

UNITED STATES NOTE

UNITED STATES NOTE

FALL 2014

# THINK NEW MEXICO

A RESULTS-ORIENTED THINK TANK SERVING NEW MEXICANS



## MAKING HEALTH CARE MORE AFFORDABLE

BY INCREASING TRANSPARENCY & ENDING PRICE DISCRIMINATION



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**THINK NEW MEXICO**

A Results-Oriented Think Tank Serving New Mexicans

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## About Think New Mexico

Think New Mexico is a results-oriented think tank whose mission is to improve the quality of life for all New Mexicans, especially those who lack a strong voice in the political process. We fulfill this mission by educating the public, the media, and policymakers about some of the most serious challenges facing New Mexico and by developing and advocating for effective, comprehensive, sustainable solutions to overcome those challenges.

Our approach is to perform and publish sound, nonpartisan, independent research. Unlike many think tanks, Think New Mexico does not subscribe to any particular ideology. Instead, because New Mexico is at or near the bottom of so many national rankings, our focus is on promoting workable solutions.

## Results

As a results-oriented think tank, Think New Mexico measures its success based on changes in law we help to achieve. Our results include:

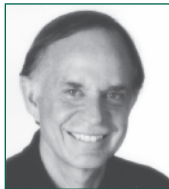
- Making full-day kindergarten accessible to every child in New Mexico
- Repealing the state's regressive tax on food and successfully defeating efforts to reimpose it
- Creating a Strategic Water Reserve to protect and restore the state's rivers
- Establishing New Mexico's first state-supported Individual Development Accounts to alleviate the state's persistent poverty
- Redirecting millions of dollars a year from the state lottery's excessive operating costs to full-tuition college scholarships
- Reforming title insurance to lower closing costs for homebuyers and homeowners who refinance their mortgages
- Winning passage of three constitutional amendments to:
  - increase the qualifications of Public Regulation Commission (PRC) commissioners,
  - transfer insurance regulation from the PRC to a separate department that is insulated from political interference, and
  - consolidate the PRC's corporate reporting unit into an efficient, one-stop shop for business filings at the Secretary of State's Office
- Modernizing the state's regulation of taxis, limos, shuttles, and movers, and
- Creating a one-stop online portal for all business fees and filings

## Think New Mexico's Board of Directors

Consistent with our nonpartisan approach, Think New Mexico's board is composed of Democrats, Independents, and Republicans. They are statesmen and stateswomen, who have no agenda other than to see New Mexico succeed. They are also the brain trust of this think tank.



**Clara Apodaca**, a native of Las Cruces, was First Lady of New Mexico from 1975–1978. She served as New Mexico's Secretary of Cultural Affairs under Governors Tony Anaya and Garrey Carruthers and as senior advisor to the U.S. Department of the Treasury. Clara is a former President and CEO of the National Hispanic Cultural Center Foundation.



**Paul Bardacke** served as Attorney General of New Mexico from 1983–1986. Paul is a Fellow in the American College of Trial Lawyers and he currently handles complex commercial litigation and mediation with the firm of Sutin, Thayer, and Browne. In 2009 Paul was appointed by U.S. Interior Secretary Ken Salazar to serve on the National Park System Advisory Board.



**David Buchholtz** has advised more than a dozen Governors and Cabinet Secretaries of Economic Development on fiscal matters. He has served as Chairman of the Association of Commerce and Industry and was appointed to the Spaceport Authority Board of Directors by Governor Martinez. David is Of Counsel to the Rodey law firm.



**Garrey Carruthers** served as Governor of New Mexico from 1987–1990 and is now President of New Mexico State University, where he previously served as Dean of the College of Business. Garrey was formerly President and CEO of Cimarron Health Plan and he serves on the board of the Arrowhead economic development center in Las Cruces.



**LaDonna Harris** is Chair of the Board and Founder of Americans for Indian Opportunity. She is also a founder of the National Women's Political Caucus. LaDonna was a leader in the effort to return the Taos Blue Lake to Taos Pueblo. She is an enrolled member of the Comanche Nation.

**Edward Lujan** is the former CEO of Manuel Lujan Agencies, the largest privately owned insurance agency in New Mexico. Ed is a former Chairman of the National Hispanic Cultural Center of New Mexico, the Republican Party of New Mexico, and the New Mexico Economic Development Commission.



**Liddie Martinez** is a native of Española whose family has lived in northern New Mexico since the 1600s. She is Community and Economic Development Director for a major contractor with Los Alamos National Laboratory and also farms the Rancho Faisan. Liddie has served as board chair of the Los Alamos National Laboratory Foundation.



**Brian Moore** is a small businessman from Clayton, where he and his wife own Clayton Ranch Market. Brian was a member of the New Mexico House of Representatives from 2001–2008, where he served on the Legislative Finance Committee. From 2010–2012, Brian worked as Deputy Chief of Staff and Washington, D.C. Director for Governor Martinez.



