[LR119]

SENATOR JOHNSON: Good morning, everyone. I'm Senator Joel Johnson and Chairman of the Health and Human Services Committee. Let me introduce, not only the members of our committee, but those of the Banking, Commerce and Insurance Committee, as well. First of all, to my immediate right is my coconspirator, Senator Rich Pahls, who is their Chairman. Then starting to my extreme right is Senator Pirsch, Senator Langemeier. Then we have members of both committees, Senator Pankonin and Senator Gay. Then to my immediate left is Senator Stuthman, Senator Howard--good morning, Gwen--and then Senator Hansen, and then Senator Christensen. So with that, let me do one thing. First of all, let me tell you that this is the hearing on LR119, and again I guess with a new group here and a lot of new people, I better give the usual things. When you do come forward, please sign in, and then spell your name for the record so that we have that available for posterity. And if you have a cell phone, please turn it off or you will be. (Laughter) Next, with that, let me just begin the morning with something that the staff was good enough to put in front of me so that we understand where we are headed this morning. With this, I always discourage people from reading things here, and then I go ahead and start out doing it, so I'm going to set a bad example to start with. At any rate, welcome to this interim study regarding healthcare pricing transparency. To begin with, let's share with the committee members and the people planning to give testimony today, that this hearing is intended to gather information on the availability of healthcare pricing to Nebraskans. This discussion is not intended to occur in the context of pending legislation. We are simply interested in what is happening in healthcare financing as it relates to the consumer, provider, the insurer, and whether or not Nebraskans have meaningful access to pricing. Many observers have noted the importance of consumer involvement in purchasing decisions as a way to control healthcare costs. We are interested in what tools consumers have that allow them to know what their healthcare actually does cost. We have prepared a list of testifiers who will provide us with this perspective. And at the conclusion of this list, we will also ask for others who may wish to testify. With that, what I have on my list is Mr.

Fred Schuster as our first testifier. Fred, thank you, and welcome. [LR119]

FRED SCHUSTER: Mr. Chairman, thank you very much, and it's good to be here, and appreciate the opportunity to address a joint session of the two committees. I'll talk a little bit about prices... [LR119]

SENATOR JOHNSON: Fred, you better spell your name first off, or I'll be in trouble. [LR119]

FRED SCHUSTER: (Exhibit 1) Okay, very good. Thank you for the reminder. It's Fred Schuster; it's S-c-h-u-s-t-e-r. It's difficult for me to just discuss price transparency without briefly mentioning or discussing the other cornerstones that make up value-driven healthcare. The other three are providing providers and consumers proper incentives, electronic healthcare, and the third one is quality measures. And once you have price and quality, you can determine value of a product. I know I don't need to mention to you that something needs to be done about healthcare costs and the impact it has on our economy. But for the sake of many others I'll go ahead and mention at least a few of them. Part of the reason why Honda overtook GM is because of rising healthcare costs in the United States. The U.S. spends about twice what other major industrialized countries do. These are 2004 figures, per capita figures. In the United States we spent $5,670; in Germany, $3,821; and Japan, $1,960. And we have about 47 million Americans that have gone, at least some period of time, last year, without having healthcare insurance. It's a very dynamic number. There are people coming on, people going off; some by choice, some are the stereotypical people that can't afford it. But there is a lot that choose not to, as well. It just kind of depends on their situation. I was without health insurance myself when I was in my twenties for a brief period of time. In 1951, healthcare occupied about 4 percent of the U.S. economy. Twenty-seven years later, in 1978, it had doubled to 8 percent. And then this year it doubled again, to 16 percent, and there are projections that within eight years it will rise from 16 to 20 percent. There is no place on the world economic leader board for a country that can't

control its cost, the cost of production. We really have, I think, two choices in this country. We can go the route that other nations have, and have a single-payer government-run healthcare system, or we can rely more on ourselves to make the right decisions. If we take the second route we do need some more information. One of the ways to start is letting people know ahead of time how much something costs. I know of no other industry where you cannot ask and receive at least an estimate, if not a quoted price, of the cost of a product or service other than healthcare. I don't believe anything...nothing but good comes from people knowing costs. If we are to control healthcare costs, we first need to know what the costs are and what we're getting for our money. But doing so is difficult, and beyond our insurance premiums and copayments, most of us really do not have a clue how much healthcare costs. Price transparency requires gathering information from insurers and payers to provide relevant information to consumers. Insurers and payers are also working to develop standards so that consumers can get a clear idea of the overall cost of treatment for an episode of care. An episode of care is kind of the whole gamut of care that you get when having a surgery, to be the hospital, the doctors, lab tests, pharmacists, rehabilitation, etcetera. Now I hope everyone has a copy of this. I don't know if you do, Senator. Okay, on page 6 and 7 of this booklet...anybody not have one? On page 6 and 7 of the brochure, is a prototype of what we would like to be able to do in price transparency, how we would like to be able to have it look. This has worked in other areas, the Medicare prescription drug program is the most recent example. Starting in January 2006, the actuaries had projected the cost of a standard plan to be $37 per month. It ended up being at $24 per month. Now some of that we believe is because of the competition. Not only could consumers see how much theses plans were costing, but the providers, the plans could also see how much their competitors were charging, and lowered the price to be competitive. Our goal is to provide better health at a lower cost for all Americans. Now, even if we adopted this today--and this is not a law that requires this; this is all voluntary so far--even if we adopted this today, I don't want to pretend that this is a panacea for everything that ails our healthcare system. It also, in conjunction with that, and maybe even more important to that, it requires a change of

self. The best way to reduce healthcare costs is to stay healthy. Now I acknowledge that I am not the poster child for this initiative, and consuming Kathleen Dolezal's chocolate chip cookies are little help either. More than 75 percent of all medical costs comes from chronic disease. Most chronic disease can be prevented or managed. Price is not given the consideration it should in healthcare, and that is a big, big problem. People who have health insurance often don't care enough about price. People who do not have healthcare insurance cannot find the price even if they do ask. Hospitals and doctors are simply unprepared to answer the question, how much will this cost? Competition on value requires the ability to not only know the cost, but to be able to compare it. Understandable standard methods of grouping medical charges are being devised. These groupings, as I mentioned, are called episodes of care. When cost is understood, it allows consumers to compare the cost and quality, such as what you've got on page 7 and 8 there. An episode of care will also give physicians and hospitals important information. Without conscientiousness of the entire cost of the medical episode, practitioners could lose sight of value. The best way to further the advantage of having price transparency is for the federal government and individual private employers to commit to offering plans that reward consumers to exercise choice based on high quality of care and competitive prices for healthcare services. The state of Nebraska could be a powerful leader in this area by actively researching what companies offer this type of information when it comes time to purchasing health insurance coverage for the employees of the state, and I would ask you to consider doing so. We've got over 800 other government, state, local, the federal government, to sign on a year ago; corporations, companies, and organizations that have signed up on this as well. CMS, the Centers for Medicaid and Medicare Services, a division of HHS, has made an initial attempt to make Medicare cost data available to the general public. I do have an exact Web site I won't read at the moment, but the Web site contains Medicare payment information for hospitals and physician services in the following categories: hospital inpatient, ambulatory surgical centers, physicians, and hospital outpatients. The Medicare payment information based on fiscal years '05 and '06 is organized by states, although in some cases by counties, according to the various medical and treatment

procedures. The Medicare payment information, admittedly is a little awkward and difficult to understand in its current situation. While this initial effort by CMS is commendable, in my judgment, it is clear that the material is not yet in a consumer-friendly format. And again, we want to change it to look a little more like what you have in front of you. The various Medicare payment files need to be reorganized and reformatted with clear definitions added so that the beneficiaries and those involved in their treatment decisions can more easily determine Medicare payment amounts for various treatments, and make informed decisions. Just to give you an example of how this could work if it's reformatted a little bit more, the CMS Web site has various, what we call a compare Web site on it. You can go to the Web site and look up various quality measures on hospitals, the home health industry, the nursing home, and others--the Medicare prescription drug plan, for example. In a one-year period, May '05 to May '06, it had over 44 million hits on it. It's in a usable, consumer-friendly way, and that's what we hope to do with this as well. Although price is important to know, so is quality. Everyone should want a medical procedure for the lowest cost possible, however, for example, when having a colonoscopy, you don't want the doctor to cut corners on the quality. Electronic records could also save costs by not having to fill out the clipboard of information every time you visit the doctor. You would no longer need to carry x-rays down the hall. The doctor would be able to e-mail prescriptions to the pharmacist, lowering the chance of getting the order wrong because of bad handwriting. It could also be helpful in sending your medical records from anywhere here in Nebraska to anywhere you might be when having a medical emergency. Providing incentives for doctors to check for diabetes, for example, could also save money. There is over 5-8 million Americans that have diabetes that don't know it yet. If they become aware, the doctor can begin the process of getting things under control. We'll continue to pay doctors on the numbers of patients they see, but we should pay more on the quality of work they do than what we do now. We are doing more with prevention, even with the Medicare modernization act, and provides more preventative services. The Welcome to Medicare physical for the first time, if you are turning 65--we started that in January '05. We also provide blood tests for cardiovascular disease, diabetes, and

others. We provide a free flu shot, free smoking cessation programs, counseling, among other things. I appreciate the opportunity to be here and make this presentation. I ask you to again consider making the four cornerstones a policy for the state of Nebraska, and approve that as some other 800 entities have also done. I would like to introduce Robert Epps with CMS. I believe, Robert, you have a few comments that you would like to make as well. [LR119]

ROBERT EPPS: Thank you, Mr. Chairman. My name is Robert Epps, and that is spelled E-p-p-s, and I am with the Centers for Medicare and Medicaid Services. I basically don't have anything to add to Mr. Schuster's remarks except to say that CMS is making a number of efforts in the way of reporting payment information. And it's on our Web site for physicians, for hospitals, inpatient, outpatient, and ambulatory surgical centers. I have to say, however, it is not ready at this point for consumers. I've spent a good deal of time in the last few weeks reviewing some of this information, and I think anyone that doesn't have a lot of time, and at least basic computer skills would be hard-pressed to make any sense out of the payment information that we have at this point. But it is an initial effort and I think it's commendable in that regard that we're taking these early steps in making payment transparency available to consumers. I would be glad to try to respond to any questions. [LR119]

