" is "unlike most markets":

> [P]atients rarely know what they'll pay for services until they've received them; health care providers bill different payers different prices for the same services; and privately insured patients pay more to subsidize the shortfalls left by uninsured patients. What's more, prices for health services vary significantly among providers, even for common procedures such as laboratory tests or mammograms, although there's no consistent evidence showing that higher prices are linked to higher quality.[2]

In a system where patients are often unable to obtain clear and complete information about the costs of services until a bill later arrives in the mail, individuals are put at significant disadvantage. Aside from being hindered in their ability to make cost-benefit calculations or to "shop around," individuals may also be unable to simply arrange their own financial affairs—it is difficult to save or plan for an

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[1] *See* Attachment B for a selection of health care transparency laws from nine jurisdictions.

[2] Martha Hostetter and Sarah Klein, THE COMMONWEALTH FUND, *Health Care Price Transparency: Can It Promote High-Value Care?* (Quality Matters Newslatter April / May 2012), available at: http://www.commonwealthfund.org/publications/newsletters/quality-matters/2012/april-may/in-focus

expense without having some sense of how large it will be. As Alaskans who testified before the State of Alaska Health Care Commission put it: "It's very hard to be a consumer in something when you don't have a clue as to what the cost is"; "Secret pricing does a lot of harm."[3]

Price opacity likely also has a significant effect on the health care system overall. It is generally known that the United States spends more on health care than any other high-income nation (while obtaining worse outcomes),[4] and that health care costs in Alaska are among the highest in the country. Health care price-transparency laws may be "one piece of [the] cost control puzzle," because market cannot operate efficiently in the absence of clear price information. The Robert Wood Johnson Foundation, for instance, believes the absence of clear pricing information to be at the root of the United States' health-care spending challenges:

> The historical opacity of health care prices is widely believed to be a major factor inhibiting the more efficient functioning of the delivery system. . . Health economists and other experts are convinced that significant cost containment cannot occur without widespread and sustained transparency in provider prices.[5]

The Foundation concludes that "[p]rice transparency might have the single biggest effect in informing the public about health care costs and could support a more efficient health care delivery system in the United States."[6] Before it was defunded in 2015, the Alaska Health Care Commission agreed that increased transparency should be a priority; the second of its "core strategies for health care transformation" issued in January 2015 was to "increase price and quality transparency" to "[p]rovide Alaskans with information on health care costs, prices and quality so they can make informed choices."[7]

The Municipal Administration began exploring this subject in earnest in June 2016, in the wake of a local forum and national articles addressing rising premiums in Alaska's health-insurance markets. Premiums for individuals who work for the Municipality, which is self-insured, are likewise rising.

The ordinance now recommended to the Assembly is a measured item. It

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3 *See* STATE OF ALASKA HEALTH CARE COMMISSION, Meeting Discussion Guide June 19-20, 2014 at slide 18, available at http://dhss.alaska.gov/ahcc/Documents/meetings/201406/June2014DiscussionGuideWnotes.pdf

4 *See, e.g.*, THE COMMONWEALTH FUND, *U.S. Health Care from a Global Perspective: Spending, Use of Services, Prices, and Health in 13 Countries* (October 2015), available at: http://www.commonwealthfund.org/publications/issue-briefs/2015/oct/us-health-care-from-a-global-perspective

5 ROBERT WOOD JOHNSON FOUNDATION, *Health Policy Snapshot: How Price Transparency Can Control the Cost of Health Care* (March 2016), Attachment A.

6 *Id.*

7 *See* STATE OF ALASKA HEALTH CARE COMMISSION, *Transforming Health Care in Alaska: Core Strategies &:Policy Recommendations* (January 2015), available at: http://dhss.alaska.gov/ahcc/Documents/2014%20FINAL-Commission-Strategies-Recommendations.pdf

does not require disclosures to be made to the government. It does not require the government to create or maintain a database of prices. It does not require providers to publish price lists, or to determine their most commonly ordered services or procedures. It also does not require any data collection or reporting related to the quality of services provided. It merely requires providers and facilities to provide a non-binding estimate of charges to a prospective patient, upon request, and to inform prospective patients that they may request such an estimate.

Requirements are set out in a new section 16.130.010. Subsections A and B would make the measure equally applicable to health care practitioners and facilities, each defined by reference to definitions contained in state statutes.

Subsection C sets out the required components of the estimate. Generally, the estimate must inform a prospective patient what the provider or facility intends to charge the patient for, and how much the provider or facility intends to charge. The measure is intended to require disclosure of all potential charges—procedures, services, products, services, facility fees and all other fees, included.

Subsections C.4 and C.5 give practitioners and facilities a choice. The choice is intended to simplify compliance for practitioners and facilities subject to the law.