**Fred Nathan** founded Think New Mexico and is its Executive Director. Fred served as Special Counsel to New Mexico Attorney General Tom Udall from 1991–1998. In that capacity, he was the architect of several successful legislative initiatives and was in charge of New Mexico's lawsuit against the tobacco industry, which resulted in a \$1.25 billion settlement for the state.



**Roberta Cooper Ramo** is the first woman elected President of the American Bar Association and the American Law Institute. Roberta has served on the State Board of Finance and was President of the University of New Mexico Board of Regents. In 2011, she was inducted into the American Academy of Arts and Sciences. Roberta is a shareholder in the Modrall law firm.



## Dear New Mexican:

Every day, New Mexicans in urban and rural communities across the state struggle to pay high and growing medical bills. Meanwhile, hospitals fight to recruit and retain doctors and keep their doors open as nearly one out of every three dollars they spend disappears into administrative costs.

I suppose you don't need to work at a public policy think tank to realize that our health care system, both here in New Mexico and across the U.S. is in crisis.

In this report, we endeavor to light a path toward a patient-centered health care system in New Mexico that would give patients the ability to comparison shop for their health care based on both price and quality wherever possible. Indeed, as we note later on, New Mexicans can find more information about the price and quality of a household appliance than we can about a common surgical procedure.

Empowering patients with this information will create positive competition in the health care system, with providers competing to offer the highest-value care, as measured by the best quality care at the most affordable price.

We believe that the recent trend toward higher deductible insurance plans makes the recommendations described in this report especially urgent. Economists argue that high deductible plans will make patients more sensitive to price, causing them to spend more carefully on their health care and ultimately helping to contain costs. Yet those worthy goals will only be possible with the enactment of transparency reforms so that patients have the price and quality data they need to make informed spending decisions.

The policy solutions in this report grew out of a series of interviews over the past six months with insured and uninsured patients, doctors and other health care professionals, insurance executives, hospital administrators, local and national experts and those who pay the bills, like employers. (They are listed in the acknowledgments at the back of this report.)

What was striking to us is that no one appears satisfied with the status quo. Indeed, every stakeholder would benefit from these reforms. As we explain in the report, patients would enjoy more affordable health care and med-

ical providers would realize cost savings from administrative waste that they could invest in improving the quality of health care, such as by recruiting and retaining doctors.

As a neutral third party, we hope that Think New Mexico may be able to help bridge the current ideological divide between Democrats and Republicans over health care. We often say at Think New Mexico we care a lot more about whether an idea works than whether it is liberal or conservative. Both political parties genuinely want to make health care more affordable. The reforms proposed in this report should appeal to both free market conservatives and pro-consumer progressives, so we are optimistic that the 2015 Legislature and Governor Susana Martinez will enact them.

Special thanks to my dedicated colleagues at Think New Mexico, whose photos appear to the right. Kristina, Jennifer, and I are delighted to welcome our new Field Director, Othiamba Umi, to the staff. Othiamba has already started working to build coalitions and organize support from across the state for this initiative.

If you would like to join this effort to create a more transparent and affordable health care system, we encourage you to visit our website: [www.thinknewmexico.org](http://www.thinknewmexico.org) and contact your elected officials. Naturally, you are also invited to join the more than 1,100 New Mexicans who invest in our work by sending in a contribution in the enclosed reply envelope or online.

*Fred Nathan*

Founder and Executive Director

## Think New Mexico STAFF



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Business Manager



**Fred Nathan**  
Executive Director



**Othiamba Umi**  
Field Director

## INTRODUCTION

The odd and opaque pricing of health care in the United States has been likened by Princeton University economist Uwe Reinhardt to shopping blindfolded in a department store and then months later receiving an incomprehensible statement with a framed box at the bottom that says, “pay this amount.”

Except that it is actually worse than that, because in the health care market, you are usually shopping for essential goods and services, like a pacemaker, not a pair of jeans.

Information about price is generally considered a necessary feature of market transactions, so when transparency around pricing is lacking, one can also expect goods and services to be more expensive than they otherwise would be.

Indeed, health care costs in New Mexico have increased from 5.9% of gross state product (GSP) in 1980 to 16.9% of GSP in 2009, the last year for which there is data. In other words, health care now consumes nearly 17 cents of every dollar New Mexicans earn and it continues to grow. Clearly this trend is unsustainable.

The consequences of our failure to control health care costs are devastating and affect the security of every New Mexico family. For instance, 62.1% of bankruptcies in the U.S. are attributable to illness and health care debt, according to a Harvard University study using 2007 data. That is up dramatically from 8% in 1981. Moreover, many of these medical debtors are well-educated, middle class homeowners—and more than three-quarters of them had health insurance.