SENATOR JOHNSON: Well, let me just kind of throw out one little thing for starters, and this isn't necessarily directed either to you or to Fred, but maybe to the people that will follow, as well. One of the things that I see that's very hard to overcome is this, is if we go back, say, 60 years or so, what you have then is the patient came in to see their physician, and as they went out the door, why, Fred, that will be $2 or something like that. And, oh, yes, and we have to get that x-ray, and that's going to be another $5, or something. And so here was your bill where you were responsible right then and there for that. Now, as our insurance programs have developed, what I see is the loss of that individual responsibility at the time, that then because it goes around a circuit and you're not responsible then and there to hold costs down, what I would see as patients doing,

is I pay a lot for insurance. I've got the gold cross plan, and so, you know, Doc, I need to stay until the next day because of things at home and there's not going to be anybody there to take care of me, and by the way, you know, I know that penicillin shots, very cheap, will do the job, but, you know, give me that real expensive one because I pay for it anyhow. So here we have the circuitous way that it seems to me is one of the centers of the problem, is that there is no incentive, or we've lost a lot of this incentive to control costs. And so you can comment on that. But I would like to hear other people comment on that, how we get around that philosophy that has grown over the decades here. [LR119]

ROBERT EPPS: I couldn't agree more, Senator. I think what we have at this present time is a system where responsibility for payment, as well as a lot of the decisions, is so diffuse that it can't be narrowed down or pinpointed toward any part of the healthcare system, whether it's the individual patient or a variety of providers that are involved in a particular case. And I think that is one of the core problems facing us with reforming our healthcare system, is bringing some focus to individual responsibility. That is a personal opinion. That's not an official CMS position, that I know of. [LR119]

SENATOR JOHNSON: Okay. Thank you. Now, any questions of our group? Yes, Senator Christensen. And don't be afraid to ask the gentleman who is retired, as well. [LR119]

SENATOR CHRISTENSEN: Well, I would just comment on that, and the fact that if we knew our costs up-front is as was explained, because I've called around before and had troubles finding out myself. If we knew our costs up-front, and we had to pay our copay the day we left, it would give that personal responsibility. [LR119]

ROBERT EPPS: It would go a long way toward bringing responsibility, I think. [LR119]

SENATOR CHRISTENSEN: And I've also been the one that believes...I happen to have

a plan that has office visits copy at zero, and I think it's wrong, from the standpoint it encourages me to go, so. [LR119]

ROBERT EPPS: I would agree. Yeah. [LR119]

SENATOR JOHNSON: Senator Pirsch. [LR119]

SENATOR PIRSCH: You gave out a handout here that has kind of a future possibility of what a screen may... [LR119]

ROBERT EPPS: Yes. That is our goal on our CMS Web site is to be able to provide consumers with that kind of information, but we are a long ways from that point. [LR119]

SENATOR PIRSCH: Yeah. Is there anything...? One of the categories is price, and that is something that doesn't exist in...there's obviously a lack of information there as to price. You said there were four categories total. Another one would be quality. Is that also going to be a difficult one to measure and give...? What is...what may be the (inaudible) of quality to you may not be quality indicators to me, or...? [LR119]

ROBERT EPPS: Yes. We're making a number of moves through, over I'd say the past five or six years. We've conducted a number of demonstration projects designed to bring out the information about quality performance, but by different healthcare provider groups. Right now, we're involved in a, it's called a physician quality reporting initiative, and I think it's fair to say that the direction we're moving with that will be a pay-for-performance system at some point. I know there are many members of Congress that would like to see a pay-per-performance system in place. The problem with that, particularly with physicians, is the matter of patient behavior. One could be the most conscientious physician in the world, but if your patients are uncooperative, you know the question there is, is it fair to put the onus on the physician for the behavior of the patient? That's not to say that we shouldn't continue to move in that direction, but

there are some very serious problems in coming up with a viable quality reporting system. [LR119]

SENATOR JOHNSON: Fred, why don't you come up and join in, if we get you a chair if you need it. [LR119]

FRED SCHUSTER: I want to comment on what you said. I also want to say you've got a really good insurance program. You don't have deductible or anything like that. But that doesn't mean you shouldn't go. I mean, as a rule, most guys just don't go, and that could be bad. I mean, you don't want to go when you have a cut finger, but you ought to go if you feel some things that you haven't felt for a while, because sooner you can get on top of whatever it is you have, you know, the better economically. And it's not just an economic issue; it's a quality of life issue, as well. And that's part of what we're trying to do with the Medicare prescription drug program is that we're giving everybody a free physical for the first time they turn 65. So they can go in and find out what's going on. There are 8 million American's that have diabetes that don't know they have it yet. And if we can get going on that and get them on the right path, that will save, not only a lot of money economically, but also extend their quality of life as well. Now, as far as quality measures are concerned, it is a little more difficult to draw it up. But quality measures have to be objective standards. They have to be the same thing that if I went in and counted, and you went in and counted, we'd come up with the same thing. We can't measure the doctor...was he or she nice to me? Or were they...those subjective type of things. We have to measure on quality things. So we use, in other areas, we use protocols to measure quality. For example, in the case of a hospital it's widely accepted in the medical community that if someone is having a heart attack one of the things you should do is give the person an aspirin. So we asked the hospitals, did you give an aspirin when admitting a patient having a heart attack? And maybe...oh, thank you, (inaudible). [LR119]

SENATOR JOHNSON: Go ahead. [LR119]

FRED SCHUSTER: Did you give the patient an aspirin when admitting them, when having a heart attack? And maybe 80 or 90 percent of the hospitals nationally did that. But what's wrong with the other 10 percent? But that is information, there's maybe five or six other measures. And these aren't things that the federal government had come up with, these are things that I think we were at the table, but things that the hospitals came up with to measure themselves, and not only for heart attacks, but we're going to have it ultimately for a lot of medical procedures. But maybe we're starting off with the top ten. So you obviously want to check your web site before you have a heart attack to know where you want to go. But there's five or six other measures like that. And it's not everything you need to know when having a heart attack, which hospital to go to, maybe closeness is important as well, and how many heart attacks the hospital treated would be something and those type of things. But those are the type of measures that we're talking about that you can have a better idea. There's a lot more that we'd like to have, but it has to be very objective things. And the people who are involved, who are being measured or tested on it are the ones that need to come up with those type of things. And that's what physicians will be coming up with for these quality measures as well. [LR119]

SENATOR JOHNSON: Okay. Any other questions? Fred, Robert, thank you very much. [LR119]

FRED SCHUSTER: Thank you. [LR119]

SENATOR JOHNSON: Appreciate your coming. Next on my list is Tim Wagner. [LR119]

TIM WAGNER: (Exhibit 2) Thank you, Senator Johnson. Senators, my name is Tim Wagner. That's T-i-m W-a-g-n-e-r. I'm the Nebraska director of insurance. And I'm here today to tell you why I believe that increased transparency in healthcare pricing would be beneficial to Nebraskans. And before I really get into my testimony, I think we ought

to go to the heart of your question, Senator Johnson, about why, how? One of the things that I think you should be aware of is that our health system was dramatically changed in the forties when we employed insurance "benefits" to get around the wage and price stabilizations that were necessary during our period of war. And so we ended up a system, the seeds of which were sewn then about full benefits that we're, unfortunately, reaping today. And we're going a long ways in trying to change that philosophy. And I believe that the increased use of HSA's, consumer-driven health plans, increased copays, and deductibles, and quite frankly the growing number of uninsureds are going to impact how we view the pricing of healthcare. And I would like to say let's start saying that we're in a fine restaurant and we sit down to dinner, and we're insured. And we have restaurant insurance. And so we have a menu and there are no prices on that menu. And so we order what we want and the table next to us has no insurance...has insurance and they order what they want. And our cost is $3, and theirs is $4. Then we have someone walking in off the street with no insurance at all. And they order from the same menu, and their cost is several hundred dollars. What we have is a pricing system or lack of a pricing system transparency, anyway, that is creating real confusion. I can't imagine a situation in any other field where we don't know what we're paying. And it's clear that health financing is under stress. I mean, that's something that isn't surprising. But what we have here in this system is a system where there's a disconnect between the people who consume individual healthcare services and the people who directly pay the provider bills. Because individuals don't pay these costs directly, they're not as price conscience as healthcare consumers as they are in other areas of their lives. And I believe that transparency in healthcare pricing will help to centers of our population: first, those that don't have the...and the very few remaining that do, the first dollar health coverage; and those that are underinsured. I say it first because I believe disclosure of health prices will have a role in containing health costs and foster greater competition within the healthcare marketplace. There are seven states that have some form of disclosure of health pricing today. There's a hodgepodge of insurers across the country that freely provide negotiated rates to their insurers. In other words, some insurers get a lower rate for

negotiating coverage than others. Currently, Nebraska does have a requirement that insurers give a good faith estimate for reimbursement rates to those in those situations where nonpreferred providers are used at the request of the insured. There is also a provision that Dr. Schaefer will refer to later regarding cost estimates. The other problem is price information is available even to insurers is, as I've been told, not of uneven quality. Provider billing practices are complex. In fact, providers have, in testimony before the New Mexico Legislature, the cost of providers billing for these services are roughly 10 percent of the cost of the service themselves. The payment procedure depends on provider coding. For example, you don't pay one price for a gallbladder removal; you pay whatever the provider bills, depending upon what procedure is used. Combine that with bundling and other practices, the price isn't necessarily understandable. While dianosis-related practice groups, i.e., gallbladder removal is a gallbladder removal as promised for making the cost of healthcare more understandable, it's really only in its early stages. All this is more important than ever with the rising uninsured population and the event of consumer-driven health plans. In an effort to enlist individuals in the fight to keep healthcare costs down and give them a stake in doing so, high deductible policies are combined with health savings accounts to allow individuals to directly obtain their healthcare services or purchase their healthcare services. This represents a creative development in the evolution of our healthcare financing system. It allows consumers to compare costs when comparing providers between the high cost of providers and the low cost provider. It may even allow customers to negotiate a better deal with the providers they've chosen. But with this consumer choice it is really at the mercy of the negotiated rates of the insurers. From an HSA context, consumers will often pay discounted rates for their healthcare piggybacking the discounts that have been negotiated by their primary insurer. While these rates need to be available to an insurer, they can be weighed before these amounts are withdrawn from their accounts. If this new model is to work there's a significant catch. How is the healthcare consumer is supposed to shop around or negotiate when they have no idea of what the posted cost is? The healthcare pricing is simply an unknown to consumers when they walk in the door. Without pricing data that

tells them one hospital will do a procedure for one figure and a hospital down the street will do the same procedure for that figure less 50 percent, how can they understand what the price...how can they really understand the price? They can't. So we get consumers competing...we get providers competing not on the cost of the healthcare they provide but on the aesthetics of their remodeled facilities. But what if I'm willing to pay to recover in a regular room as opposed to private suite, if I can save 50 bucks? What if I can save the same amount by having a CT scan done by a provider who has a better negotiated rate with my insurer? The problem with the current pricing system doesn't give me the option of balancing those trade-offs, unless you do some real significant detective work. There are additional challenges because simple disclosure is not enough. Pricing information needs to be meaningful. A list of average fees or even total charges does not reflect the bottom line of what the consumers obligation is for the service provided, nor does it provide a reliable way to compare prices among providers. Moving to a system where people understand the cost is going to be a very difficult process for providers, for payers. But it will be one in which I believe there will be some meaningful return to the individuals that are ultimately paying for the care, whether it's directly or via the payment of premiums. So with that, I'd like to take any questions that the committee may have. [LR119]