Subsection C.4, "rack or individualized rate," allows practitioners and facilities to disclose either what they would charge a person who has no insurance, or what they will charge the person requesting the estimate, given the person's particular insurance coverage or other status affecting the magnitude of charges. Subsection C.5 allows a physician (e.g., a surgeon) or facility (e.g., a surgical center) to include or omit charges necessary to a procedure that will be made by others (e.g., an anesthesiologist, a lab or an imaging center); if the charges are omitted, the physician or facility must inform the patient that the estimate is not all-inclusive, and the patient must be provided with information about the identity of others who may charge.

The choice is intended to simplify matters for practitioners and facilities, without destroying the utility of the estimate. An individual patient will be most interested in what he or she will ultimately have to pay. The estimate will either provide the patient with that amount, or will provide the patient with the means to discover for him or herself what that amount will be.

Regarding the later, individuals with insurance who are provided pricing information for those without insurance should be able to provide the billing codes contained in the estimate they received to their insurance provider, and receive from their insurance provider pricing information more relevant to the patient's particular situation. Likewise, individuals who are not given an "all inclusive" estimate should be empowered from the required disclosure of "others who may charge," to contact all such persons and obtain estimates of any undisclosed charges.

The measure does not apply to emergency services, and would not prohibit actual charges from differing from the estimate.

While the measure is principally intended to aid health-care consumers, the measure may provide an incidental benefit to practitioners and facilities as well. At

least one hospital network has concluded that providing estimates to patients prior to services being performed measurably increases the likelihood that patients will ultimately pay.[8]

To afford a reasonable transition period, the ordinance would become effective 60 days after approval.

By vote on February 1, 2017, the Anchorage Health and Human Services Commission adopted a resolution supporting the introduction of this ordinance.

THE ADMINISTRATION RECOMMENDS APPROVAL.

Prepared by:	William D. Falsey, Municipal Attorney
Concur:	Melinda Freemon, Director Department of Health and Human Services
Concur:	Lance Wilber, Director Office of Management and Budget
Concur:	Robert E. Harris, CFO
Concur:	Michael K. Abbott, Municipal Manager
Respectfully submitted:	Ethan A. Berkowitz, Mayor

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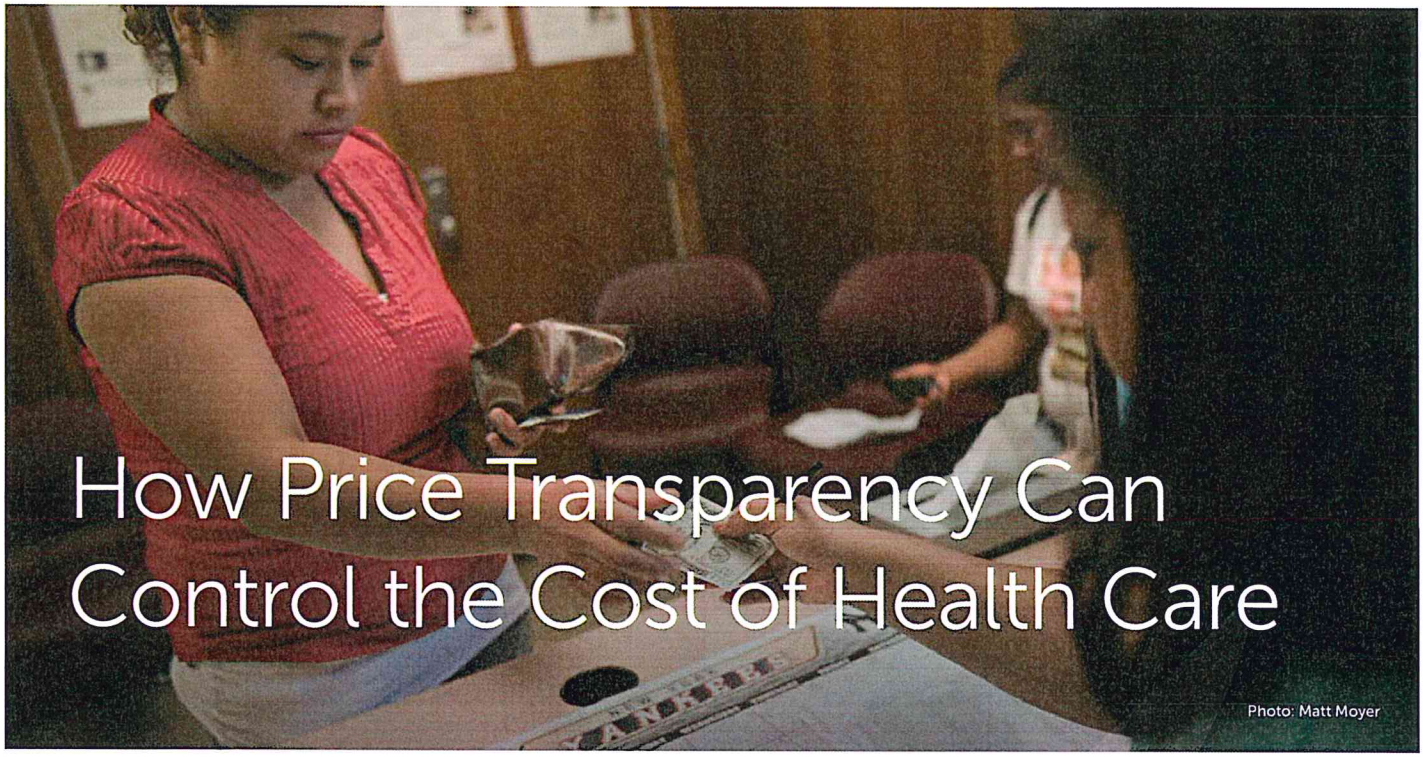
[8] *See, e.g*, Ron Shinkman, *HFMA ANI 15: How one hospital system uses proactive communications to boost patient collections* (Jun. 24, 2015), available at http://www.fiercehealthcare.com/finance/hfma-ani-15-how-one-hospital-system-uses-proactive-communications-to-boost-patient:

> [F]our years ago, the system began to offer upfront patient responsibility/price estimates to everyone who were scheduled for procedures that involved an out-of-pocket liability estimated at $250 or more. The number of price estimates offered jumped from a little more than 2,500 in 2010 to nearly 40,000 last year.
>
> . . .
>
> Collections from patients at point-of-service climbed from less than $3 million in 2009 to $5.7 million in 2013, although it dipped to $5.4 million last year.

See also Diane Watkins, FHFMA Vice President, Revenue Cycle Saint Luke's Health System, *Saint Luke's Health System: Improved Patient Financial Experience, Increased POS Collections by 26%*, available at: http://www.hfma.org/anihandouts/xtbce9adrpp1/D13.pdf (when patients know what they might owe, they are more likely to make a payment).

Robert Wood Johnson Foundation



How Price Transparency Can Control the Cost of Health Care

Photo: Matt Moyer

Top Takeaways

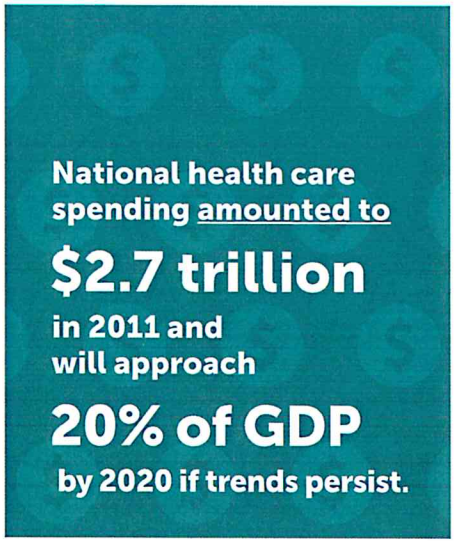
Health care spending will total nearly 20 percent of the country's gross domestic product (GDP) in the next five years. This snapshot delves into policies that may help curb the price of health care over time and make insurance and treatment more widely accessible.

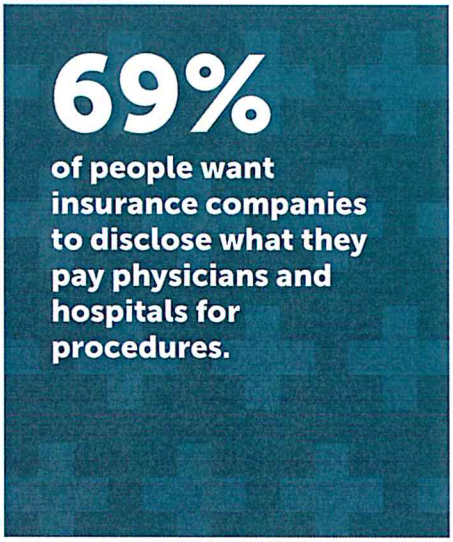
Price transparency might have the single biggest effect in informing the public about health care costs and could support a more efficient health care delivery system in the United States.

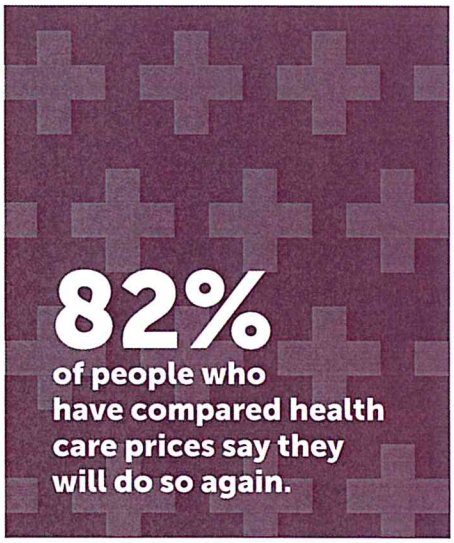
More and more people are becoming increasingly curious about the price of their health care, and understand that more expensive does not necessarily mean better. But people still do not realize that health care prices vary significantly between providers for the same services.