## 2014 State Ranking: Access & Affordability of Health Care

Massachusetts	Indiana
Connecticut	Missouri
Minnesota	Tennessee
Vermont	Kentucky
District of Columbia	West Virginia
New Hampshire	Alaska
Delaware	North Carolina
Wisconsin	Alabama
Iowa	Colorado
Maine	Oregon
North Dakota	Wyoming
Rhode Island	California
Maryland	Oklahoma
Hawaii	Georgia
Pennsylvania	Louisiana
Virginia	Utah
New York	Arizona
South Dakota	Idaho
Michigan	Montana
New Jersey	South Carolina
Kansas	Florida
Ohio	Mississippi
Nebraska	Nevada
Illinois	Arkansas
Washington	Texas
	<b>New Mexico</b>

*The states are ranked from best to worst, using indicators such as the number of “adults who went without care because of cost in the last year” and the percentage of “individuals with high out-of-pocket spending.”*

Source: The Commonwealth Fund, “Aiming Higher: Results from a Scorecard on State Health System Performance, 2014.” May 2014.



Even individuals who have health insurance are facing exorbitant out-of-pocket costs as employers increasingly shift to policies with high deductibles and co-pays in an effort to keep their costs down.

Meanwhile the rising cost of health insurance makes New Mexico businesses less willing and able to hire more employees at a time when we desperately need to strengthen New Mexico's private sector economy. A recent article in the *Fiscal Times*, "Why a Part-Time Workforce is the New Normal," suggests that the growing cost of health care is one of the primary causes of this new trend.

State taxpayers also bear a heavy burden from health care costs, which now devour well over \$1.7 billion annually, the largest category in New Mexico's \$6.2 billion state budget after public education. Health care costs have been growing faster than the rest of state spending for decades and threaten to crowd out funding for public schools and higher education.

We cannot rely on the federal government to fix this for us. While the Affordable Care Act has made health care accessible to more New Mexicans and reduced the numbers of uninsured from approximately 20% of New Mexico's population to about 15%, it has done little to contain soaring medical costs, despite its name. So it is up to the states to make health care more affordable.

This is especially urgent in New Mexico, where we rank 51st of the 50 states and the District of Columbia in health care affordability and access, according to a 2014 study by the Commonwealth Fund (Commonwealth), a private nonpartisan foundation that supports health care reform.

## Top 20 Developed Countries for Percent of National GDP Spent on Health Care in 2011

United States	17.7%
Netherlands	11.9%
France	11.6%
Germany	11.3%
Canada	11.2%
Switzerland	11.0%
Denmark	10.9%
Austria	10.8%
Belgium	10.5%
New Zealand	10.3%
Portugal	10.2%
Japan	9.6%
Sweden	9.5%
United Kingdom	9.4%
Spain	9.3%
Norway	9.3%
Italy	9.2%
Greece	9.1%
Iceland	9.0%
Finland	9.0%

Source: OECD Health Statistics 2013, OECD.

What accounts for health care being so unaffordable for so many? It is not because patients overuse medical care, as commonly thought. In fact, despite anecdotal instances to the contrary, Americans in the aggregate don't go to the doctor as often as citizens of other developed countries and too often put off seeking medical care until conditions are critical, according to Commonwealth.

## Top 30 Developed Countries for Life Expectancy in 2011

RANK	COUNTRY	LIFE EXPECTANCY
1	Switzerland	82.8
2	Japan	82.7
3	Italy	82.7
4	Spain	82.4
5	Iceland	82.4
6	France	82.2
7	Australia	82.0
8	Sweden	81.9
9	Israel	81.8
10	Norway	81.4
11	Netherlands	81.3
12	New Zealand	81.2
13	Luxembourg	81.1
14	Austria	81.1
15	United Kingdom	81.1
16	Korea	81.1
17	Canada	81.0
18	Germany	80.8
19	Greece	80.8
20	Portugal	80.8
21	Finland	80.6
22	Ireland	80.6
23	Belgium	80.5
24	Slovenia	80.1
25	Denmark	79.9
26	United States	78.7
27	Chile	78.3
28	Czech Republic	78.0
29	Poland	76.9
30	Estonia	76.3

Source: OECD Health Statistics 2013, OECD.

So if the high cost of health care is not due to the quantity of health care we use, it must be due to the quality. Actually, the U.S. ranks near the bottom of the list of developed countries in most

health indicators, such as infant mortality and life expectancy, according to research by OECD, the Organization for Economic Cooperation and Development.

The tragic fact is that higher health care expenditures in New Mexico and the U.S. do not result in longer life expectancy or more years of good health for Americans than citizens of other countries, according to the OECD. So why then is health care so expensive in New Mexico and across the country relative to the rest of the world?

One big contributing factor that does help to explain why health care is so expensive in New Mexico and elsewhere in the U.S. is that the current system makes it impossible to shop around on the basis of price and quality of care. (While it is obviously impossible to comparison shop during a medical emergency, only about 10% of health care costs are incurred during emergencies.)