SENATOR JOHNSON: Any questions? Senator Christensen. [LR119]

SENATOR CHRISTENSEN: Well, a comment anyway. Something else, I believe, needs addressed is the fact that because of my insurance provider I have to have approval. So I'll call in and get an approval for a hospital. But then I'll get a nonapproved physician. And how do I get this determined? Because you know if I...to get the cheapest rate for the hospital I make sure I go to the right one that's within my insurance plan. But then several of the technicians aren't approved, so I get the high rate. And that's something that's not fair to the consumer. If the hospital is approved, the doctors need to be approved. [LR119]

TIM WAGNER: The real issue, Senator, is how do we create rationality in an irrational system? [LR119]

SENATOR CHRISTENSEN: Very true. [LR119]

TIM WAGNER: How do we really create or have a system where people, in my mind and where ultimately we go, why do we...why have we...we have created this system of negotiation in the purchasing of healthcare. But why is it that...why are the costs different for me having one procedure than my wife having the same procedure? Why...you know, there is no...there is no...very little commonality left. And I think I would comment directly to this point and how it's affected the Nebraska insurance community. I would say 20 years ago, Mutual of Omaha was the "gold standard" when it came to visibility in healthcare payment. Because of the fact, the negotiation and getting prices based on...or paying benefits based on negotiated rates, you needed a mass, a huge mass of people. And so what we are slowly doing is we are creating a system where there will be very few private payers left. And we're seeing it in some states. One insurer can have up to 75 percent of the...we're taking the competition...we are, hopefully, going to gravitate to some kind of an oligopoly rather than a free...you know, a total system where there are a number of players or payers. And it's all been part of this process. I don't know...I know I didn't answer your question because I really don't know the answer as to what would happen. [LR119]

SENATOR JOHNSON: We'll let you have a follow-up, then we'll go to Senator Gay. [LR119]

SENATOR CHRISTENSEN: Just an additional comment. You know, I always ask for a cost analysis before I pay the bill. And when we had our last child, just 21 months ago, we forgot to take Tylenol in with us. We were charged $8 per Tylenol. If people realized what they could save, if they just looked over a cost analysis sometime, what they could save by taking their own Tylenol in, you'd understand. [LR119]

TIM WAGNER: Senator, you're an exceptional individual. And I wish more people were doing this same kind of comparisons that you are. But I venture to say that you're in the less than 1 percent that is analyzing the cost of their care that way. [LR119]

SENATOR JOHNSON: Senator Gay. [LR119]

SENATOR GAY: Tim, you had mentioned about the pricing information, where you can't get pricing information. I think that is changing. We'll discuss that more later. But when people, consumers are comparing their prices, wouldn't the market, if we created a better environment for the market too, they would go out and seek my business instead of...CMS is just saying, well, we don't have this; we're a ways away from doing this. Wouldn't the market then, in order to get my bucks, provide me we're the lowest cost on this, this, and this? And you see it on your phone plans. I mean you're bombarded with 20 options. But ultimately, how do we get to that point where on the paying customers, you mentioned the restaurant, where if you're not paying, you're not shopping your price, you don't care. Like Murph says, Senator Christensen, I don't care, I'm not paying for it. But a vast majority of us are still paying for our health insurance and we're trying to shop around. But how do we go and set something up? And you probably can't answer this immediately, but maybe it's something that we need to think about. How do we set it up that the market starts coming to me, not letting the government create some plan on quality pricing and those things, but we create an environment that the market is then seeking my business and my families business a little more? How would you do that, in a short summary. That's a big question, but how do we do that? [LR119]

TIM WAGNER: Senator, I have been, you know, in the business process you collect information, then you ruminate, then you have a vision, and then you try to execute on that vision. I'm still collecting information. And I've hardly got to the ruminating process. In other words, this is such a difficult issue. And how do we get competition? And then you have the issue that was...the gentleman that proceeded me, the quality of care, how

do you evaluate the physician and maybe one, you know, or the facility? And I believe those are pretty subjective. And I don't know. You say cost versus quality. You know there's that paradigm there. And we have a system, in my opinion, where medicine is an extremely personal, personal relationship. And for some it's a real paradox--the business aspects of medicine versus the human aspects. I don't know how to...I can't (laugh. [LR119]

SENATOR GAY: One follow-up question. [LR119]

SENATOR JOHNSON: Sure. [LR119]

SENATOR GAY: I think we're doing it in the financial planning business, the business I'm in. It's subjective measurement, a little bit. But you have people that come in and say, well, why would you do this, why would you do that? So I think it's subjective. You can say if it's false advertising, we could kind of monitor that a little bit. So I don't know the answer either. And maybe down the road we need to explore it. But it's being done now in other industries where I can't just go out and promise the world to somebody without a regulator saying, hey, that's not right. [LR119]

TIM WAGNER: One of the things, and of course it is happening in your financial...the financial services industry, as well as the technology that drives the changes. In medicine the driving is so fast and the costing associated with the new procedures, and you know, it's mind-boggling, more than I can handle. [LR119]

SENATOR JOHNSON: Senator Pirsch. [LR119]

SENATOR PIRSCH: You had mentioned in your testimony that Nebraska currently requires a good faith estimate of reimbursement rate where nonpreferred providers are used. You had mentioned there were seven states that require some degree of disclosure. Are there any other types of common statutory disclosure requirements in

these other states, other than the one that's in place here in Nebraska? Is there kind of a common... [LR119]

TIM WAGNER: I do not have that information, Senator. But I could get an analysis of those statutes, to see if, from our staff, to see whether we can...something. And I can forward those to you. [LR119]

SENATOR PIRSCH: Okay, that's great. That would be helpful. Just how have you seen...when did the Nebraska require it? What year did that go into effect? [LR119]

TIM WAGNER: It was fairly recent legislation, I'd say maybe four years ago. That's an estimate on my part. [LR119]

SENATOR PIRSCH: Um-hum. [LR119]

TIM WAGNER: But it was fairly recent. [LR119]

SENATOR PIRSCH: How do you see that requirement playing out? Is that just in itself, alone anywhere helpful or useful? Or is it just perhaps a first step towards something that may prove to be useful? [LR119]

TIM WAGNER: I think it's more...how do I want to say this? I think it's a statute that is a good statute. I mean it's...but how much the public understands that it exists, and how much it's used, I don't know. [LR119]

SENATOR JOHNSON: Senator Howard. [LR119]

SENATOR HOWARD: Thank you. Tim, I really agree with you. I think there's a lot more that goes into this than strictly the dollars and cents. When you stop to think that you're trusting another human being with a surgical outcome for yourself or maybe your child,

you want to really have a trusting relationship with that physician. And at that point, you're not interested in cutting corners, you know, or if this is going to be $50 cheaper for me in the long run. If you're under that anesthetic and you're on that table and somebody is cutting into you and you have no control, you're going to want to believe they're going to pull you through it. And I think until we really look at that critically, the rest of it is going to be (laugh) secondary. At that point, it's really more, who do I have confidence that can do this for me? Who do I have a relationship with? And I think along with that, I think most people that carry insurance they're paying into that insurance, paying those premiums, and they really are entitled to that care. The deductible is one thing, and you always weigh that out and say, you know, maybe a less invasive procedure would cover it. But when it comes right down to it, I think you need to be able to trust the person that's going to have their hands in your body. [LR119]

SENATOR JOHNSON: Any other questions of Mr. Wagner? Tim, thank you very much. [LR119]

TIM WAGNER: Thank you. [LR119]

SENATOR JOHNSON: Next I have Dr. Joann Schaefer. [LR119]

DR. JOANN SCHAEFER: (Exhibit 3) Good morning. My name is Doctor Joann Schaefer, spelled J-o-a-n-n S-c-h-a-e-f-e-r. I'm the chief medical officer and director of the division of public health in the Department of Health and Human Services. The availability of cost information to patients is an interesting story to tell. I don't know a physician who is unwilling to tell a patient how much his or her fees are for a procedure. But anecdotally, I hear all the time that you can't find a meaningful accurate way to get a cost estimate for your healthcare. We all know that healthcare costs are eating up a larger part of our income than it used to in the past. My colleagues tell me that having to enter into collections for unpaid medical bills is common place, and that introduction of consumer-driven healthcare plans is interestingly enough one of the reason why. Faced

with high deductibles which can't...which can be as much as $10,000 for a family plan, patients are unable to make these obligations. Perhaps as a consequence of this, patients are getting more sophisticated. In my former practice, I had folks who would self-diagnose themselves with printouts from WebMD and other similar sites and would treat their office visit as a second opinion. Faced with a more informed patient, I was also and often confronted with questions about their share of the cost. These questions came from patients who were paying for the cost out-of-pocket, so their interaction with me had a direct impact on their wallets. As a physician, the healthcare of my patients was the first concern. But I have to tell you that in primary care you also are directly involved in their ability to pay for these services. Those without means still need the care, and I often found myself on one end of the phone, pleading with organizations with sliding fee scales to accept my patients in need of services that I could not perform and/or I was working within the bounds of my institutional rules on their payment plans. The fact is that I appreciate the patient that is involved in his or her healthcare, and providers can play a large role in educating patients by offering our costs up front when requested. This may have some certain and uncertain ancillary benefits. For instance, physicians may go into collections less often when their patients know the cost of the procedures up front on a family budget and can plan these anticipated expenses. In addition, defensive medicine is also a driver of healthcare costs, and when patients are paying for these costs, they start taking control of their own healthcare, making choices on whether or not they want the service performed. Often we physicians need a reality check that someone is in fact paying for these services, and questioning the diagnostic value of services has a distinct value in the patient-provider relationship. As a provider that revealed my institutionally set fees when asked, I was able to help my patients who were not able to afford the out-of-pocket expenses for healthcare, but not all the time. From my experience, I can tell you that transparency is not the true and total...I'm sorry, is not the total cure for the rising costs of healthcare, but is an important tool to help reign in some of the increases, especially for patients who are uninsured and underinsured. In 1985, the Legislature adopted the Hospital Consumer Information Act. This addressed some substantive issues related to uniform billing and claim forms.