Attachment A

Key Facts







Price Transparency as a Cost-Lowering Tool

Understanding the price of health care services can be confusing. Rates vary depending on where the service is provided, what kind of insurance the patient has, and other factors. It's difficult, therefore, for patients to determine the amount they will pay for a given test or procedure. Many people are calling for greater price transparency in health care, where patients can clearly see the price of a treatment and determine how much they will pay out-of-pocket before receiving care.

Rising costs can't be controlled until the price of health care is made transparent and consumers know the price of services being provided to them.

Experts have long agreed that price transparency in the health care industry has a number of positive consequences. It is an important information gathering tool for consumers who want to compare prices so they can make more informed decisions about their health care. Most people in America want greater price transparency and would compare health care prices if given the option, according to Public Agenda.

However, price transparency does not only serve an educational purpose—it actually lowers the cost of health care. According to an article in Health Affairs, both price transparency and reference pricing—the cost consumers can anticipate paying for a given procedure or health

Attachment A

service—have helped reduce costs in the long run. "The historical opacity of health care prices is widely believed to be a major factor inhibiting the more efficient functioning of the delivery system," according to the Robert Wood Johnson Foundation. "Health economists and other experts are convinced that significant cost containment cannot occur without widespread and sustained transparency in provider prices."

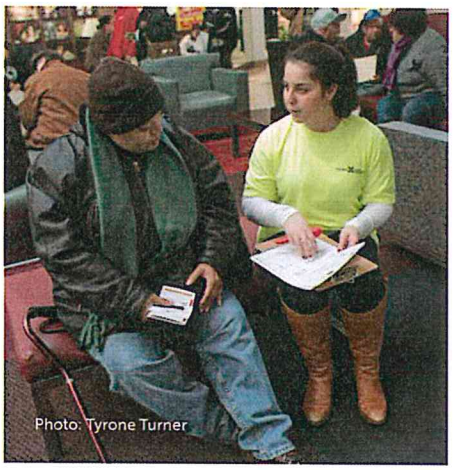


Photo: Tyrone Turner

The average health insurance premium in America has increased by 69 percent in the past decade, according to the Kaiser Family Foundation. With premiums increasing, families have to make more educated purchasing decisions in the health marketplace to save money, especially those families with higher deductibles. But accurate price information is hard to come by considering the default price opacity in most states. The Healthcare Financial Management Association cites a recent report where the U.S. Government Accountability Office asked dozens of health care providers about their price for a knee replacement. The estimates given ranged from $33,000 to $101,000. This wide range in prices is difficult to account for, and without more comprehensive price transparency, consumers face a difficult time choosing the most cost-efficient option.

Price Transparency is Smart Policy

Price transparency does not only serve an educational purpose—it actually lowers the cost of health care.

Catalyst for Payment Reform, a group that ranks states based on the sophistication of their price transparency policies, gave **45 states** an "F" grade this year when it came to health care price transparency.

More than half of people in America say they have tried to find out about the price of health care before getting care, according to Public Agenda. And the ones who have found out about health care prices are looking for value. A majority believes that more expensive care does not equate to better care. This demonstrates the demand for transparency among consumers, and the recognition among consumers that price variation in health care is often an arbitrary divide that does not necessarily reflect quality of care.

Photo: Tyrone Turner

All-Payer Claims Databases (APCDs), according to the Robert Wood Johnson Foundation, are online databases that comprehensively collect medical and pharmacy claims across the state to create a full picture of price data. New Hampshire established an APCD in 2008, which gives its residents an opportunity to evaluate price differences across multiple settings and providers. Recent improvements to New Hampshire's system garnered it the only "A" rating in this year's Catalyst for Payment Reform ranking. APCDs, however, have recently experienced

Attachment A

a setback due to a Supreme Court ruling in March 2016 that states can no longer mandate insurers to submit claims data that is at odds with the softer requirements laid out in the 1974 Employee Retirement Income Security Act.

In addition to public ACPDs, the Healthcare Financial Management Association highlights a number of other tools that can be used to increase price transparency. These include tools from the insurance company, like Member Payment Estimator by Aetna®, similar tools from hospital associations and provider organizations, as well as crowd sourced platforms like ClearHealthCosts. Price transparency tools can be both public and private, but in order to free up the data currently locked in by non-disclosure agreements and contractual limits, states must pass legislation that mandates increased price sharing across providers, hospital networks, physicians and consumers. Increased price transparency combined with reference pricing, the price consumers can expect to pay for services, has shown to put pressure on providers to lower their prices.

More than half of people say they have tried to find out about the price of health care before getting care.