A 2014 analysis by the Health Care Incentives Improvement Institute gave New Mexico a grade of "F" for its poor health care pricing transparency. Indeed, New Mexicans can get more information about the price and quality of a car or household appliance than we can about our health care.

A better system would remove the blindfolds from patients and their doctors and be transparent about price and quality. Patients would have the ability to shop for the highest quality, most affordable care, while hospitals and other health care providers would have the information that they need to compete for those dollars.

The ability to comparison shop is common in just about every economic sector one can think of, but it is remarkably rare in the health care industry in New Mexico.

## HOW HEALTH CARE LOST ITS PRICE TRANSPARENCY

Prices for health care were not always so hidden.

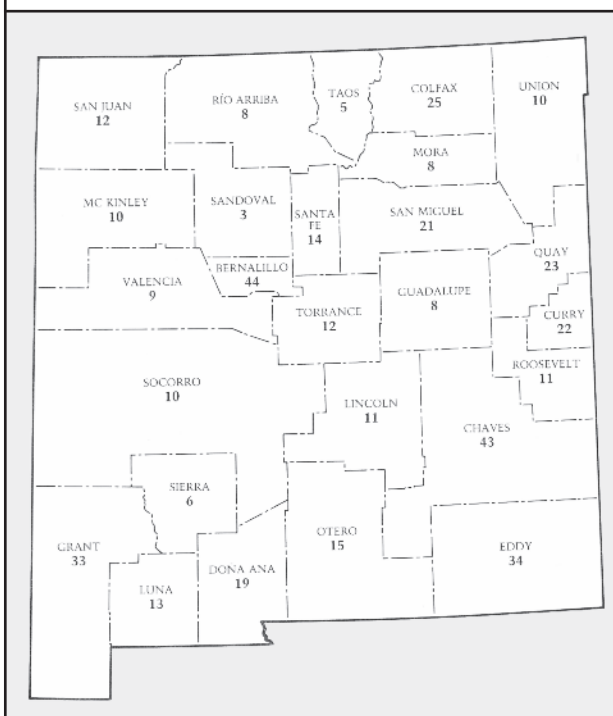
In the 1800s, the practice of medicine in New Mexico was conducted mostly in private homes. Doctors traveled by foot or horseback and were limited in the tools that they could use by what would fit in a hand-held case or saddlebag. Patients were charged by the procedure, although doctors were often not paid in cash, but rather “in kind” with crops, services, or whatever goods the patient could provide.

At statehood in 1912, there were 429 doctors in New Mexico, according to the American Medical Directory, many of them working in the state’s numerous tuberculosis sanatoriums. Health insurance had not yet been invented and was not necessary since most Americans spent only about \$5 a year (about \$140 in 2014 dollars) on health care.

The lack of demand was driven by the fact that at that point medical care was somewhat primitive and unlikely to be effective. In New Mexico, early local treatments included wolf liver boiled in wine and dried rosin made from deer lungs.

The quality of health care began to improve around the 1920s, with advancements such as science-based medical education and improvements in surgery and infection control. This increase in effectiveness led more New Mexicans to seek medical care and spurred construction of hospitals across the state. In 1921, the federal government created the predecessor of today’s Indian Health Services to provide health care to members of federally recognized Indian tribes.

### Number of doctors in each NM county at statehood in 1912



Source: Spidle Jr., Jake W. *Doctors of Medicine in New Mexico: A History of Health and Medical Practice 1886-1986*. UNM, 1986.

As health care improved and became more professional, it also became more expensive. With the onset of the Great Depression, patients nationally were having trouble paying their hospital bills. This led to the introduction of health insurance in 1929.

Health insurance began modestly when the hospital at Baylor University introduced Dallas public school teachers to a plan that would cover up to 21 days of hospital care in exchange for fifty cents per month. It was called Blue Cross. Blue Shield plans followed shortly thereafter to cover the cost of physician services.

The first health care insurance in New Mexico was developed by Presbyterian Hospital in Albuquerque





*Dr. Ernest Ceriani makes a house call, 1948. Photo by W. Eugene Smith courtesy Time & Life Pictures, Getty Images, #50514644.*

in 1940 as Hospital Service Inc. New Mexicans could purchase it through groups at work for a monthly cost of \$2.00 for a family or 75 cents for an individual. Presbyterian Hospital employees themselves were the first to enroll. In 1945 Blue Cross and Blue Shield of New Mexico took over the plan.

One side effect of this new system of paying for medical care was that, for the first time, it divorced medical procedures from price. Patients knew the cost of their portion of the health insurance premium, but not the cost of the medical care itself.

If the Great Depression was the catalyst for the invention of employer-based health insurance, it was another accident of history, World War II, that caused health insurance to spread rapidly across the country, including New Mexico.

During the war, there was a shortage of workers and wages were frozen by government decree. This made it more difficult for companies to attract scarce workers, so employers competed by offering more generous health care insurance as a benefit.