While these provisions were superseded by the Standardized Health Claim Form Act in 1994, two sections remain although with little attention paid to them. Under current law, hospitals are required to provide a written estimate of the average charges for a diagnostic condition or medical procedure that is personalized to account for any needs of the patient who is requesting that information. Hospitals are also required to provide notice to the public that these estimates are available on request. This is what is available. Medicare has started revealing their reimbursements nationwide. There are some healthcare systems around the country that are also doing this on their own, including some in our own backyard. But these costs aren't meaningful if they don't reflect the actual amount owed by the patient, thereby allowing the patient to compare costs between providers. We need to be aware, however, of the realities of healthcare financing. Physician charges only make up part of the overall cost. For instance, when having a baby at any hospital in the state the total cost for a normal delivery has several components: The delivering physician's fee, the facility charge for the mom and baby, the anesthesiologist fee, lab, pathology charges, pharmaceutical costs, and a few other things. And this is for a normal delivery. If a C-section needs to be performed for the baby in trouble, an OB or surgeon could have fees attached, and other complications could call for more specialists for mom, and if the baby is in trouble, yet even more specialists will be called. It is a complex scheme, an primary care physicians often find themselves at the beginning and at the tail-ends of it. The total cost isn't easy as one request and one estimate, as you can see. And it is very fragmented. But as medical care becomes more team-oriented, we may see its financing follow suit. Until that day arrives though, we need to make sure that providers aren't held to an unreasonable standard when providing cost estimates. I do believe it's in the cards, however, to get as close to accurate as possible. As Tim Wagner testified earlier, I believe that pricing transparency is key to allowing patients to make economically informed decisions about their healthcare in order to stem the rising costs. I'd be happy to answer any questions. [LR119]

SENATOR JOHNSON: I don't know if we're going to invite you back, Senator

Christensen. (Laugh) Go ahead. [LR119]

SENATOR CHRISTENSEN: You know, I agree totally. You can't anticipate all the variable costs and things this way. And I can say that one of my childs was extremely cheap to have, after having a very expensive one. We got to the hospital, her water broke before we got in, we got up there. They got no monitors hooked up, they got nothing. Doctor had one glove on, and we had a baby, that was cheap. (Laughter) I liked it. Scared my wife a little bit, but I liked it, it was very cheap. But you know, I think there's sometimes that if we had the situation of because of malpractice, we quite often do too many tests, which drive it up. And I've gotten to the point, I ask the doctor, do we really need this test? And I'm one that I would sign a waiver that said I didn't want C, D, and F tests done, just the A and B, because I believe in keeping the costs down and necessary, because I've paid so much out-of-pocket. All seven of my children have come out-of-pocket. And so I ask a lot of questions of, how much do I have to have? And so I think if we had some type of system this way where people...because the doctors have been very good to me, saying, you know, I'd like to do this and this, and we probably should do it. And I'm going, whoa, what's this probably? Do we really need it? And they'll say, no. And they know me well enough. I'm not a sue-happy individual. I had a classic case of I could have and didn't. And most people aren't that way. So for doctor's safety, I wouldn't have a problem signing that release that I didn't request these. But I think we could really save a lot of costs if we didn't do so much over testing. [LR119]

SENATOR JOHNSON: Senator Pahls. [LR119]

SENATOR PAHLS: Doctor, I have a question. And I don't know this. Can you sign away the rights of a child? Let's say that you're a physician and something does happen. And if I signed off that, you know, no, that's okay, but I don't know that a child, can you sign away the rights of that child? Let's say something happened in the birth. I don't know if...can you do that? [LR119]

DR. JOANN SCHAEFER: That's a complex question. It depends on the... [LR119]

SENATOR PAHLS: Well, but I don't know if somebody else has the right to sign away? Maybe they do. I don't know. But I do know, just from personal experience, I've a family member who is a doctor. And she thinks getting away from the baby delivery business, she almost has to just because I think of the constant fear that something could happen. So there is a stress factor there in that profession. [LR119]

DR. JOANN SCHAEFER: Absolutely. [LR119]

SENATOR PAHLS: But I will say one thing, I'm a little bit disappointed in your testimony because you didn't sing it. (Laughter) I don't know if you've ever heard this doctor sing. This person can...I was at a conference this...at Joslyn this summer, and you did a great job of singing. [LR119]

DR. JOANN SCHAEFER: Thank you. That is my stress modification program. [LR119]

SENATOR PAHLS: Well, I'll tell you, it's unbelievable. I was telling the person next to me, I know that person. [LR119]

SENATOR JOHNSON: Great. Any other questions? Joann, thank you very much. [LR119]

DR. JOANN SCHAEFER: Thank you. [LR119]

SENATOR JOHNSON: Next on my list, I don't have a person, I have an organization: Nebraska Medical Association. [LR119]

_____: We'll waive off, and comment at the end. [LR119]

SENATOR JOHNSON: All right, fine. Next Bruce...are you back there, Bruce? [LR119]

BRUCE REIKER: Yes. [LR119]

SENATOR JOHNSON: Do you pronounce your name "Reeker" or "Rieker", by the way? [LR119]

BRUCE REIKER: I pronounce my last name "Reeker". But I'm not testifying. Kevin Conway is going to testify... [LR119]

SENATOR JOHNSON: Oh, good. (Laugh) [LR119]

BRUCE REIKER: ...(inaudible). Thanks. [LR119]

SENATOR JOHNSON: Yes. Some of you might know Bruce pretty well. Worked with him for years. Why don't you come forward then, sir, and welcome. [LR119]

KEVIN CONWAY: Thank you. I'm sorry. I thought you said Nebraska Medical Association. So... [LR119]

SENATOR JOHNSON: No, they're going to pass for a while. [LR119]

KEVIN CONWAY: (Exhibit 4) Okay. We were having a conversation, so apologize for that. Good morning. My name is Kevin Conway, K-e-v-i-n C-o-n-w-a-y. I work for the Nebraska Hospital Association and I appreciate the opportunity to testify this morning. Good morning, senators, chairmen Pahls and Johnson, and committee members. On behalf of the 85 member hospitals and the 39,000 individuals that they employ, I appreciate the opportunity to testify today regarding LR119. As providers of healthcare and as major employers in Nebraska, the NHA's member hospitals recognize the

importance of increasing the consumer's awareness and understanding of their healthcare. To that end, transparency of pricing and quality are important components. The Nebraska hospitals are already accustomed to public reporting and transparency. They do so for the external cause of injury registry; brain and head injury registry; trauma registry, and other state level registries. Nebraska Revised Statutes 71-2076 requires each hospital to make available a listing of the 20 most common diagnostic related groups, or DRGs, with charge information. In addition, Nebraska Revised Statute 711-2075 requires a hospital to provide a written estimate of charges when requested by a perspective patient. Realizing that the above reporting is not enough for the consumer, the NHA's Board of Directors directed the NHA to develop additional resources that will provide more transparency. Through an Issue Strategy Group, formed last year, the NHA is already well into the process of developing a public web portal designed to enable consumers to review hospital charge information. Hospital charge transparency is not enough. Hospitals are only one part of a patient's episode of care. True consumer awareness and choice will not happen until there is transparency on all aspects of their care; from the provider to the payer. With each episode of care, the consumer will need to know what to expect from other providers, and most importantly, the payers and those managing their healthcare financial transactions. Providers know the recommended courses of treatment and their charges for those services; but only the payers know the terms and condition of each health services contract (deductibles, copays, coinsurance, etcetera) specific to each patient and each provider involved in the patient's episode of care. Only when the consumer can make a choice on what is the best value to them based on recommended treatment, expected outcomes, and financial implications, will we have true transparency. Thank you for the opportunity to testify at the hearing today. And I appreciate any questions. [LR119]

SENATOR JOHNSON: Any questions of Kevin? Sure, Senator Gay. [LR119]

SENATOR GAY: I've got one. When patients come in the door, what percent, and I know you don't probably have this filed away in your head, but just ballpark, understand,

first of all, how their insurance works? Most of them just...here's my deductible, here's my card and come in. But how many people now are using HSA's or they have their what I call pay flex card B, or you know, where you're loaded up on your card, prepaid thing? [LR119]

KEVIN CONWAY: The health savings accounts or high deductible... [LR119]

SENATOR GAY: Well, the health savings account, but then the prepaid, on your debit card; not so much health savings, but how many people are coming in even knowing that...they're taking proactive measures to save money? Or are they just coming in still saying, here's my card, whatever, take care of me? Is it increasing, or is it... [LR119]

KEVIN CONWAY: I don't have any real empirical evidence. I do have regular meetings and talk to billing office managers. And they are seeing the increase of those types of plans with either high deductible HSA or there's a debit card involved. But they are not telling me that there is general increase in awareness on what this is truly costing them. The consumer, the patient is seeing it more as out-of-pocket expense that the insurance company used to cover underneath their classic paying with zero deductible or zero copay. [LR119]

SENATOR GAY: Okay. So a quick follow-up, if I could, Joel. So when they come in, they're just saying...they're looking for way to save their taxes is all they're doing on a lot of these things. You go to your employee benefits meeting; hey, I can save some taxes because it's deferred comp. I put it in this thing. But they aren't really at this point...I should put it into your head, but are they really understanding any of this transparency we're talking about? Is it 2 percent, 10 percent? Just give me a ballpark on your hospitals. [LR119]

