

JUNE 2018
DRAFT

Children, Families, Health, and Human Services Interim Committee
Sue O'Connell, Research Analyst

FINAL REPORT TO THE 66TH MONTANA LEGISLATURE

**HJR 20:
HEALTH CARE PRICE TRANSPARENCY**

CHILDREN, FAMILIES, HEALTH, AND HUMAN SERVICES INTERIM COMMITTEE MEMBERS

Before the close of each legislative session, the House and Senate leadership appoint lawmakers to interim committees. The members of the Children, Families, Health, and Human Services Interim Committee, like most other interim committees, serve one 20-month term. Members who are reelected to the Legislature, subject to overall term limits and if appointed, may serve again on an interim committee. This information is included in order to comply with 2-15-155, MCA.

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Summary

This report is a summary of the work of the Children, Families, Health, and Human Services Interim Committee, specific to the Committee's 2017-2018 House Joint Resolution 20 study as outlined in the Committee's 2017-18 work plan and HJR 20. Members received additional information and public testimony on the subject. This report is an effort to highlight key information and the processes followed by the Children, Families, Health, and Human Services Interim Committee, and the subcommittee it appointed on this topic, in reaching its conclusions.

To review additional information, including audio minutes and exhibits, visit the Children, Families, Health, and Human Services Interim Committee website: www.leg.mt.gov/cfhhs. Reports specific to the study can be found on the [HJR 20 study page](#) on the committee's website.¹

¹ The URL for the HJR 20 Study web page is <http://leg.mt.gov/css/Committees/Interim/2017-2018/Children-Family/Committee-Topics/hjr20/hjr20.asp>.

TABLE OF CONTENTS

Children, Families, Health, and Human Services Interim Committee Members	i
House Members	i
Senate Members.....	i
Summary	iv
Overview	1
Transparency in Montana.....	3
Current Law	3
Proposed Legislation	3
Health Care Under the Microscope.....	5
Meeting 1: The Economics of Health Care	5
Meeting 2: Reimbursement, Pricing, and Cost-Reduction Models	6
Meeting 3: Transparency Laws and Tools.....	8
Montana Transparency Efforts	9
Conclusions and Recommendations.....	10
Action by the Full Committee.....	11
Appendix A: Subcommittee Members.....	12
Appendix B: Letter to the Office of Public Instruction	13
Appendix C: Links to Pre-Meeting Reading Materials.....	15

HJR 20: HEALTH CARE PRICE TRANSPARENCY

OVERVIEW

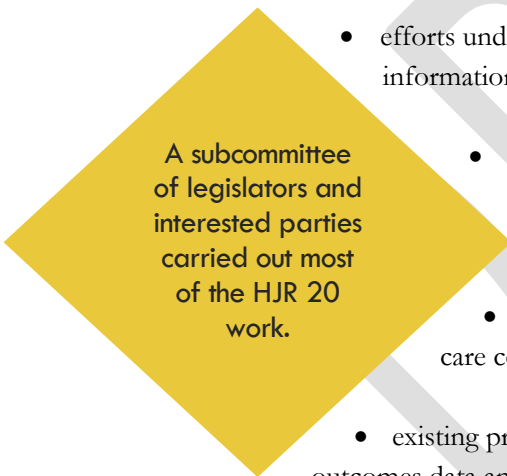
House Joint Resolution 20, calling for a study of transparency in health care pricing, was proposed at the same time the 2017 Legislature was considering several bills involving health care pricing. The bills generally tried to make it easier for consumers to obtain estimates of the costs of their medical care, know whether health care providers were in their insurance networks, and avoid surprise medical bills. In some instances, the bills sought to encourage consumers to shop around for some health care services in an effort to reduce overall health care costs to themselves and their insurers.

All bills died in the process. One made it as far as Governor Bullock's desk but was vetoed, leaving only the study resolution to advance the topic.