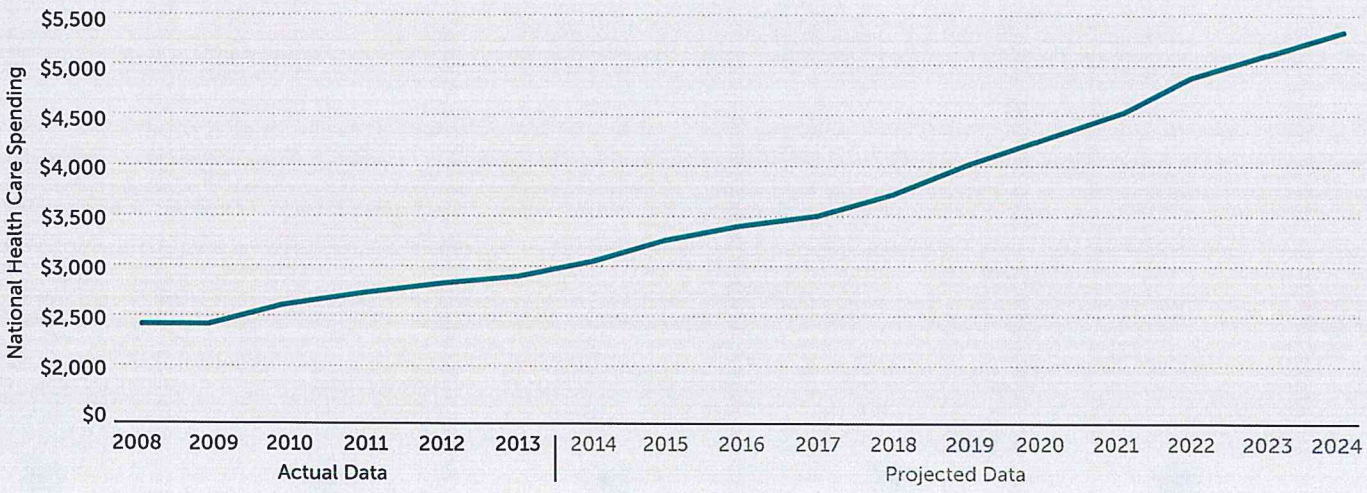
The cost of health care is expected to rise by more than

85%

over the next

20 years.

Projected Annual Cost of Health Care in the United States
Dollars in Billions



SOURCE: Centers for Medicare and Medicaid Services, 2015

Attachment A

The Agenda

- One way state governments can combat price opacity is by empowering providers and insurance personnel to talk about pricing, as well as guiding people toward reliable price information and explaining to them how prices vary across providers, according to Public Agenda.
- The Catalyst for Payment Reform says states can fight price opacity through legislation and litigation.

Many providers and insurance companies have succeeded in keeping health care prices opaque using non-disclosure agreements and restrictive gag clauses in contracts. Because of this, a majority of states have been unsuccessful in achieving greater price transparency to help consumers make educated choices about their health care.

However, a greater push from local governments and advocacy groups for greater price transparency has led to establishing online databases and passing legislation that calls for greater disclosure from providers.

Want to Know More?

Understanding Healthcare Prices: A Consumer Guide

Kaiser Family Foundation Health Benefits Survey, 2014

Health Care Price Transparency From the U.S. Government Accountability Office

The Basics of All-Payer Claims Databases

Background

After the U.S. government passed the Patient Protection and Affordable Care Act (ACA) in 2010, millions of previously uninsured people became consumers in the health insurance market. Many of these consumers bought basic health care plans, which means that their new insurance would cover most but not all of their health care expenses. With such a plan, a patient could pay anywhere between $458 or $56,000 for an appendectomy, according to George Washington University.

This enormous price disparity for insured people under the ACA has sparked recent conversations about the importance of price transparency as a cost containment mechanism, as well as a valuable source of consumer information.

Attachment A

ATTACHMENT B

~ Selection of Price Transparency Laws ~

This attachment includes laws from California, Connecticut, Massachusetts, Minnesota, Nebraska, Ohio, South Dakota and Texas.

For additional enactments, see NATIONAL CONFERENCE OF STATE LEGISLATURES, *Transparency And Disclosure Of Health Costs And Provider Payments: State Actions* (updated August 2015), available at: http://www.ncsl.org/research/health/transparency-and-disclosure-health-costs.aspx

California

See CAL. HEALTH AND SAFETY CODE §1339.585 *Estimates of charges by hospital* (enacted in 2005) (emphasis added):

> **Upon the request of a person without health coverage, a hospital shall provide the person with a written estimate of the amount the hospital will require the person to pay for the health care services, procedures, and supplies that are reasonably expected to be provided to the person by the hospital, based upon an average length of stay and services provided for the person's diagnosis.** The hospital may provide this estimate during normal business office hours. In addition to the estimate, the hospital shall provide information about its financial assistance and charity care policies and contact information for a hospital employee or office from which the person may obtain further information about these policies. If requested, the hospital shall also provide the person with an application form for financial assistance or charity care. This section shall not apply to emergency services[.]