KEVIN CONWAY: You know, I'd be just really hard-pressed to say what percentage of consumer really understands that. And I can just use myself as an example. I feel I'm

fairly informed on healthcare financing. I've been involved for over 20 years now with healthcare and the financing world. Been a consumer for a bit longer than that. Finding out the information I need to find out, knowing who to talk to at our insurance companies and who to talk to at the providers has been very difficult. Just some recent occurrences for me trying to make the decision, which is going to be the best financial for me, with injuries in my family, to have surgery and follow-up rehab care done with that surgery, it was very, very difficult to put all those pieces together. Through my due diligence, I thought I had the right answer. And when it came down to the final conclusion I did not have the right answer. It did not meet what I thought I was understanding. It's a very difficult world to understand. For the layman it is extremely difficult. There are components...we heard about financing, so just the pricing side; quality becomes even more difficult. You have what's a better quality measure? Do you have outcomes as a quality measure? Do you have processes? We heard Centers for Medicare/Medicaid Services, Fred Schuster, discuss the process measures--are they getting ace inhibitors, aspirin on admission, those type of things, or is it patient perception that's a quality? All the hospitals are required to participate in patient satisfaction surveys. Is that truly the measure of quality? Were they happy with their care? Did they feel they were treated appropriately? [LR119]

SENATOR GAY: Thank you. [LR119]

SENATOR JOHNSON: Senator Christensen. [LR119]

SENATOR CHRISTENSEN: I guess you know or realize we can't do without transparency. But I, for one, have called before, ahead of having the baby to see if I could get a discount to prepay. And that don't work very well. Nobody knows what they're doing. But you know I really believe that if we had the transparency and things, because there are a lot of elective surgeries and things like having a child and things way, as Senator Howard said, they're going to go to the doctor they want. But if we had transparency in pricing, then the hospitals, I believe, could lower their amount of

uncollectibles just by the fact people know up front. And then you could give them a discount for paying up front, I think it would help the hospitals out a bunch. [LR119]

KEVIN CONWAY: And some hospitals...and a lot of that depends on the plan. There are plans that do not allow you to collect any anticipated deductibles or coinsurance up front. You have to wait for the plan or the payer to send an explanation of benefit to both the patient or their member and the hospital. And then at that point you can say, your portion of the bill is $300. But I know there are hospitals out there that are taking practice steps. They can see that's part of their consumer satisfaction side of their business to help that person understand what's going to happen to them. And say, we anticipate your deductible is going to be this, your coinsurance is going to be this based upon past history with these type of procedures and these type of payers. [LR119]

SENATOR CHRISTENSEN: And the same way with, like I said, we had the seven kids without insurance to do it. If I could have had a discount, I would have prepaid it. Yeah, there would have been some Tylenol or something added on, you know, you can't finish it. But if you could get that initial, I would take a discount to do it. [LR119]

KEVIN CONWAY: And really that has changed in the last couple of years. I'm not sure how hold kids are. We have...the Hospital Association, the Nebraska hospitals have really embarked upon charity care and discount policies. Prior to some federal government rulings, a couple, about four years ago, it really was not seen as a legal thing for a hospital to give an up-front discount for prompt pay. Because of Medicare's rules that said, well wait, you're giving them a discount you're not giving us as a federal payer. Medicare reinterpreted their regulations and hospitals embarked upon creating charity care and discount policies. [LR119]

SENATOR CHRISTENSEN: Very good. [LR119]

SENATOR JOHNSON: Well, one of the things that hasn't been touched on here yet and

I see with a few of the people that we've got coming up that I think we need to touch on and that's this is that one of the things is that we've kind of been going on here is if all hospitals are the same. And obviously they're not. And where you have a preponderance of the knife and gun club going to your hospital and so on, they don't have insurance. So somebody has to pay $8 for the Tylenol to cover that. And one of the other things that's happened in the last several years now is that there are things in hospitals that make money and there are things that lose money. Pediatrics, for instance, almost always loses money. And so that how do you make up the difference with those? And so if you are transparent, so what? You still have these expenses that one hospital has to cover and another one doesn't. So that's why I see a real problem with our specialty hospitals. Believe me, the specialty hospitals weren't created as, you know...the parts of general hospitals that lose money didn't create specialty hospitals. (Laugh) It's the ones that made money that have left. So how are we going to take care of that? And I think that's one of the really big problems as we look at this. And so if we'd have anymore comments about that, why I'll let you...let's go to Senator Pirsch first. [LR119]

SENATOR PIRSCH: Well, that kind of brings up a good point. As transparency takes foot in the healthcare sector, does that mean that costs that have purposefully in the past, perhaps, been more as the chairman says, certain ones subsidizing other ones? As costs become clear and consumers become aware of the costs and go to those I would presume lower cost areas, does that mean that in certain areas then prices may rise for pediatrics or something of that sort? [LR119]

KEVIN CONWAY: You know I used to joke about it when I worked for a healthcare provider. Worked on cost analysis and pricing analysis, I always just called it the amoeba man. You punch in...you remember when we were kids, you had those little rubber guys and you punch in one area, it pops out somewhere else. Kind of the same thing. When you're working on your pricing strategy there are certain markets that really don't cover their direct expenses. Medicare, for example, on the average for the state of

Nebraska pays hospitals less than their cost of providing the services. So if a hospital wants to maintain their mission and be able to stay open and provide services in the future, they have to have a slight margin for that. So they have to charge higher in other areas to make up that loss. So as we listen to national debate about hospital Medicare prices going down, you realize that goes up in some other areas. [LR119]

SENATOR PIRSCH: Might that pretend that certain kind of broader or hospitals covering a broad array of health type of coverage, from pediatrics to whatnot, may tend to become more specialized, more focused in certain areas then and not be as generalized? [LR119]

KEVIN CONWAY: I don't know. I'm not sure if that's going to really happen, especially in the greater part of Nebraska. There are a lot of hospitals that they are the only hospital in their community, so they tend to provide a lot of...a large array of services for their community members. [LR119]

SENATOR PIRSCH: Thank you. [LR119]

SENATOR JOHNSON: Any other questions? I see none. Thank you very much, sir. [LR119]

KEVIN CONWAY: All right. [LR119]

SENATOR JOHNSON: Next I have Monica Seeland. Is Monica here? [LR119]

KEVIN CONWAY: Monica is not here. I was testifying on behalf of the Nebraska Hospital Association. [LR119]

SENATOR JOHNSON: Okay, fine. Thank you. Bruce, do you want to...any further comments or... [LR119]

BRUCE REIKER: No, he's much smarter than I am. (Inaudible.) [LR119]

SENATOR JOHNSON: (Laugh) No comment. Wayne Sensor. Wayne, thank you. Come on up and welcome. [LR119]

WAYNE SENSOR: My name is Wayne Sensor, W-a-y-n-e S-e-n-s-o-r. I am the CEO of Alegent Health, based in Omaha, Nebraska. Chairman Pahls and Chairman Johnson, thank you very much for this opportunity as well as members of the two committees for me to chat a few moments with you today about a topic that we have great passion and great interest in. I would like to thank you for this opportunity on behalf of the 8,600 employees of Alegent Health, the 1,300 physicians that are our partners, and the 2,500 volunteers that help us provide services on a daily basis. Fascinating testimony and discussion you've had thus far today. And I would love to embark on the social and economic issues facing healthcare specifically in this country at a more systemic level. I will, however, focus my remarks on transparency and costs specifically. And perhaps under question/answer we can talk about some of the other global issues that you've expressed interest in today. Alegent Health as an organization has long embraced the notion of transparency, period. We believe as a provider that Americans, Nebraskans have a right to know, they have a right to know how good you are as a provider, and they have a right to know what you believe it will cost for the services that they've been provided. As an organization, we don't espouse philosophy without also acting. And indeed, in September 2005, we began to publicly report our quality scores. Not the end-all, be-all. You have to start somewhere. We indeed used the CMS core measures, which were referenced earlier today, starting with 10 measures, growing to 20 measures, and this year now 30 metrics that we report both in local newspapers, as well as on our web site. You can go look at each of our metropolitan hospitals and see how indeed we are performing and what makes up those scores for each of those major diagnosis. I would acknowledge that this is about...this conversation today, this testimony, is really about cost transparency. Why I started with quality is I happen to

believe, as a healthcare professional, quality is always the first and foremost important part of the value equation. So having said that, let's talk about cost for a few moments and what our posture is on cost of healthcare. I think if really we want to engage people in their healthcare, if we truly want to give Americans and Nebraskans specifically a chance to begin to get engaged in the decision process, we simply must provide some understanding of what real cost is. You know I'm struck by the notion when you think about healthcare and you think about every other element of our lives, what other good or service do we buy where you don't know how good it is and you don't have a clue what it's going to cost? And we could talk about the genesis of that and the history and why we find ourselves in this point, but we are at this point. We don't generally know how good it is. And we generally don't know what it's going to cost. And yet, arguably, it's one of the most important decisions we make in our lives and indeed entrusting someone for the care or the life and death of ourselves or a family member. In January of this last year, Alegent Health, after a year's worth of development, rolled out a service we call My Cost. It is a web-based product. If any of you are intrigued enough to jump on your computer tonight, it is Alegent.com. You do not have to be a patient of ours. You don't have to ever have shopped with one of our physicians or one of our facilities. Alegent.com, and here in a nutshell is how it works. My Cost, blue button on the right-hand side of our web site, will begin to ask you a series of questions. There's two logic trees. The first logic tree is an insurance logic tree. It will ask you who your employer is. It will ask you what insurance plan you have. And it will ask you your specific membership identification in that plan. At the speed of light, if you will, it will then go out to a third party insurance data base and it will validate what specific plan you are a member of. The importance of that is, as you could appreciate, if you type in United Health Care, there are hundreds and hundreds of United Health Care plans. If you type in Blue Cross Blue Shield of Nebraska, there are still hundreds and hundreds of plans. And all we know at that point really is you're insured. My Cost will go out and validate specifically what plan you have a membership in. It will then come back and say, what price, test or procedure are you specifically interested? Our data base at this point has about 500 procedures and tests that are included in the data base. We used