HJR 20 was the top-ranked study among legislators in the poll conducted after the 2017 Legislature adjourned. The study was assigned to the Children, Families, Health, and Human Services Interim Committee.

The resolution requested a study that would look at:

- the factors influencing the pricing of health care services, including differences attributable to the models that different health care providers use for providing services;
- efforts undertaken in other states and by entities within the state to make health care cost information more widely available to consumers;
- ways to improve consumer understanding of the different factors affecting the health care prices that are charged and that consumers are responsible for paying;
- methods for encouraging consumers to make informed decisions about health care costs;
- existing price transparency tools and health care quality measures, including health care outcomes data and hospital accreditation data; and
- ways to ensure that health care price transparency efforts provide consumers with information about both the costs and the quality of health care services they may be considering.



A subcommittee of legislators and interested parties carried out most of the HJR 20 work.

At its organizational meeting in June 2016, the committee agreed to create a subcommittee made up of legislators and public members to carry out the bulk of the work proposed in HJR 20. Rep. Kathy Kelker, sponsor of the resolution, was named presiding officer of the subcommittee and organized the meeting topics and materials.

HJR 20: HEALTH CARE PRICE TRANSPARENCY

The 15-member subcommittee met four times to review health care pricing and transparency topics in depth. Members discussed:

- the role of Medicare, Medicaid, and private health insurers in the pricing and reimbursement of health care services;
- model cost reduction programs being used around the country and in Montana,
- the ways in which new medical technology and prescription drugs have affected health care prices;
- the role of patients, health care providers, and health care payers in health care pricing, the use of health care services, and the payment of those services;
- the consumer's needs in health care price transparency efforts;
- best practices for transparency tools and examples of transparency tools used in other states and by entities in Montana; and
- the ongoing effort by a broad group of stakeholders to develop a Montana Health Information Exchange, which will allow providers to share patient records and better coordinate care for patients who are being treated by multiple providers.

Members spent much of their final meeting in small-group discussions that allowed for in-depth conversations about the information they received during the study and the proposals they wanted to make to the full committee. At the conclusion of their work, they recommended that the Children, Families, Health, and Human Services Interim Committee:

1. offer strong support for the maturing of the Montana Health Information Exchange as a way to potentially address transparency and to lower costs;
2. not pursue any legislation related to an all-payer transparency tool;
3. seek advice from the Office of Public Instruction about the best way to approach health literacy for high school students;
4. not to pursue additional state guidelines for health care transparency;
5. allow individual legislators to pursue bills to clarify consumer responsibility for out-of-network bills and balance bills, perhaps using an amended version of House Bill 123 from the 2017 legislative session; and
6. pursue options for reducing prescription drug costs, including hearing a planned presentation on drug prices from the State Auditor's Office in June and considering following up on the new information.

The full committee accepted all of the recommendations except the final one.

HJR 20: HEALTH CARE PRICE TRANSPARENCY

TRANSPARENCY IN MONTANA

While transparency legislation dominated much of the health care-related discussion in the 2017 Legislature, lawmakers actually took the first steps toward making health care price information more accessible to Montanans in 2009. That year saw passage of the Patient’s Right to Know the Costs of Medical Procedures Act and the Patient’s Right to Know of Insurance Coverage Provisions Act, companion laws designed to give patients a better idea of both the total cost of their medical treatment and the costs that would come out of their own pocketbooks.

Current Law

The two bills enacted in 2009 both involved medical treatment costing more than \$500, and both required that the information be provided only if consumers asked for it.