See also § 1339.56. *List of charges for common services and procedures*

> (a) Each hospital shall compile a list of 25 common outpatient procedures and shall submit annually to the office a list of its average charges for those procedures, in a method determined by the office. The office may develop a uniform reporting form for the purposes of this subdivision and may require hospitals to file this completed form with the office. The office shall publish this information on its Internet Web site.
>
> (b) The office shall establish a list of the 25 most commonly performed inpatient procedures in California hospitals, as grouped by Medicare diagnostic-related group. The office shall develop a list of each hospital's average charges for those procedures, if applicable, and shall update the list at least annually. The office shall publish this information on its Internet Web site.
>
> (c) Each hospital shall provide a copy of the lists described in subdivisions (a) and (b) to any person upon request.

Connecticut

See CONNECTICUT GENERAL STATUTES ANNOTATED § 38a-1084a *Consumer health information Internet web site. Report to be provided to exchange. Hospital disclosures to patients. Commissioner of Social Services to submit Medicaid data to exchange* (enacted 2016) (emphasis added):

. . .

(c) Not later than July 1, 2016, and annually thereafter, the Insurance Commissioner and the Commissioner of Public Health shall, to the extent the information is available, jointly report to the exchange and make available to the public on the Insurance Department's and Department of Public Health's Internet web sites: (1) The fifty most frequently occurring inpatient primary diagnoses and procedures in the state; (2) the fifty most frequently provided outpatient procedures performed in the state; (3) the twenty-five most frequent surgical procedures performed in the state; and (4) the twenty-five most frequent imaging procedures performed in the state. Such lists contained in the report may include bundled episodes of care and be compiled using discharge and claims data available to said departments. At the request of the exchange, such lists may be expanded to include additional admissions and procedures.

. . .

(e)(1) On and after one hundred eighty days after the report described in subsection (c) of this section is initially made available to the public on the Insurance Department's and Department of Public Health's Internet web sites, **each hospital shall**, at the time of scheduling a diagnosis or procedure **for nonemergency care**, regardless of the location or setting where such services are delivered, that is included in the report submitted to the exchange by the Insurance Commissioner and the Commissioner of Public Health pursuant to subsection (c) of this section, **notify the patient of the patient's right to make a request for cost and quality information**. **Upon the request of a patient for a diagnosis or procedure** included in such report, **the hospital shall, not later than three business days after scheduling such diagnosis or procedure, provide written notice, electronically or by mail, to the patient who is the subject of the diagnosis or procedure concerning:**

(A) **If the patient is uninsured, the amount to be charged for the diagnosis or procedure if all charges are paid in full without a public or private third party paying any portion of the charges, including the amount of any facility fee, or, if the hospital is not able to provide a specific amount due to an inability to predict the specific treatment or diagnostic code, the estimated maximum allowed amount or charge for the admission or procedure, including the amount of any facility fee**;

(B) the corresponding Medicare reimbursement amount or, if there is no corresponding Medicare reimbursement amount for such diagnosis or procedure, (i) the approximate amount Medicare would have paid the hospital for the services on the billing statement, or (ii) the percentage of the hospital's charges that Medicare would have paid the hospital for the services;

(C) **if the patient is insured, the allowed amount, the toll-free telephone number and the Internet web site address of the patient's health carrier where the patient can obtain information concerning charges and out-of-pocket costs**;

(D) The Joint Commission's composite accountability rating and the Medicare hospital compare star rating for the hospital, as applicable; and

(E) the Internet web site addresses for The Joint Commission and the Medicare hospital compare tool where the patient may obtain information concerning the hospital.

Florida

See FLORIDA STATUTES ANNOTATED § 395.301 *Price transparency; itemized patient statement or bill; patient admission status notification* (enacted 2016):

. . .

(b) 1. **Upon request, and before providing any nonemergency medical services, each licensed facility shall provide in writing or by electronic means a good faith estimate of reasonably anticipated charges by the facility for the treatment of the patient's or prospective patient's specific condition**. The facility must provide the estimate to the patient or prospective patient within 7 business days after the receipt of the request and is not required to adjust the estimate for any potential insurance coverage. The estimate may be based on the descriptive service bundles developed by the agency under s. 408.05(3)(c) **unless the patient or prospective patient requests a more personalized and specific estimate that accounts for the specific condition and characteristics of the patient or prospective patient**. The facility shall inform the patient or prospective patient that he or she may contact his or her health insurer or health maintenance organization for additional information concerning cost-sharing responsibilities.

2. In the estimate, the facility shall provide to the patient or prospective patient information on the facility's financial assistance policy, including the application process, payment plans, and discounts and the facility's charity care policy and collection procedures.