consumer focus groups to give us some guidance around what they might be interested in. Suffice it to say if I have chest pains and I'm on the way to the emergency department, I'm probably not going to stop, jump on the Internet, and figure out how much it's going to cost me. But I do believe that in today's environment if my doctor has just ordered an MRI and it's maybe optional, maybe iffy, or if I'm scheduling an elective procedure, a planned procedure, I think it is exceptionally relevant to have an idea what that will cost. The data base is searchable. You can type in a category you are interested in. You can type in the scientific terms, or you can type in the lay term. That is to say you can type in CAT scan, even though of course it's not really a CAT scan, and that will get you to a plethora of different choices. Is it of the full body? Is it of the neck? Is it of the abdominal region, etcetera. Once you've typed in that procedure, the My Cost service will then come back and it will say, Wayne Sensor, for your insurance plan that particular test or procedure was purchased at a price of X. It is now relevant to you on a personal level. This isn't a blended rate, not a Medicare rate, not an average rate, this is for your plan what that cost was purchased...that...excuse me, test was purchased at. Secondarily, because we're bouncing off an insurance web site, we also happen to know what your copay is, and if you've reported your deductible accurately, we also know your year-to-date deductible and copay. And it will then tell you an estimated out-of-pocket cost for you at an individual level. Now what you have is the price of that CAT scan for your plan, and the estimated out-of-pocket based on your copay and your deductible. The second logic tree, equally important, is for the growing number of Nebraskans who do not have health insurance. Likewise, if you indicate you don't have health insurance, it takes you down a different logic tree. It will then provide for you a retail price. It's not a charge master price, it's not the price of the best contract, largest network that we have. It's a retail price that would be a reasonable payment for an individual. And that directly links to our financial assistance policy. You can prequalify, if you've just priced for a particular procedure and you think you're going to have difficulty paying for that procedure, you can prequality, all instantaneously, before you've ever gotten off your web. You know I acknowledge that there's lots of activity on this topic across the United States. There's federal conversation occurring. Many states are in the

midst of conversation, and many other organizations have begun to provide leadership relative to providing price information or cost information. Our approach, very definitively and very intentionally is we think that if cost information is going to be relevant, it must be the cost that you as an individual will experience at the end of the day and not some blend that's made up of tremendously different prices. Just to give you a glimpse on the journey that we're on thus far, I shared that we brought that web site up in January of this last year, as of last week, we have had 23,000 people go to My Cost and generate cost estimates for specific procedures. Considerably more people than that have gone to the web site and played with it, but 23,000 people since January have actually gone in and worked through the model to get a price of a certain procedure. A few moment ago, during the question and answer of one of my other colleagues, there was some comment about market forces is what I would roughly say. You know I, in essence, am consciously and intentionally suggesting as a provider that there is a place for market forces in healthcare. And that if indeed we encourage and support transparency, if we help consumers understand how good are you and what do you cost, that what you're really doing is welcoming market forces into the equation. And I sincerely believe, like every other segment of this economy, that if we encourage market forces to be brought to bear relevant, real information, I think something predictable will occur. I think you'll see the market will gravitate toward high-quality providers who are efficient providers of healthcare. And frankly as a provider and as a professional healthcare executive I encourage and look forward to that day. I think it's better for American's. I think that it's better for institutions. I'm going to conclude my remarks with that. There is so much we could talk about and I would relish that opportunity. We don't have all the answers. My cost is a step in the right direction. It is primarily a hospital and hospital outpatient based model at this point in time. In the upcoming year, we look forward to enhancing that model, certain bringing physician costs along with the hospital charges would be appropriate, likewise we look forward to adding more than 500 procedures, although I think we have the majority that folks are most interested in. And last but not least, our full intention, come this winter, is to share openly with our colleagues across the United States our learnings relative to cost and quality transparency so that we can encourage

other to join this journey and experience some of the same positive things that we have as an institution. Thank you so much for the opportunity to testify with you today. And I would love to field any questions you'd be interested to ask. [LR119]

SENATOR JOHNSON: You got one right here. Senator Pahls. [LR119]

SENATOR PAHLS: Wayne, I have a question. Now, how many would you call competitors do you have in your area? [LR119]

WAYNE SENSOR: I am blessed to have a robust competitive environment, as I think you're familiar with Omaha. We have two teaching colleges, hospitals in our community, a wonderful children's facility, and several carve-out facilities, and one large not-for-profit health system, as well as Alegent Health. [LR119]

SENATOR PAHLS: Okay. Could I go to...do they have a system that I could go to? Let's say that I'm trying to broker a deal that...the best deal that I could get for let's say having my appendix taken out, not on an acute basis. I mean, could I go to each one of those? [LR119]

WAYNE SENSOR: (Laugh) My chuckle there is three weeks ago I was the recipient of an emergency appendectomy, so I know a bit about that, as a matter of fact. (Laughter) [LR119]

SENATOR PAHLS: (Inaudible.) [LR119]

WAYNE SENSOR: We've connected. [LR119]

SENATOR PIRSCH: So did you check My Cost? (Laughter) [LR119]

WAYNE SENSOR: I did not. I went from the emergency room to the O.R. [LR119]

SENATOR HOWARD: Yeah, where did you go? (Laughter) [LR119]

WAYNE SENSOR: I went to an Alegent hospital, thank you. [LR119]

SENATOR JOHNSON: Is this where the term "cost cutting" comes into effect? (Laughter) [LR119]

WAYNE SENSOR: Oh no, no, no. Actually, I like to refer to it as my ultimate immersion experience as a hospital executive. There's nothing like laying in the bed to understand healthcare. You know, as you're undoubtedly, Senator Pahls, familiar, this is an Alegent initiative. And our posture is control what you can control. And while I'm participating in federal conversations on this very topic on several different venues, have talked to many, many trade organizations on this topic. You know, what I have control over is the nine hospitals of Alegent. And I believe, that if you do the right thing and you do it with gusto and sustainability, that others will follow. So the answer to your question is, I think it's variable. I think my colleagues in Omaha, specifically, would do their best to answer the question if you called and said, I want to know the cost of. It would generally involve several telephone conversations, a couple days will pass, and there will be a follow-up with you. And you will have to sort out the apples to apples comparison to make sure you are comparing the same. I think they would make good faith efforts. Our position is just let's formalize it, let's embrace it, and let's make it easy for people to do. Thank you. [LR119]

SENATOR JOHNSON: Got a couple down here. Senator Gay. [LR119]

SENATOR GAY: Thank you. Wayne, when we talked about the market forces, earlier I think somebody said, and this may be wrong, you said hundreds of plans and the complex cost of collection is 10 percent of healthcare costs, I think somebody said. So insurers have these hundreds of plans, doesn't make any sense. But if the market was

driving these forces and consumers actually did have transparency, the prior...Kevin Conway said, you know, I've been in this forever and I don't understand it. I mean, I shouldn't put words in his mouth, but you heard that. So we don't even understand this quite yet. But wouldn't the insurers, if we had a market-driven economy and consumer-driven economy, cut that hundreds of plans down to more simplistic forms that we could all understand? I mean, can you explain how that could work, if a market was driving this vehicle instead of insurers driving the vehicle? [LR119]

WAYNE SENSOR: I'm going to as succinctly, Senator Gay, as I can, take a quick stab at this. And I could answer that philosophically, but I'm going to chose to answer that out of experience, if I may. Alegent Health, I shared, 8,600 employees strong, plus our dependents, two years ago rolled out a consumer-driven health plan for our own workforce. And I must very quickly say that term alone scares me. You need to be exceptionally careful to understand what it means. Certainly, health savings account and health reimbursement accounts, the tools that the federal government gave us to fund such plans are an important point or part of a consumer driven plan. But even more powerful is, what are the benefits that you wrap around those high deductible plans? If it's just about high deductible, then I think the verdict is out. At Alegent Health there are two features that wrap around our HSA's and two HRA's. First is, if it's preventative care and it's indicated for your age cohort, it is free. You know, we've paid for incidence of illness in America forever, and yet to this day many, many, many plans will pay poorly or not at all for us to have the most basic and most incredible important tests. I'm 50 this year. I'm happy to celebrate. I have colon cancer history on both side of my family. We know exactly what I need to have done, it was free. Why wouldn't we want me to do that? So the first feature is free if it's indicated for your age cohort. We're self-insured, why would we not pay for that? The second umbrella of our entire plan is we directly remunerate our employees; we pay them for lifestyle changes. Single greatest determinate of how much healthcare you will consume in your lives is not heredity, it's lifestyle. You know, we know what the risk factors are. You know, they have to do with eating well, exercise, consumption of alcohol, and smoking. Those are

the big risk factors. And so to our workforce we've said, you know what, we'll literally drop money into your HSA's, your HRA's for you to grab hold of and deal with the risk factors that are affecting your consumption of health or your health, in general. And by the way, this isn't just the obvious weight loss, smoking cessation, this is dealing with your chronic asthma, dealing with your diabetes, etcetera, etcetera, etcetera. A very wide menu of chronic and acute conditions. And the results, back to your point a moment ago, we spent a year communicating to our workforce, a full year how consumer-driven health can work, your role, how you make choices about your families needs, because you know every feature isn't right for every family. I'm an empty nester. My wife and I are healthy, except for my appendix. And that's a very different situation than people that are already living with chronic conditions. And I'm here to tell you with great passion and gusto that our workforce, from housekeeping and food services, to bedside caregivers, to our employed physicians got it. Eighty-eight percent of our workforce voluntarily now participates in one of our consumer-driven plans, 88 percent. We still have this traditional PPO. It's expensive, you got no risk, 88 percent have chosen to participate. And I can tell you I would...I'll spare you the metrics, but I can tell you definitively without flinch, I have a healthier workforce today than I did two years ago, and isn't that awesome. I have a healthier workforce. People have taken control of their health. They're actively making decisions and choices with information and knowledge about quality and cost. And I'm compelled to say the very last part of this, although I've not said it publicly before, and by the way, we saw a dramatic change in the cost of health services to our own employees. Go figure. People are making great informed decisions about money they have control of. They are exercising more prevention than ever before. And while we've seen, like most of your organization and businesses, about a 8 to 10 percent increase in our healthcare costs on an annual basis, between plan years one and two we saw a 1 percent increase in the cost of healthcare for our employees and the benefits, including all of the wellness, all of the prevention, all of the education of the new plan. So my summary answer, Senator Gay, is you know, I think Americans are smart people. And I think if we took the time and energy to educate and to help people understand their options and have the courage to

share information that will arm them to make informed decisions, I think they will make good decisions. [LR119]

SENATOR JOHNSON: Senator Pankonin. [LR119]