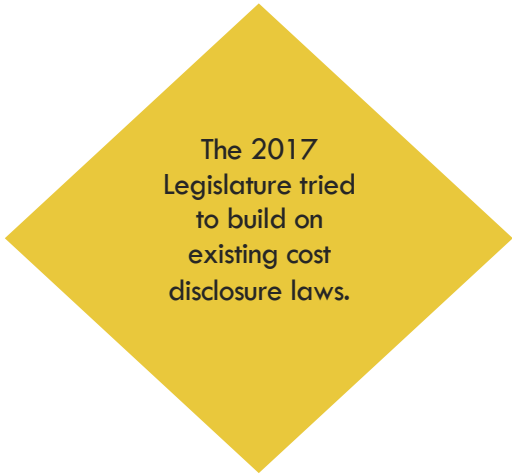
The Patient’s Right to Know the Costs of Medical Procedures Act requires hospitals, surgicenters, clinics, and health care providers to give a good-faith estimate of charges for a health care service or course of treatment that the patient is either receiving or has been recommended to receive. The Patient’s Right to Know of Insurance Coverage Provisions Act requires health insurers to provide a summary of an insured person’s coverage for a specific service or course of treatment.

The laws apply to both physical and mental health care, to any provider licensed to provide physical or mental health care in Montana, and to any insurer regulated under state law.

Proposed Legislation

Four bills introduced in the 2017 legislative session sought to build on the existing disclosure laws in order to make it easier for consumers to understand the costs they would incur for medical services and to avoid unexpected costs. Various versions of the bills also included incentives for consumers to shop for certain services, as a way to encourage competition and reduce overall health care costs.

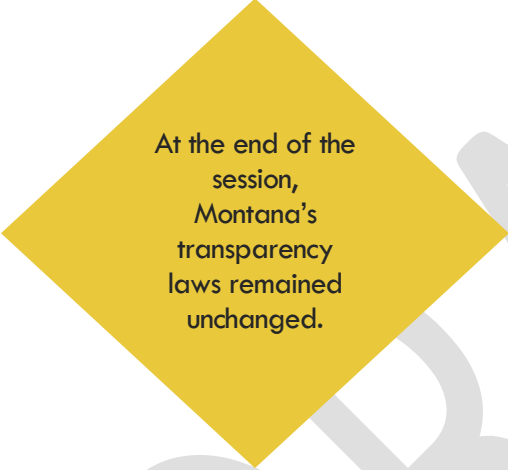
[House Bill 123](#) by Rep. Amanda Curtis was designed to reduce the chance for so-called “surprise” medical bills in which people received unexpected bills for services they thought would be covered by insurance. The bill as drafted would have changed the current cost disclosure laws to require health care providers to indicate the health insurance networks in which they participate; indicate whether services from other health care providers may be needed to complete care; and indicate whether an estimate of the charges for other services must be obtained separately. It also would have required insurers to provide information about out-of-pocket costs from nonparticipating health care providers; inform patients of their right to opt out of receiving services from a



HJR 20: HEALTH CARE PRICE TRANSPARENCY

nonparticipating provider; and provide a list of participating providers located within a reasonable distance. The bill was amended throughout the process and died when a conference committee's work on the bill was not accepted by the Senate. The final version of the bill included many of the provisions contained in Senate Bill 96.

[House Bill 400](#) by Rep. Greg Hertz would have required providers to disclose more information about the costs of the health care services they offer. The bill called for health care providers and facilities to make their chargemaster or another list of billed charges available for each health care service they offer. Providers also were to indicate the network status of the provider for the patient's health plan, if known, and say whether the services of other providers may be necessary. A provider or facility that failed to disclose the information would have been unable to collect on any amounts owed by the patient or to take any action that might affect the patient's credit rating. The bill was tabled in the Senate Public Health, Welfare, and Safety Committee.



At the end of the session, Montana's transparency laws remained unchanged.

[Senate Bill 96](#) by Sen. Cary Smith expanded on the disclosure requirements for both health care providers and insurers by adding provisions related to out-of-pocket costs. It also required insurers to establish websites where insured individuals could get information on the payments that the insurers would make to in-network providers for certain services that were considered "shoppable." Insurers were to offer cash or other incentives to people who chose to receive shoppable services from providers who charged less than the average price paid by the insurer for the service. Consumers could have filed complaints with the Department of Justice if they believed a health care provider had failed to provide a good-faith estimate; providers could not have tried to collect

any disputed amounts until the complaint was resolved. The bill was tabled in the House Human Services Committee, but key elements were amended into HB 123.