As economic historian Melissa Thomasson explains: "You start from 9 percent of the population [having health insurance] in 1940 to 63 percent in 1953....It just grows by gangbusters. By the 1960s, 70 percent is covered by some kind of private, voluntary health insurance plan."

In 1965 Congress established Medicare (to cover the elderly) and Medicaid (to cover the poor). Today these programs serve just over one million New Mexicans, about half the state's total population. Medicare and Medicaid were based on the Blue Cross model, so it is not surprising that these government programs, like private health insurance, remove the health care consumer from knowing or really affecting the cost or quality of care.

The Affordable Care Act (ACA), which was enacted in 2010, did not change that. As Steven Brill wrote in a 2013 special issue of *Time Magazine*, which traced his effort to decode and examine seven random medical bills, "Put simply, with [the ACA] we've changed the rules related to who pays for what, but we haven't done much to change the prices we pay."

The outcome of this history is a system in which health care costs continue to spiral upward. Health care that took about six cents of every dollar earned by New Mexicans in 1980 and now takes 17 cents of every dollar is predicted to be 20 cents in 2021 and 22 cents by 2038, according to the Congressional Budget Office.

Yet even as expenses soar, New Mexicans have far less information than they had a century ago about the cost of their medical care. To understand how we can make New Mexico's health care system more affordable, it is first necessary to understand how this lack of price transparency and a perverse system of price discrimination contribute to higher prices.

## HOW LACK OF TRANSPARENCY, GAG CLAUSES, AND PRICE DISCRIMINATION KEEP PRICES TOO HIGH

The lack of price transparency hides wild variations in the cost of health care in New Mexico.

In 2013, for the first time, Medicare released information about what hospitals had charged for common medical procedures and the prices Medicare had actually paid. This provided a small window into health care pricing in New Mexico, although of course it only included information about Medicare patients. As the chart on page 13 illustrates, what New Mexico hospitals charge varies dramatically across the state.

The chart highlights two points that are essential to understanding the pricing of health care in New Mexico. First, as Steven Brill testified, “by any def-

inition this is no one’s idea of a functioning marketplace.” In every instance, the high charge for treatment is several multiples of the low charge.

For example, the charge for treating septicemia (blood poisoning) in a hospital varies from an average of \$19,556 in Taos to an average of \$72,346 in Las Vegas. In other words, it is nearly four times more expensive to have septicemia treated in Las Vegas than it is in Taos, even though the hospitals in those two towns are only about 77 miles apart.

Likewise, in May of 2013, Winthrop Quigley of the *Albuquerque Journal* found a variation of \$31,184 between prices for installing a heart stent at four different hospitals in Albuquerque. While it is true that some hospitals are treating sicker patient populations than others, the extreme differences in average price cannot be explained by patient demographics alone.

The second point is about Medicare. The Medicare rate of reimbursement is set by federal law and is the amount the federal government estimates is the actual cost to the hospital of performing a procedure, taking into account the necessary personnel, equipment, and facility costs. In the chart on page 13 there is a very narrow difference among the prices Medicare pays (right column) versus a very broad range of what hospitals charge for the same medical treatments across New Mexico (left column).

The difference can be explained by the market clout of Medicare and also the fact that the government officials who run Medicare enjoy much greater access to pricing data than most patients, either privately insured or uninsured. In most cases, patients are just presented with a bill that is often several multiples of the true cost. They have no



Illustration by Aaron Bacall, courtesy Cartoonstock, image #aban720.

way to know the true cost or even to know that by simply driving 77 miles down the road they can save up to \$53,000 for the very same medical treatment (naturally, this is only applicable for cases that are not medical emergencies).

Patients need this pricing data more urgently than ever as they are shouldering an increasing proportion of their health costs themselves. Individual deductibles have grown 84% in New Mexico between 2003 and 2011, according to Commonwealth. Similarly, the Silver and Bronze insurance plans established by the ACA in New Mexico carry average family deductibles of \$6,000 and \$10,386 respectively, and the majority of Bronze plans require patients to pay 30% of doctor fees.

One might think that the variation in pricing between hospitals in New Mexico reflects variations in quality. After all, in most markets price corresponds to quality. This is the basis for the common refrain that “you get what you pay for”... except it isn't true in the case of healthcare pricing.

Counterintuitively, patient outcomes, like mortality and hospital readmission rates, do not correlate with price.

Many studies have documented this unexpected relationship between quality and price in the health care field. A 2012 study in the *Annals of Surgery*, for example, revealed that hospitals with the highest rates of avoidable complications also tend to have higher prices.

Likewise, the Dartmouth Atlas Project, which examines regional variations in health care spending, concluded in 2009 that: “Over the past 10 years, a number of studies have explored the relationship between higher spending and the quality and outcomes of care. The findings are remarkably consistent: higher spending does not result in better quality of care.”