SENATOR PANKONIN: Thank you, Senator Johnson. First of all, Wayne, your enthusiasm is contagious and your passion is obvious. But I think what will be interesting, whether at the state level, and obviously I think there's going to be...with the presidential campaign, this is going to be a big topic. But what I'm hopeful of, and a lot of the things you're just talked about, is that we don't move to a single payer system, like Europe, where there is rationing of care, and I think there is some...I have a daughter that just came back, there...spending two years in Spain, and says really smoking is so much worse there than in the United States because who cares. So I think we do...hopefully, in this country we can come up with some kind of a hybrid situation that encourages what you just talked about, and yet we're able to control the costs, better quality, but not to go to a single payer that rations care as we know happens in Europe and those environments. So I'm hopeful, and with folks like you in the industry that can give us good examples, that we can come upon that and at the state level, obviously, foster some of that as well. So thanks for coming. [LR119]

WAYNE SENSOR: Senator, thank you very much. That was not a question, but I'm compelled to quickly react, if I may, Senator Johnson. That's what keeps me up at night. You know there are elements of our healthcare system today that American's do really like: the bond between our physicians and our patients, the incredible infrastructure that we have available to the lucky insured Americans. Most of us in this room probably feel like we have pretty decent healthcare. But the storm clouds are incredible and frightening. And my fear and what keeps me up at night is if we don't make some steps in the right direction, that the inevitable outcome will be our federal government will step in with a single payer system. And the choice and the freedom and the wonderful attributes that we do have in our system today will be lost and lost for all time, and we'll

find ourselves in topics like rationing, which I tell you, as a healthcare executive, I'm not prepared to make. So I'm hopeful that if we can get these topics out there, gain some traction around them, you know, kind of debug them, if you will, that indeed we can really make some headway before that's inevitable. [LR119]

SENATOR PANKONIN: Well, thanks for your leadership and your organization's leadership, as good examples of what can maybe be done. [LR119]

WAYNE SENSOR: Thank you. [LR119]

SENATOR JOHNSON: I want to kind of go a little bit different direction for just a second. We've got Blue Cross Blue Shield people to follow you, so I want to kind of address this question to both of you. I don't know how much you know about it, and I just remember hearing about it a couple of years ago. There was an experiment out in Spokane, Washington, and as I recall what they did is that they had where you could go to your computer and then here would be a list of primary care physicians at a price range, and then another price range, and so on. And then you picked out who, out of those groups that you want. Then that was figured over here as that price for that. Then for women, for instance, of a child bearing age, it would list those obstetricians, for instance, that they might see. Again, here's the price ranges for those. You...that went into the computer as you chose and so on. For 70-year-old men this might say urologist for prostate problems, etcetera. At any rate, they had all of these there. And then you pushed the button and it gave you what the cost of your insurance plan would be. This was just for the physicians. It did this same kind of thing with hospitals, as I recall, but specifically remember it for the physicians. And I remember two other things. It talked about price controls by the market forces. There was one physician who was much higher and in this group that guy was never picked. Nobody listed him for their specialist. He lowered his prices and he started getting picked again. On the other hand, there was one physician who was a specialist who apparently had a wonderful reputation around Spokane, and nobody cared what his charges were. Again, you can

see market forces in the other direction. Are you familiar with this? I thought it was kind of a novel thing because people then also got rewarded, I think there were given two emergency room visits per year to the hospital. But if they went five times, then the next year their insurance went up significantly, those kind of things. Is there any place for this? I guess I'll address the Blue Cross people and so on to respond as well. [LR119]

WAYNE SENSOR: I will, Senator Johnson, defer to my Blue Cross colleague. I am not familiar with that particular model. And it does make me wonder if it's still in place today, or if it's been modified. I will obliquely respond by saying, you know, the journey that we're on as an organization and the template that we're attempting to set for others to follow is, in essence, the consumer report of healthcare. If you are contemplating the birth of a child, as an example we've used several times today, why should you not know how many complicated births have been performed in that facility, what high level support services do you have, what's the infection rate, the complication rate, and oh by the way, in addition to the clinical metrics side-by-side, what's the cost of a noncomplicated birth? My vantage point is we're making steps that direction. But what I really see in the future is a consumer report of healthcare. And I think American's deserve that. And this Spokane model would be sort of a take of that from my vantage point. [LR119]

SENATOR JOHNSON: Any other questions? [LR119]

_____: Thank you, appreciate it. [LR119]

SENATOR JOHNSON: Okay, thank you very much. [LR119]

WAYNE SENSOR: Thank you. [LR119]

SENATOR JOHNSON: Next I do have Blue Cross Blue Shield of Nebraska. Do we have a representative of theirs here? Thank you. Come on up. [LR119]

MICHAELA VALENTIN: Good morning or bordering on afternoon. I'll make this short. [LR119]

SENATOR JOHNSON: Yeah, but we're in good shape. [LR119]

MICHAELA VALENTIN: It's almost lunch time. (Laugh) [LR119]

SENATOR JOHNSON: You're my kind of witness. (Laughter) [LR119]

MICHAELA VALENTIN: I need to eat lunch. My name is Michaela Valentin, M-i-c-h-a-e-l-a V-a-l-e-n-t-i-n, and I am the lobbyist for Blue Cross Blue Shield of Nebraska. Today I come to you supporting transparency. And I just want to echo a little bit of what other testifiers have said before. First of all, it was our understanding that the legislative resolution proposes that insurers provide cost information. And we're happy to do that on our healthcare pricing, which would actually be our discounted rates. But the only issue with that is we would provide that information to our clients. We wouldn't provide it to everyone, because we negotiate our discounted rates. And that's contractual information. Our concern is that people who don't have health insurance would not be privy to that kind of information, so where do they go? And like Wayne Sensor was speaking about a data base, the My Cost data base, that is something that we should consider taking to a higher level and making it available to all people who need any kind of care through a hospital or provider. We would support a data base that had hospital information there, provider information, so that the consumer could cost compare across the board. And I understand that there are some issues with how do you input your meaningful information that you need to discern what kind of services you're going to need at what cost. But I think with the advent of technology, that could be something easily addressed. I know that Wayne had mentioned that they have logic trees for people who have insurance and people who don't have insurance. And that is a great place to start and just build on that particular data base. We think it's really

important that the quality and cost estimates are available to the general public. And we want to make sure that that is specific to the person's situation. We kind of see it as a real world example is if you want to buy a car, you might not have time to figure out, okay you know, if I want to buy a Honda, I don't want to go to Williamson and then this other Honda dealer, and other, and other. So if you can put in your information and if you have insurance or if you have providers that you're using, or if you don't, put that information in. And if it would bring up, you know, five different doctors that would amputate your leg at this, you know, particular cost. But you (laughter)... [LR119]

_____: Whoa, what an example. [LR119]

MICHAELA VALENTIN: You have to...but you have to consider there's, you know, a caveat there. You have to build in for, you know, possible complications, too. And that's going to cost more money, obviously. So we would like a data base that is available to everyone, not just something that would come through individual insurers. I mean we're happy to provide our discounted rates to our clients, but obviously that's not going to help somebody who doesn't have insurance. So with that, I wanted to tell you, Senator Johnson, that I am not familiar with that study that you cited. But we do have a technical expert in this area, and I will ask him if he is familiar with it. [LR119]

SENATOR JOHNSON: Okay, yeah. I'm kind of curious of whatever became of it. [LR119]

MICHAELA VALENTIN: Thank you. Are there any questions? [LR119]

SENATOR JOHNSON: Senator Gay. [LR119]

SENATOR GAY: Just...I got a quick comment. You brought up that car example on...I was talking to a dealer the other day. And I said, so how's business? He goes, good. But they make very little dollars on the new cars because there is so much information

out there from the free market competition. You can go on any web site and compare anything on that. But here in healthcare we can't do that. But what I'm saying is the consumer asked for that, it's driving the marketplace. And they responded to it. And healthcare, a little bit, I think we're behind. Now we got the federal government saying everyone has not done anything, and now they're going to take drastic measures, possibly, and regulate, you know, medicine. But I'm just saying I just think that's a great example of how a transparent market will lower these costs. So however you get to it, I don't know if it's government telling you, you have to do this. But the market will drive that ultimately. So I think that's a good example to show it works. The information is out there, the consumer will use it if we put it out there. So... [LR119]

MICHAELA VALENTIN: Thank you. I agree with you. And we're willing to work with this committee and with the Governor's Office, should any legislation come out of today. Thank you. [LR119]

SENATOR JOHNSON: Okay, fine. Thank you very much. Next I have Jan McKenzie. I see in the back of the room. [LR119]

JAN McKENZIE: (Inaudible remarks from audience.) [LR119]

SENATOR JOHNSON: Okay. Great. And next then I have Sheri Smith written in. Sheri, we're not that hungry. You... [LR119]

SHERI SMITH: Oh okay. I'll try and be brief. My name is Sheri Smith. It's S-h-e-r-i S-m-i-t-h. Senators Johnson and Pahls, and members of this community...committee, I thank you for allowing me to talk with you today. I am the administrator of Urology PC, urology surgical center, here in Lincoln. And I want to tell you a little bit about what we do in our practice to educate patients. We have one physician that is dedicated as our patient accounts manager, who talks with every patient coming in about financial arrangement. We don't wait for our patients to come to us and say, what is this going to

cost? If they have a surgery scheduled, they go and talk to our patient's account manager. She gets on the phone. She makes a call to the insurance company. She finds out what their deductible is, how much they've met of their deductible, what their coinsurance is. Obviously, if it's a covered procedure, preauthorizes it, the whole works. The problem we run into, and that works great for those insurance companies that we have contracts with. The problem we run into are for those insurance companies that we do not have contracts with. We are not able to get from them what they will pay on these procedures. Now I have to admit some ignorance here, and I wasn't aware until yesterday about the state law that insurance companies are required to provide that information to you. However, the request has to be in writing. And they have up to two weeks to send that response back to the insured. So we are going to pursue that. From here on out we're developing a form and including the legislation. So we will get that for our patients. I am not opposed to transparency at all. We do it every day. We provide this for our patients. I am somewhat concerned about making this a state law. And I have a couple reasons for that. We do a good faith estimate. But medicine is not an exact science and things change. And I just want to give you an example of some of the surgical cases that we schedule. We might schedule a cystoretrograde, stoma nip (phonetic), possible stent, possible eswell (phonetic). Now that doesn't mean anything to you, I know. But this is what our schedulers deal with all the time. This is what my patient accounts manager deals with every day. We go in and we give the worst case scenario to the patient. And then if it's less than that, they're happy because we didn't charge them as much as we told them we were going to. But what if we give this estimate, say we're going to go in and just do a cystoretrograde, looking into the bladder. And we get in there and discover that there are tumors or something like that, and then we have to go further and we do more tests. Is the patient going to hold us accountable? I'm afraid that if it's in state law saying that you have to provide this estimate, what happens. And it's not...I'm not concerned about what our liability will be, but it's the patient perception at that point in time. If the patient perceives that they've been misled, or they perceive that they've been overcharged, whether they have or not, that's their perception. Their perception then gets spread among other people. The

