Testimony submitted on behalf of the Cicero Institute/Cicero Action regarding HB 1594.

BY: Adam Meier, Senior Fellow and Legal Counsel, the Cicero Institute/Cicero Action

Position: Neutral

Thank you Chair Lee, Vice Chair and members of the Committee.

My name is Adam Meier and I'm a Senior Fellow and Legal Counsel for the Cicero Institute and Cicero Action, a nonprofit that advances entrepreneurial solutions to public policy problems nationwide. Before joining Cicero, I served as the HHS Cabinet Secretary in Montana and Kentucky. Thank you for allowing me to testify on HB1594, sponsored by Representative Hendrix.

The healthcare sector lacks the hallmarks of most other functioning markets. In most markets, price transparency exists—consumers know the prices—yet in healthcare, the prices for the same goods or services vary significantly, and it's often difficult for patients to know in advance what they will be paying.

Certainly, recent efforts have been made to improve cost visibility and transparency, such as requirements to provide good faith estimates for out-of-pocket expenses and federal transparency efforts requiring price disclosure for the most common procedures at hospitals. Yet, significant gaps remain. Many services are provided outside of the hospital setting, and significant inconsistency remains in how services are priced within these settings.

This is probably best demonstrated through our study at the Cicero Institute in 2023. We surveyed several providers in the Nashville area to request the cash price for diagnostic colonoscopies (CPT code 45378), including normal services within that procedure bundle. Cash prices ranged from $541 to $4629, while the average insurance rate ranged from $2,126 to $2,592. We also found that it was not always easy to get such providers to disclose cash prices.

The study authors identified several reasons for why cash prices could or would not be disclosed, such as…

1. Patients must set an appointment with the provider to conduct an assessment for medical necessity before the provider would offer a cash price quote.

2. Providers required surveyors to be a current patient within their system before disclosing the price over the phone.

3. Billing representatives that suspected surveyors had health insurance refused to disclose the cash price because they believed the surveyor had another form of payment and actively tried steering them away from paying out-of-pocket.

This all demonstrates how complicated and opaque healthcare pricing is, even for someone who is motivated to shop for lower-cost care.

The provisions included in HB 1594 would build upon federal transparency efforts, extending requirements currently on hospitals to most other North Dakota providers. This would provide patients with access to more information needed to shop for healthcare services.

Finally, it is worth noting that North Dakota would not be in uncharted territories here. Other states have passed similar requirements, and other still are considering similar actions.

For example, even as of 2020, a study showed that Minnesota, Alaska, Massachusetts, Florida, Nebraska and Tennessee require carriers and/or providers to supply price information to patients, and more than a dozen overall had some sort of price transparency requirement. States have began to build on those policies, adding requirements for deductible credit for those who shop and pay cash or services, even when out of network (see, e.g., AZ, TN, TX, ME).

Thank you again for the opportunity to speak on the bill and healthcare price transparency.