3. The estimate shall clearly identify any facility fees and, if applicable, include a statement notifying the patient or prospective patient that a facility fee is included in the estimate, the purpose of the fee, and that the patient may pay less for the procedure or service at another facility or in another health care setting.

4. Upon request, the facility shall notify the patient or prospective patient of any revision to the estimate.

5. In the estimate, **the facility must notify the patient or prospective patient that services may be provided in the health care facility by the facility as well as by other health care providers that may separately bill the patient, if applicable**.

6. The facility shall take action to educate the public that such estimates are available upon request.

7. Failure to timely provide the estimate pursuant to this paragraph shall result in a daily fine of $1,000 until the estimate is provided to the patient or prospective patient. The total fine may not exceed $10,000.

See also F.S.A. § 456.0575 *Duty to notify patients* (enacted 2016):

. . .

(2) **Upon request by a patient, before providing nonemergency medical services** in a facility licensed under chapter 395, **a health care practitioner shall provide, in writing or by electronic means, a good faith estimate of reasonably anticipated charges to treat the patient's condition** at the facility. The health care practitioner shall provide the estimate to the patient within 7 business days after receiving the request and is not required to adjust the estimate for any potential insurance coverage. The health care practitioner shall inform the patient that the patient may contact his or her health insurer or health maintenance organization for additional information concerning cost-sharing responsibilities. The health care practitioner shall provide information to uninsured patients and insured patients for whom the practitioner is not a network provider or preferred provider which discloses the practitioner's financial assistance policy, including the application process, payment plans, discounts, or other available assistance, and the practitioner's charity care policy and collection procedures. Such estimate does not preclude the actual charges from exceeding the estimate. Failure to provide the estimate in accordance with this subsection, without good cause, shall result in disciplinary action against the health care practitioner and a daily fine of $500 until the estimate is provided to the patient. The total fine may not exceed $5,000. The provision of an estimate does not preclude the actual charges from exceeding the estimate.

Massachusetts

See MASSACHUSETTS STATUTE § 228. *Advance disclosure of allowed amount or charge for admission, procedure or service* (enacted 2012):

> (a) Prior to an admission, procedure or service and upon request by a patient or prospective patient, a health care provider shall, within 2 working days, disclose the allowed amount or charge of the admission, procedure or service, including the amount for any facility fees required; provided, however, that if a health care provider is unable to quote a specific amount in advance due to the health care provider's inability to predict the specific treatment or diagnostic code, the health care provider shall disclose the estimated maximum allowed amount or charge for a proposed admission, procedure or service, including the amount for any facility fees required.
>
> . . .

Minnesota

See MINNESOTA STATUTE 62J.81. *Disclosure of payments for health care services* (enacted 2004) (emphasis added):

Subdivision 1. Required disclosure of estimated payment.

(a) **A health care provider**, as defined in section 62J.03, subdivision 8, or the provider's designee as agreed to by that designee, shall, at the request of a consumer, and at no cost to the consumer or the consumer's employer, **provide that consumer with a good faith estimate of the allowable payment the provider has agreed to accept from the consumer's health plan company for the services specified by the consumer, specifying the amount of the allowable payment due from the health plan company**. Health plan companies must allow contracted providers, or their designee, to release this information. **If a consumer has no applicable public or private coverage, the health care provider must give the consumer, and at no cost to the consumer, a good faith estimate of the average allowable reimbursement the provider accepts as payment from private third-party payers for the services specified by the consumer and the estimated amount the noncovered consumer will be required to pay**. Payment information provided by a provider, or by the provider's designee as agreed to by that designee, to a patient pursuant to this subdivision does not constitute a legally binding estimate of the allowable charge for or cost to the consumer of services.

(b) A health plan company, as defined in section 62J.03, subdivision 10, shall, at the request of an enrollee intending to receive specific health care services or the enrollee's designee, provide that enrollee with a good faith estimate of the allowable amount the health plan company has contracted for with a specified provider within the network as total payment for a health care service specified by the enrollee and the portion of the allowable amount due from the enrollee and the enrollee's out-of-pocket costs. An estimate provided to an enrollee under this paragraph is not a legally binding estimate of the allowable amount or enrollee's out-of-pocket cost.

. . .

See also § 62J.823. *Hospital pricing transparency* (enacted 2006) (emphasis added):

Subdivision 1. Short title.

This section may be cited as the Hospital Pricing Transparency Act.

Subd. 2. Definition.

For the purposes of this section, "estimate" means the actual price expected to be billed to the individual or to the individual's health plan company based on the specific diagnostic-related group code or specific procedure code or codes, reflecting any known discounts the individual would receive.

Subd. 3. Applicability and scope.