other issue that I with transparency, making it a law, is that a new patient coming into our practice may come to us for hematuria, that's blood in the urine. That could be a variety of things coming in. If the patient calls up, hasn't been seen before, and says, I want to know how much this is going to cost me to come see your urologist. There is no way that we could give that person any kind of estimate. If the person comes in and the person has had CT scans and IVP's, previous tests and brings them in, that's great, we won't have to repeat those tests. But your schedulers or your patient accounts managers, your billing people, your administrative people are the ones who are giving these estimates, don't have that information. They're not medical people and they can't make that determination. Therefore they could be coming in for something...kidney stone. Kidney stone, if you have a lithotripsy done, it's a fairly extensive and expensive procedure. If you come in with just a urinary tract infection, that could be treated with a series of antibiotics. Huge difference in the cost if they come in bringing their CT scans, saves them a lot of money in our office. But we don't know that. And we can't give that information. And if we were to say, it's going to cost you $100 to come in an see the doctor for hematuria, patient gets in there and has to have CT scans, we've added several more hundreds of dollars to that bill. And then the patient's perception is now affected that we have not given them accurate information as far as their cost, and that could filter on down to how they feel about the doctor's professional medical opinion. So that is my issue with that. The other issue that I have with transparency is a procedure in our surgery center is all-inclusive. We get charged...we get to charge one fee, it's a facility charge. It doesn't matter if we do any radiology during that time, if we provide any medications, it's all included in that cost, that one bill. Now, if you were to go to the hospital and have that same procedure done, you could possibly get charged by a radiologist for radiology charges, for any kind of medications that were given during that time, that's not all-inclusive. And that's not something that they would be able to give you in a cost estimate anyway. So if our cost estimate for a procedure was maybe $150 higher, but there's no radiology charges, there's no medication charges, but you get that at the hospital, the patient isn't getting a true and accurate analysis of what their out-of-pocket cost might be. I just made a few notes here, when I was listening to

testimony earlier, that I just would like to touch upon. Senator Gay, you had asked about the number of patients using health savings accounts and the flex cards. Yes, we are seeing a tremendous increase in that in our practice. And that leads to some collection issues as well because the $10,000 deductible, the $5,000 deductible, people don't have that kind of money sitting around to pay it out-of-pocket. So that's another reason why we try to educate our patients up front, because we don't want that sticker shock when they get the bill. They know up front what it's going to cost, approximately, and how do they want to pay it? We ask that up front to find out that information. I do have a couple suggestions. This is kind of in the broader picture of healthcare costs. I would like to see...we're talking today about fees, what the physicians, or the hospitals charges are going to be. And there could be a range in that. But what I would like to see is maybe more consistency in what health plans will cover. And I'd like to give you an example of we provide robotic prosthetectomies as an option to our patients having prostate cancer. Robotic prosthetectomies have been around for a long period of time. However, it is amazing how many times we make calls to insurance companies to precert. this procedure, only to be told that it's considered experimental and they will not cover it. The last one that I dealt with personally took us over two months, numerous letters, numerous calls. Fortunately, the patient was very well educated, who had a family member who had worked for the Department of Insurance, knew her way around, and she helped her husband get this procedure covered. But not everyone is that savvy about how to handle these type of situations. And we do our best. And we provide letters and we provide written documentation. But there are some payers that just say we're not going to cover it because it's...we deem it experimental. I think that should be something that we need to look at. The other thing, Senator Christensen, I just wanted to make a comment on yours. When the hospital is in-network, but the providers are not, we have situations that we've turned down quite a few contracts. And insurers have come to us and said, we would like to put you in our network. But when we see their reimbursement, or some of the other issues within the contract, we decline to participate, because it doesn't make economic sense for us to do so. We are incredibly busy. Our physicians have a very difficult time keeping up with the demand as it is. And

from a business perspective, we choose the patients that are going to pay the best. If you're going to see X number of patients, you might as well pick the ones that have the best reimbursement. Some of the contracts that we've been offered have some bundling edits that there is...I don't if you all are familiar with the correct coding initiative. These are global; some of them come from CMS, some of them come from the AMA, about codes that can't be billed together; and codes that if you bill one and you have another code, it's inclusive. So you only get reimbursed for the one procedure. Some of the insurance companies that we contract have their own bundling edits. They don't follow any of the other CCI, or Correct Coding Initiatives, they make their own edits. And that is an issue with a lot of the insurance companies is that they can do that, and you are bound by those guidelines. And so that is why a lot of times the physicians may not be participating in the same plan that the hospital is, just for those particular issues. The last thing I would like to just bring up is that we probably need some reasonable reimbursement for procedures. I think it was Kevin or one of the previous testifiers had mentioned that you don't make money on Medicare patients. And that is really true. I wish I would have brought it today, but I did just a little analysis for one of my physicians several years back on what the physician actually got out of a Medicare patient for just a run of the mill patient level. And it was just dollars, a few dollars by the time you pay your receptionist, your transcriptionist, your laboratory technician, your nurse, and pulling all of that out. There was very little left over for physician compensation. And I don't know how many of you were aware of this, but there are primary care physicians in Lincoln, Nebraska today that are not accepting new Medicare patients. I guess there is one last thing that I would like to bring up here. We're talking about how we can have consumer-driven healthcare. And I'm not disagreeing with any of this testimony. However, I think maybe we need to take it just a step further. And we were talking about this data base that we're going to put all these physician fees and all of this into. Maybe it would be a good idea to look into doing something like that with the payers as well. Maybe we could look at doing this huge data base that says, this is your premium for this insurance company, and this is their coverage plan, these are the types of procedures that they cover, this is your coinsurance requirement, you know, that might

help the population be a little bit better educated and maybe a little bit more selective in the plans available to them also. Does anyone have any questions? [LR119]

SENATOR JOHNSON: I see none, Sheri. Thank you very much. [LR119]

SHERI SMITH: Okay, thank you. [LR119]

SENATOR JOHNSON: Okay. The NMA people deferred until last, although we will see if there is anybody else after you as well. Welcome. [LR119]

DAVID BUNTAIN: Thank you. Senator Johnson, Senator Pahls, I'm David Buntain, B-u-n-t-a-i-n. I'm the registered lobbyist and I'm an attorney for the Nebraska Medical Association. I recognize the lateness of the hour. And I'll just make a couple of comments. Mrs. Smith, I think, has covered a lot of the practical issues that we are concerned about as far as how transparency would be implemented in physician offices. We support the concept of transparency. Our concern is whether it's something that at this point needs to be mandated or not. When we became aware of this proposed legislation, or the proposal I guess, we really don't have specific legislation to look at, at this point, we did pull the officer managers of offices that are connected...there's an office manager organization that is connected with the Medical Association. And I'm continuing to receive e-mail responses to the questions that we asked. All of the offices responded that they are currently providing pricing information for diagnostic procedures, if they receive calls for patients. And they regard this as being a part of the services that they provide to their patients. One physician's office, from Grand Island, responded we give good faith effort at estimates; we know charges for pregnancy, vaginal and C-section delivery global; however, ultrasounds, nonstress tests, etcetera are variable; all ENM codes have set prices, however, it's difficult to know ahead what code will cover the visit. The number of problems, medications evaluated and prescribed, labs ordered and reviewed, medical decision may be involved. And that is a common theme of the responses that we got that particularly with office visits, often you

don't know until you've had the office visit what the scope of it is going to be or what is associated with that. Another office responded, we do work with patients who request approximate costs, but this is not usually for routine services, this is for additional procedures that are ordered by the provider and usually performed at a subsequent visit. The other theme that comes through the responses is that there is a significant disparity between what a charge is to a patient and what the patient may ultimately pay. And this is because of the overlay of third party payment. And the providers don't know and can't tell normally what the out-of-pocket is going to be, what the deductible is going to be with the third party payers. And that then creates the kind of situation that Mrs. Smith was describing, where all the patient hears is it's going to cost me this amount of money. And then when all of this goes through the process, it sometimes can take a month or two, they end up paying something different. And regardless of how many caveats you put in on a good faith estimate, what the patient is going to have heard is this is what you're ultimately going to pay. And if they end up paying more, that can affect the rest of the relationship with that physician, even if it isn't the physician who's...and normally it isn't the physician who's giving the estimate. So I think we want to work with your committees, we want to work with the Legislature and with the administration to see if there are things that we can do that make sense and that try to...that accomplish the goal, which is to get more information to the consumer. But I think because of the kinds of complexities you've heard about earlier, it will take some work on the part of everyone affected in order to come up with a solution that makes sense. So with that, I'd be glad to respond to any questions. [LR119]

SENATOR JOHNSON: Are there any questions? Senator Pahls. [LR119]

SENATOR PAHLS: I just have a question. We just heard from a previous testifier that more doctors are not willing to have elderly, Medicare. I mean, is that getting to be a problem for the elderly? Which I'm going to be there one of these years. (Laugh) [LR119]

DAVID BUNTAIN: It is not a universal problem. There are situations in certain practices where...and part of it has to do with the mix of patients within a practice. If you have a large component of Medicare and/or Medicaid patients because of the low reimbursement levels, in effect your other patients are cross-subsidizing. So, you know, it's...we do have concerns. That's something we do pay close attention to. [LR119]

SENATOR PAHLS: Thank you. [LR119]

SENATOR JOHNSON: Any other questions? I see none. [LR119]

DAVID BUNTAIN: Thank you. [LR119]

SENATOR JOHNSON: Are there any one else in the audience, or is there anyone else in the audience that would like to speak this morning? Senator Pahls, is co-chair here. Any other comments? [LR119]

SENATOR PAHLS: You did a good job. [LR119]

SENATOR JOHNSON: We didn't get done on time. [LR119]

SENATOR PAHLS: That I was watching, because I (inaudible) 11:30. (Laugh) [LR119]

SENATOR JOHNSON: All right. The one thing before we close that I think we can all go home with is this, if you go to a restaurant and there is no prices on the menu, don't volunteer to pick up the check. (Laughter) With that, we're adjourned. [LR119]