Dr. Elliott Fisher of the Dartmouth Institute for Health Care Policy and Clinical Practice explains that higher quality care actually tends to be less expensive because it is focused on preventive health and avoiding errors, which can lead to shorter hospital stays and fewer readmissions. The opposite holds true too: lower quality care can be more expensive because it leads to more readmissions to treat avoidable complications.

The weird relationship between price and quality holds true in New Mexico's Medicare data as well. For example, Rehoboth McKinley Christian Health Care Services in Gallup charges \$15,472 to treat heart failure and earns a 98% on one of Medicare's quality indicators for this treatment (measuring whether patients are given clear discharge instructions about best practices for post-procedure care). Meanwhile, the priciest hospital for treating heart failure, Eastern New Mexico Medical Center, charges \$56,396 and received a score of 84%. Looking at all of the price and quality data provided by Medicare, the clear conclusion is that the differences in price have nothing to do with the quality of care.

Even more absurd than the fact that prices vary wildly from hospital to hospital across the state with no correlation to quality is the fact that prices for the *same* procedure performed by the *same* doctor at the *same* hospital also vary wildly, based on who is paying the bill.

This is illustrated by the chart on page 14, which is reprinted from the *Wall Street Journal* and which documents what a single MRI costs in Dearborn, Michigan. (We would have preferred to have had a New Mexico example but that information is not available). It is also dramatically illustrated by one New Mexican's odyssey to discover the cost basis of his medical bills.



## Average NM Hospital Charges for Six Common Conditions High, Low, and Mid-Range Prices

		Average Charge from Hospital	Average Price Medicare Paid
<b>SIMPLE PNEUMONIA &amp; LUNG INFLAMMATION</b>			
Northern Navajo Medical Center, Shiprock	<i>Low</i>	\$9,838	\$7,386
Artesia General Hospital, Artesia	<i>Mid</i>	\$22,801	\$7,058
Alta Vista Regional Hospital, Las Vegas	<i>High</i>	\$40,612	\$7,306
<b>HEART FAILURE &amp; SHOCK</b>			
Rehoboth McKinley Christian Health Care Service, Gallup	<i>Low</i>	\$15,472	\$8,497
Presbyterian Hospital, Albuquerque	<i>Mid</i>	\$29,545	\$8,748
Eastern New Mexico Medical Center, Roswell	<i>High</i>	\$56,396	\$8,894
<b>PULMONARY EMBOLISM</b>			
Mountain View Regional Medical Center, Las Cruces	<i>Low</i>	\$19,258	\$4,743
San Juan Regional Medical Center, Farmington	<i>Mid</i>	\$22,608	\$6,717
Eastern New Mexico Medical Center, Roswell	<i>High</i>	\$50,615	\$5,302
<b>BRONCHITIS &amp; ASTHMA</b>			
Rehoboth McKinley Christian Health Care Service, Gallup	<i>Low</i>	\$9,106	\$4,512
Presbyterian Hospital, Albuquerque	<i>Mid</i>	\$19,178	\$4,127
Lea Regional Medical Center, Hobbs	<i>High</i>	\$29,860	\$4,757
<b>SEPTICEMIA (BLOOD POISONING)</b>			
Holy Cross Hospital, Taos	<i>Low</i>	\$19,556	\$15,695
Plains Regional Medical Center, Clovis	<i>Mid</i>	\$41,916	\$9,846
Alta Vista Regional Hospital, Las Vegas	<i>High</i>	\$72,346	\$11,836
<b>MAJOR JOINT REPLACEMENT</b>			
Gerald Champion Regional Medical Center, Alamogordo	<i>Low</i>	\$31,453	\$15,486
Los Alamos Medical Center, Los Alamos	<i>Mid</i>	\$55,013	\$16,798
Carlsbad Medical Center, Carlsbad	<i>High</i>	\$86,803	\$11,619

Source: Center for Medicare and Medicaid Studies, Diagnosis-Related Group (DRG) Summary for Medicare Inpatient Prospective Payment Hospitals, Fiscal Year 2012. The full dataset for the top 100 most frequent discharges at all hospitals in New Mexico is available at: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Inpatient2012.html>

## Range of Prices for an MRI at One Hospital

Hospital chargemaster price	\$2,844
United Healthcare price	\$1,990
Blue Cross price	\$617
Aetna price	\$520
Cigna price	\$341-362
Medicare rate	\$335

*Chart shows the price of an MRI of the knee, hip, or ankle at Oakwood Healthcare System in Dearborn, Michigan. Source: Wall Street Journal, "How to Bring the Price of Health Care Into the Open." February 23, 2014.*

Meet David Rigsby, a former volunteer emergency medical technician and a farmer in Embudo, New Mexico who raises and sells about 1,200 organic turkeys annually. He hasn't had health insurance coverage for more than two decades. Today there are 316,964 New Mexicans like David living without health insurance coverage, about 15.2% of the state's population.