[Senate Bill 362](#) by Sen. Ed Buttrey expanded on the disclosure requirements for health care providers, including network status and whether services may be needed from other providers. A provider who failed to disclose the information could have faced financial penalties. The bill also required insurers to create transparency tools that would allow insured individuals to determine their out-of-pocket costs and potential costs of out-of-network services, along with quality ratings or measures for providers offering the health care service. The bill originally required insurers to offer a financial incentive to people who chose lower-cost health services of acceptable quality. However, that requirement was removed from the final version of the bill. The bill passed the Legislature but was vetoed by the governor.

At the end of the 2017 session, Montana's health care transparency laws remained unchanged from the versions passed in 2009, setting the stage for the HJR 20 study.

HJR 20: HEALTH CARE PRICE TRANSPARENCY

HEALTH CARE UNDER THE MICROSCOPE

When the full Children and Families Committee turned the HJR 20 study over to the subcommittee, the group of 15 legislators and stakeholders took a close look at:

- health care pricing and payment practices;
- changes in the models of providing care;
- existing transparency laws and tools in Montana and elsewhere; and
- the needs of consumers.

The members spent full days in September, January, February, and March hearing presentations and talking with panels of experts about questions prepared and posed by Rep. Kelker, the presiding officer. They also discussed terminology related to each topic and read materials selected by Rep. Kelker and Josh Poulette of the Legislative Fiscal Division in advance of each meeting. The materials were designed to provide background information as well as fodder for conversation as the subcommittee delved into the study topics and worked on the five goals it identified for its work:

- understand provider costs and reimbursement sources;
- identify factors that set health care prices;
- determine what consumers want and need to know about health care costs and pricing;
- identify effective methods and processes for educating consumers about health care costs and pricing; and
- determine the role the State of Montana should play in ensuring health care pricing transparency.

Meeting 1: The Economics of Health Care

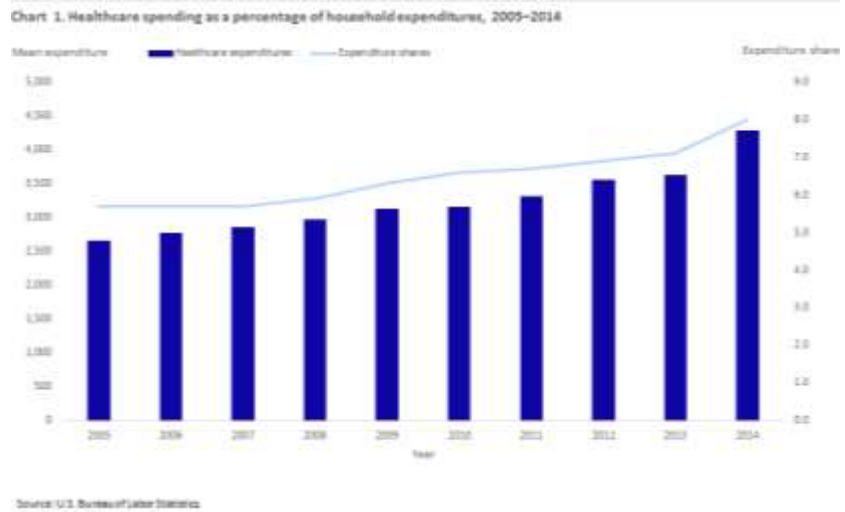
To prepare for their initial meeting, subcommittee members read the first chapter of the sixth edition of *Health Policy Issues: An Economic Perspective*, by Paul J. Feldstein. The reading focused on the increase in medical expenditures in the United States over the past several decades, during a time when Congress created and expanded the Medicare and Medicaid programs and more employers provided health insurance coverage to their employees.