Any hospital, as defined in section 144.696, subdivision 3, **and outpatient surgical center**, as defined in section 144.696, subdivision 4, **shall provide a written estimate of the cost of a specific service or stay upon the request of a patient**, doctor, or the patient's representative. The request must include:

(1) the health coverage status of the patient, including the specific health plan or other health coverage under which the patient is enrolled, if any; and

(2) at least one of the following:

(i) the specific diagnostic-related group code;

(ii) the name of the procedure or procedures to be performed;

(iii) the type of treatment to be received; or

(iv) any other information that will allow the hospital or outpatient surgical center to determine the specific diagnostic-related group or procedure code or codes.

Subd. 4. Estimate.

(a) **An estimate provided by the hospital or outpatient surgical center must contain:**

(1) the method used to calculate the estimate;

(2) **the specific diagnostic-related group or procedure code or codes used to calculate the estimate, and a description of the diagnostic-related group or procedure code or codes that is reasonably understandable to a patient**; and

(3) a statement indicating that the estimate, while accurate, may not reflect the actual billed charges and

that the final bill may be higher or lower depending on the patient's specific circumstances.

(b) The estimate may be provided in any method that meets the needs of the patient and the hospital or outpatient surgical center, including electronically; however, a paper copy must be provided if specifically requested.

Nebraska

See NEBRASKA REVISED STATUTES § 71-2075 *Written estimate of charges; when required; notice* (enacted 1985):

(1) **Upon the written request of a prospective patient, his or her attending physician, or any authorized agent of the prospective patient, each hospital,** except hospitals excluded under section 1886(d)(1)(B) of Public Law 98-21, the Social Security Act Amendments of 1983, **and ambulatory surgical center shall provide a written estimate of the average charges for health services related to a particular diagnostic condition or medical procedure** if such services are provided by the hospital or center. Such written request shall include a written medical diagnosis made by a health care practitioner licensed to provide such diagnosis. The prospective patient or his or her agent may also provide to the hospital or center the prospective patient's age and sex, any complications or co-morbidities of the prospective patient, other procedures required for the prospective patient, and other information which would allow the hospital or center to provide a more accurate or detailed estimate. Such estimate shall be provided within seven working days from the date of submission of the written request and information necessary to prepare such an estimate.

(2) All hospitals and ambulatory surgical centers shall provide notice to the public that such hospital or center will provide an estimate of charges for medical procedures or diagnostic conditions pursuant to subsection (1) of this section. Such public notice shall be provided either as a part of the advertising or promotional materials of the hospital or center or by posting a notice in an obvious place within the public areas of the hospital or center.

Ohio

See OHIO REV. CODE ANNOTATED 5162.80 *Provider of medical services to provide estimate* (enacted 2016) (emphasis added):

> (A) **A provider of medical services** licensed, accredited, or certified under Chapter 3721., 3727., 4715., 4725., 4731., 4732., 4734., 4747., 4753., 4755., 4757., or 4779. of the Revised Code **shall provide in writing, before products, services, or procedures are provided, a reasonable, good-faith estimate of all of the following for the provider's non-emergency products, services, or procedures**:
>
> (1) **The amount the provider will charge the patient or the consumer's health plan issuer for the product, service, or procedure**;
>
> (2) **The amount the health plan issuer intends to pay for the product, service, or procedure**;
>
> (3) **The difference, if any, that the consumer or other party responsible for the consumer's care would be required to pay to the provider for the product, service, or procedure**.
>
> (B) Any health plan issuer contacted by a provider described in division (A) of this section in order for the provider to obtain information so that the provider can comply with division (A) of this section shall provide such information to the provider within a reasonable time of the provider's request.

South Dakota

See SOUTH DAKOTA STATUTES § 34-12E-8 *Disclosure of fees and charges upon request* (enacted 1994):

> All fees and charges for health care procedures shall be disclosed by a health care provider or facility upon request of a patient.

Texas

See TEXAS HEALTH & SAFETY CODE § 324.101 (enacted 1997) (emphasis added):

. . .

(d) **The [health] facility shall provide an estimate of the facility's charges for any elective inpatient admission or nonemergency outpatient surgical procedure or other service on request and before the scheduling of the admission or procedure or service**. The estimate must be provided not later than the 10th business day after the date on which the estimate is requested. The facility must advise the consumer that:

(1) the request for an estimate of charges may result in a delay in the scheduling and provision of the inpatient admission, outpatient surgical procedure, or other service;

(2) the actual charges for an inpatient admission, outpatient surgical procedure, or other service will vary based on the person's medical condition and other factors associated with performance of the procedure or service;

(3) the actual charges for an inpatient admission, outpatient surgical procedure, or other service may differ from the amount to be paid by the consumer or the consumer's third-party payor;

(4) the consumer may be personally liable for payment for the inpatient admission, outpatient surgical procedure, or other service depending on the consumer's health benefit plan coverage; and

(5) the consumer should contact the consumer's health benefit plan for accurate information regarding the plan structure, benefit coverage, deductibles, copayments, coinsurance, and other plan provisions that may impact the consumer's liability for payment for the inpatient admission, outpatient surgical procedure, or other service.