Perversely, it is these uninsured patients who are charged the full sticker price for medical services, or what the hospitals call their "chargemaster rate," under the current health care system. Yet, it is the uninsured who are usually the least able to afford those prices.

David's case is typical of many uninsured patients in New Mexico. What is different about him is that he asked lots of questions about his medical bills, something most uninsured New Mexicans generally don't do.

David's story, chronicled recently by Patrick Malone on the front page of the *Santa Fe New*

*Mexican*, began in 2005 with a colonoscopy and a hernia repair. Both were outpatient procedures at a local hospital, meaning David didn't spend the night. The procedures were performed at the same time and took about an hour in an outpatient clinic.

Before the procedures took place, David paid \$3,250 up front as the hospital required because he is uninsured. He expected that he would receive a final bill for the remaining balance after the procedures were completed. However, he was "floored" and "brought to tears" to receive multiple bills totaling more than \$18,000.

Over time, David paid the fee for his primary physician and another \$3,950 in hospital charges, but he balked at paying the remaining balance to the hospital because, he told us, it seemed "irrationally high." The hospital's collections agency then threatened David with another \$9,000 charge if he didn't pay the rest of the hospital's bills.

That is when David began researching how hospitals set their prices. After about a year of discussions with health care providers and other experts, he learned a lot about how the system works. Among the things he learned is that hospitals in New Mexico (and across the country) charge rates for their services that are much higher than what Medicare estimates is the cost of performing those same services. In David's case, if he had been on Medicare he would have had to pay about \$2,400, four times less than what he ultimately paid and about eight times less than what he was initially charged by his local hospital.

David's original hospital charges came from what is known as the chargemaster list, which is a phonebook-sized list developed individually by

every hospital. It essentially produces a “sticker price” for every possible medical good or service one might receive in a hospital. The chargemaster list is publicly disclosed by law in California but not in New Mexico or most other states.

The sticker prices in the chargemaster are generally exponentially higher than what Medicare will pay and also far more than what you would pay online or at a local drugstore for goods like an aspirin, a toothbrush, or bandages. An analysis by Malone and the *Santa Fe New Mexican* revealed that hospitals in New Mexico set their chargemaster rates “547 percent higher on average than the Medicare rate of reimbursement.”

Hospitals respond that very few customers actually pay the chargemaster rates. Medicare and Medicaid set their own payment rates, private insurance companies negotiate different price schedules, and hospitals often end up discounting charity cases. So why, then, do they have chargemaster rates at all?



David Rigsby looking through some of his medical bills. Photo by Jane Phillips, courtesy the *Santa Fe New Mexican*.

There appear to be three reasons. The first is cost shifting. Many New Mexico hospitals argue that Medicare and Medicaid rates are set below their actual costs of care. This is supported by a report to Congress by the Medicare Payment Advisory Commission, which found that hospitals nationally collected reimbursement from Medicare that was 5.4% lower than their collective costs. Those underpayments force hospitals to shift costs to other patients. (On the other side, cost control advocates like Neel Shah, Assistant Professor at Harvard Medical School, argue that hospitals go well beyond recovering their losses from low Medicare reimbursement rates.)

Hospitals also do not want to leave any money on the table if a wealthy uninsured person becomes a patient. “You don’t really want to change your charges if you have a Saudi sheikh come in with a suitcase full of cash who’s going to pay full charges,” hospital CEO Dr. Warren Browner told the *New York Times* in a 2013 article titled, “As Hospital Prices Soar, a Stitch Tops \$500.”

Setting aside the question of how many uninsured Saudi sheikhs enter New Mexico hospitals, the extra revenue derived from high chargemaster rates helps to pay for modern medical equipment, charity care, and the 24-7 staffing that New Mexico hospitals need to keep their doors open.

The final reason hospitals use chargemasters is as a starting point in negotiating with insurance companies to determine the rates that patients with private insurance will ultimately pay. Historically, insurance companies have negotiated rates as a percentage of the chargemaster prices, with larger insurance companies paying a lower percentage of chargemaster rates than smaller



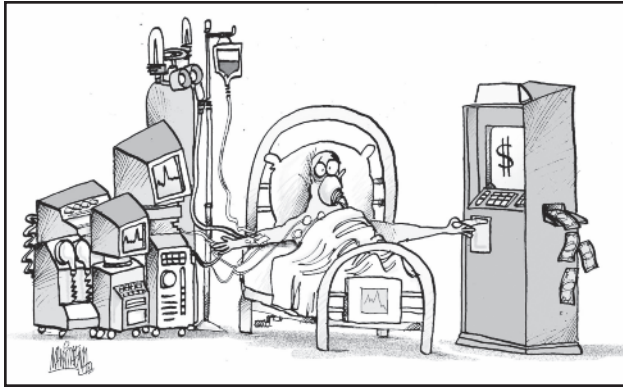


Illustration by Alfredo Martirena, Cartoonstock image #amrn115.

insurance companies for the same treatments and procedures. (Insurance companies have less and less leverage in these negotiations because of the trend of hospitals purchasing doctors' practices and consolidating wherever possible.)