Feldstein suggested that medical spending had increased in part because patients who were privately insured or receiving health care through a government-funded program did not have to pay the full costs of their care. Consumers began to expect more choice in health care providers and access to the latest in medical technology and prescription drugs. Health care costs also were influenced by not just the increased use and cost of those services, but also by the fact that more people were living longer and many of them had greater access to a widening array of health care services, often paid for by Medicare.

HJR 20: HEALTH CARE PRICE TRANSPARENCY

Members reviewed the chart below that shows how health care spending has grown as a percentage of household expenditures.

A panel of health care providers representing large hospitals, critical access hospitals, small private practices, and private clinics discussed their operating costs, their profit margins, and the steps their organizations have taken to reduce costs. They said their profit margins are generally low because they have high fixed costs, such as personnel and equipment. Some health care providers benefit from the fund-raising efforts of an affiliated foundation or from other donations they receive.



The providers also discussed their efforts to reduce costs by:

- focusing on efficiencies;
- emphasizing preventive care;
- bundling their services;
- providing some procedures in their offices or on an outpatient basis to avoid additional facility fees;
- taking part in purchasing consortiums to receive lower prices on supplies; and
- reducing the use of some high-cost services.

Meeting 2: Reimbursement, Pricing, and Cost-Reduction Models

The subcommittee continued its work by reading the second chapter of the Feldstein book, “How Much Should We Spend on Medical Care.” Members also reviewed information in advance of the meeting about payment models in other countries and potential changes to Montana’s health care delivery system identified by the Governor’s Council on Health Care Innovation and Reform in a June 2016 report. At the meeting, members heard a presentation on the changes occurring in delivery of health care services, leading to a more coordinated and less fragmented system of services. And they talked with two panels of speakers who answered questions about reimbursement and pricing and about model cost reduction programs.

HJR 20: HEALTH CARE PRICE TRANSPARENCY

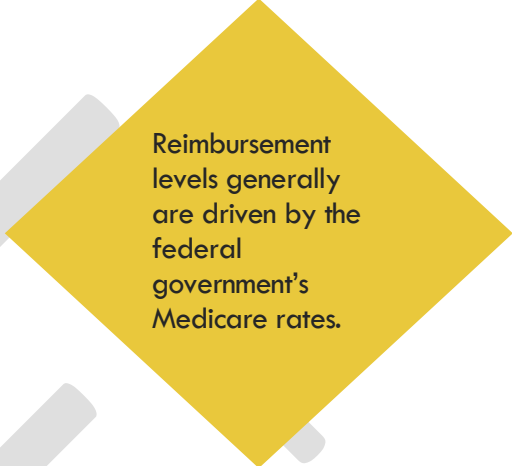
The Feldstein book noted that the United States spends more on health care than any other country. The author suggested the level of spending could be attributed at least in part to the fact that American health care consumers have the ability to choose their health care providers and, often, the level of service they receive. In addition, they often do not have to worry about the costs because they pay little out of their own pockets for the services.

Panelists discussed the entities other than patients that pay for the costs of health care services. Payers include Medicare, Medicaid, the Veterans Health Administration, the Indian Health Service, workers' compensation insurers, and health insurers. The speakers noted that government programs have become a larger percentage of the payment mix and often reimburse providers at a level that is lower than their costs.

Insurance companies come the closest to covering the costs of care. But overall reimbursement levels are generally driven by the federal government, which sets reimbursement rates for Medicare. The payment for many other programs is tied to the Medicare rate in some way, but the payment levels vary from program to program or insurer to insurer. As a result, patients often have different out-of-pocket costs for the same procedures – depending on whether they are uninsured, insured, or covered by a government program. Differences also exist among insured patients, depending on the details of their insurance plans.

Subcommittee members also learned about model cost-reduction programs that are being put in place in health systems around the country. Many of the models include changes not only to the reimbursement for medical services but also to the way the services themselves are provided. New models include:

- integrating behavioral health care with physical health care;
- using bundled payments, where a provider receives a single payment for a set of services instead of separate payments for each service or item provided;
- coordinating care when a patient needs care from multiple providers;
- using evidence-based medicine;
- creating patient-centered medical homes, in which insurers pay an extra monthly fee to primary care providers who closely monitor a patient's health condition and adherence to a treatment regimen;
- focusing on population health to improve the health of the entire population and reduce health disparities among population groups;
- using reference-based pricing, in which an insurer or employer bases reimbursement for a health care service on a base price and patients are responsible for paying the difference between the actual charge and the reference-based reimbursement if they choose to obtain care from an out-of-network provider;
- using mid-level professionals, such as physician assistants, nurses, or nurse assistants, to provide routine care at a lower cost;



Reimbursement levels generally are driven by the federal government's Medicare rates.

HJR 20: HEALTH CARE PRICE TRANSPARENCY

- using telemedicine;
- using value-based pricing, where providers are paid based on their success at improving patient outcomes, keeping costs down, and providing patient satisfaction;
- encouraging wellness services such as health screenings, immunizations, and health coaching to prevent illness and maintain or improve a patient's general health.

Panelists also discussed ways in which new medical technology and prescription drugs increase the costs of health care, the administrative costs associated with processing claims for medical care, and the fact that higher-cost care does not always mean that the care is of a higher quality or has better outcomes.

Meeting 3: Transparency Laws and Tools

In preparation for their third meeting, subcommittee members reviewed a number of articles and studies discussing standards for transparency tools and the information consumers need when it comes to making decisions about health care services and the costs of the services. Rep. Kelker also prepared materials outlining transparency tools in high-performing states and the criteria used by a national group and others in rating transparency tools.

A panel of speakers discussed consumer needs and identified several areas of importance to consumers, including up-to-date information that is consistent among the entities providing it, the degree to which their insurance plan will cover a specific service, and the full extent of the services for which they could be billed. Speakers also said the complexity of the billing and insurance systems makes it difficult for consumers to understand some of the information even if it's provided — making education on health care and health insurance an important factor in the discussion.

The committee reviewed studies showing that the manner in which cost and quality information is displayed affects how likely consumers are to use the data make decisions about their health care. Essentially, tools that interpret the data for the user and highlight the best options for the consumer make it easier to use and benefit from the tools. Those concepts were encapsulated in the graphic on the following page by Judith Hibbard, a University of Oregon researcher. The graphic provides a comparison of hospital costs and quality ratings for a knee replacement.²

² Hibbard, Judith, "Best Practices to Maximize Consumer Use," Report Card on State Price Transparency Laws 2016, Health Care Incentives Improvement Institute-Catalyst for Payment Reform, July 2016.

HJR 20: HEALTH CARE PRICE TRANSPARENCY

Hospital	Improved Functioning	Prevention of Complications	Average Costs	High Value*
Evergreen Hospital	Average	Below	\$32,685	
Lakeview Hospital	Better	Better	\$23,815	✓
Woodland Hospital	Below	Below	\$44,686	
Sierra Vista Hospital	Better	Better	\$25,652	✓
Parkdale Hospital	Average	Average	\$38,789	

* High Value=High Quality and Low Cost

Montana Transparency Efforts

The subcommittee also heard about existing transparency efforts in Montana.

Montana Health Information Exchange

Since late 2016, numerous health care providers, insurers, and associations have been working to establish the Montana Health Information Exchange. The exchange would create a secure means for providers to share information about patients, coordinate their care, and avoid duplicative tests or procedures.

Following an initial exploratory meeting in 2016, five task forces have worked on different aspects of the Health Information Exchange: the governance structure, the clinical and quality needs, privacy and security concerns, business and finance aspects, and the necessary technology for putting the exchange into place. Meanwhile, a pilot project in Billings has been testing the concepts involved in the Health Information Exchange on a smaller scale and providing feedback to the larger group to help refine the statewide efforts.

Stakeholders in the statewide effort were planning to develop a business plan by fall 2018 that would identify the amount and sources of funding for establishing and maintaining the exchange.

MHA Transparency Tool: Informed Patient

The Montana Hospital Association has been providing general pricing information to consumers since the mid-1990s, starting with brochures that were available in hospital waiting rooms and distributed elsewhere in the community. The MHA created a transparency website in 2009 that is still in use today. Known as MT Informed Patient, the site offers consumers not only price information but also tips on preparing for a hospital stay, understanding their bills, and navigating a variety of post-hospital services.

HJR 20: HEALTH CARE PRICE TRANSPARENCY



The Montana PricePoint feature of the website allows consumers to compare the prices charged by different Montana hospitals for the same procedure.

Blue Cross Blue Shield Transparency Tool

Like many insurance companies, Blue Cross Blue Shield of Montana offers its covered members a transparency tool that provides not only the cost of numerous health care services, but also real-time data on bills paid for the patient, whether the patient has met the plan's deductible or out-of-pocket limits, and a list of providers in the patient's network. The tool allows consumers to shop for services and also includes quality ratings for providers.

Blue Cross is experimenting with a pilot project offering its own employees a financial incentive to shop for services.

CONCLUSIONS AND RECOMMENDATIONS

The subcommittee wrapped up its work with a look at Colorado legislation for transparency tools, model national legislation on surprise medical bills, and Utah legislation on prescription drugs. Members then broke into small groups to discuss in depth the ideas generated by their work, through the lens of the information they had gathered over five months.

Subcommittee members agreed that health care nationally and in Montana is changing significantly as providers move toward new models of care that focus on outcomes and better coordination of care. They also concluded that transparency tools already exist for many Montana consumers but often are not used. They agreed that consumers face a complex web of requirements and information when trying to figure out their health care costs and could benefit from education on health insurance and the health care system in general, including medical billing procedures.

Based on those conclusions, the subcommittee recommended that the Children, Families, Health, and Human Services Interim Committee:

1. offer strong support for the maturing of the Montana Health Information Exchange as a way to potentially address transparency and lower costs;
2. not pursue any legislation related to an all-payer transparency tool;
3. seek advice from the Office of Public Instruction about the best way to approach health literacy for high school students;

HJR 20: HEALTH CARE PRICE TRANSPARENCY

4. not to pursue additional state guidelines for health care transparency;
5. allow individual legislators to pursue bills to clarify consumer responsibility for out-of-network bills and balance bills, perhaps using an amended version of House Bill 123 from the 2017 legislative session; and
6. pursue options for reducing prescription drug costs, including hearing a planned presentation on drug prices from the State Auditor's Office in June and considering following up on the new information.

Action by the Full Committee

Rep. Kelker reported the subcommittee's conclusions and recommendations to the Children, Families, Health, and Human Services Committee in March 2018.

The committee accepted all recommendations except Recommendation #6, relating to prescription drugs. Members noted that the State Auditor's Office has the ability to propose legislation on its own if its work indicated the need for legislation.

HJR 20: HEALTH CARE PRICE TRANSPARENCY

Appendix A: Subcommittee Members

The Children, Families, Health, and Human Services Interim Committee agreed to create a 16-member subcommittee for HJR 20 made up of four legislators and 12 representatives of health care providers, insurers, employers, taxpayers, and consumers. Associations representing those groups were invited to select members to participate in the subcommittee. The Montana Taxpayers' Association declined to appoint a member, citing workload concerns involving other interim studies.

Entity Represented	Appointee	Title/Organization	City
Children and Families Committee	Rep. Kathy Kelker	Presiding Officer/Legislative Member	Billings
	Sen. Albert Olszewski	Legislative Member	Kalispell
Economic Affairs Interim Committee	Sen. Ed Buttrey	Legislative Member	Great Falls
	Sen. Tom Facey	Legislative Member	Missoula
Montana Hospital Association	Bob Olsen	Vice President, MHA	Helena
	John Hill	President and CEO, Bozeman Health	Bozeman
	Cherie Taylor	CEO, Northern Rockies Medical Center	Cut Bank
Chamber of Commerce	Kevin Larson	President, EBMS, Inc.	Billings
	Sarah Swanson Partridge	General Manger, Farm Equipment Sales Inc.	Glasgow
	Connie Prewitt	Chief Financial Officer, Billings Clinic	Billings
Montana Medical Association	Dr. Roman Hendrickson	Ruby Valley Hospital	Sheridan
Department of Administration	Marilyn Bartlett	Administrator, Health Care and Benefits Division	Helena
State Auditor's Office	Kris Hansen	Chief Legal Counsel	Helena
Insurer	Jen Hensley	Government Relations Manager, PacificSource Health Plans	Helena
Consumer	Olivia Riutta	Outreach and Engagement Manager, Montana Primary Care Association	Missoula

HJR 20: HEALTH CARE PRICE TRANSPARENCY

Appendix B: Letter to the Office of Public Instruction



Children, Families, Health, and Human Services Interim Committee

65th Montana Legislature

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COMMITTEE STAFF

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April 13, 2018

Elsie Arntzen, State Superintendent
Montana Office of Public Instruction
P.O. Box 202501
Helena, MT 59620-2501

Dear Superintendent Arntzen,

The 2017 Legislature approved House Joint Resolution 20, for an interim study of transparency in health care pricing. The study was assigned to the Children, Families, Health, and Human Services Interim Committee, which agreed to have a 15-member subcommittee of legislators and stakeholders review the topic and make recommendations on how to provide consumers with clear information on the costs of the health care services they receive.

Among other things, the subcommittee discussed both the complexity of the medical billing process and the wide range of costs that consumers could experience, depending on the type of health insurance coverage they have and the network of providers who are covered by their insurance policies.

The subcommittee members agreed that a need exists for consumers to be well informed about the many factors that influence the costs of their health care services. Members received information showing that individuals with low health literacy have annual health care costs of \$13,000, compared with \$3,000 for people with high health literacy levels. Many adults also have trouble understanding basic health information such as vaccination charts or prescription labels.

The subcommittee members discussed the various avenues that could be used to help consumers improve their health literacy, including better explanations from health

HJR 20: HEALTH CARE PRICE TRANSPARENCY

insurers and health care providers, more information from employers, and basic education on these topics through the schools.

Because the Office of Public Instruction supervises and works so closely with Montana's public schools, the members thought your office might be able to provide the Children and Families Committee with information on the best way to improve the health literacy of Montanans, particularly Montana students who will be faced in the near future with making choices that could significantly affect both their physical and financial health when it comes to selecting and using health insurance and health care services.

The subcommittee recommended that the Children and Families Committee consult with your office for suggestions on how to best improve the health literacy of high school students. The full committee accepted that recommendation.

I'm writing on behalf of the committee to convey the request and to let you know that we would appreciate any suggestions your office would be able to offer.

Thanks in advance for your consideration of our request.

Sincerely,

Sen. Mary Caferro
Presiding Officer

CI0425 8102soxb.

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HJR 20: HEALTH CARE PRICE TRANSPARENCY

Appendix C: Links to Pre-Meeting Reading Materials

Subcommittee members received a number of materials in advance of each meeting to inform their conversations on the scheduled topics. Following is a list of the materials, all of which can be found on the [HJR 20 Study web page](#) under the heading “Pre-Meeting Reading Materials.”

- [The Rise of Medical Expenditures](#), *Health Policy Issues-An Economic Perspective: Sixth Edition*, Paul J. Feldstein
- Montana Code Annotated
 - 50-4-512: [Disclosures Required of Health Care Providers](#)
 - 50-4-512: [Disclosures Required of Health Insurers](#)
- [How Much Should We Spend on Medical Care?](#), *Health Policy Issues-An Economic Perspective: Sixth Edition*, Paul J. Feldstein
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