The more insurance companies there are, the more byzantine the pricing structure becomes. Meanwhile, patients who go outside of their insurance networks for care are often subject to the full chargemaster sticker price, like the uninsured.

During the negotiations between providers and insurance companies, both sides generally agree to what is known as a "gag clause." These provisions prohibit disclosure of the rates agreed to by the hospitals and the insurance companies so that their competitors will not learn their rates. However, this also means that employers are prevented from learning what rates have been negotiated by their insurance company on behalf of their employees. A 2014 survey by the Healthcare Financial Management Association found that gag clauses are prevalent in agreements between insurers and health care providers.

The bottom line is that medical prices in New Mexico often vary dramatically for the same pro-

cedure in the same hospital with the same doctor based on who is paying, and no one seems to know what anyone else is paying. Generally, however, we would expect that it follows the same pattern seen across the nation: Medicare and Medicaid pay the lowest prices, followed by those patients who are covered by large insurance companies who can use their larger market share to negotiate better deals, then those who are covered by smaller insurance companies. Finally, uninsured patients are charged the most, the full chargemaster sticker price. There is a term for all of this. It is called price discrimination.

This brings us back to David Rigsby. Ultimately, the local hospital reduced David's bill, leaving him to pay a total of \$9,754 for the colonoscopy and hernia repair (including \$2,431 that went to the collection agency).

"It seems wrong," David told us in an interview. "I had to pay several times more than someone on a government health plan or someone on a commercial insurance plan simply because I don't have health insurance."

The health care market in New Mexico (and in the U.S. generally) is dysfunctional and getting worse. Chargemaster lists, secret gag clauses, and a general lack of transparency around pricing make it impossible to establish a functioning market. As a result, medical consumers in New Mexico, who are now paying higher and higher deductibles, cannot shop around between different health care providers for the best quality and price.

But what if some sunshine was focused on prices and patient outcomes and the veil of secrecy around chargemaster lists and gag clauses were lifted?

## INCREASING TRANSPARENCY & ENDING PRICE DISCRIMINATION

### Removing the Blindfold: Making Health Care Prices and Quality Transparent

When doctors Keith Smith and Steven Lantier founded the Surgery Center of Oklahoma in 1997, they did something revolutionary: they provided all the costs of their procedures up front.

For the first few years, Smith and Lantier gave out price quotes over the phone to anyone who called. Word quickly spread among uninsured patients in the Oklahoma City area that the Surgery Center offered prices that were six to ten times lower than those at other hospitals in the area.

Then in 2009, the Surgery Center launched a website to allow potential patients to easily see the prices of all the procedures the Center offered. The prices provided on the website are guaranteed and just about all-inclusive. (Any additional costs that may be incurred for a particular patient are disclosed after an initial consultation, well before the operation.)

As soon the website went live, the Surgery Center began receiving inquiries from across the U.S. and even Canada, and the patients began flooding in. Today the Surgery Center has grown from 12 doctors to over 40, and about 10% of the center's patients come from outside Oklahoma, from states including New Mexico.

"Hospitals are having to match our prices because patients are printing our prices and holding that in one hand and holding a ticket to Oklahoma City in the other hand and asking that hospital to step

up," says Surgery Center co-founder Dr. Smith. "So we're actually causing a deflationary effect on pricing all over the United States."

### The Transparency Trend

In 2003, Maine became the first state to create an "all-payer claims database," which collected health care payment information from everyone responsible for paying the bills—including private health insurers, self-insured employers, Medicaid, and Medicare—and used that data to make cost information available to the public.

This transparency effort was one piece of a larger health care reform initiative prompted by Maine's skyrocketing health care costs, which had doubled between 1994–2004. Governor John Baldacci, who championed the reform legislation, hoped that if patients had access to cost and quality data, they would be able to select the highest value health care providers.

Maine used the information from the all-payer claims database to launch a website that provided average health care pricing information in a user-friendly format. For the first time, patients were able to see the different prices being paid for the same medical procedure at different hospitals across an entire state.

Maine's legislative package of health care reforms, including its enhanced transparency, did make a difference in slowing the growth of health care costs. Between 2003–2008, health care spending nationally grew at a rate of 14% a year, while in Maine it grew at 9% a year. By 2010, the state was able to document that employers had saved \$180 million from reduced health insurance costs.

## States with Public Health Care Transparency Websites

<b>Arizona</b>	<a href="http://pub.azdhs.gov/hospital-discharge-stats/2012/Utilization.html">http://pub.azdhs.gov/hospital-discharge-stats/2012/Utilization.html</a>
<b>California</b>	<a href="http://www.oshpd.ca.gov/HID/DataFlow/">http://www.oshpd.ca.gov/HID/DataFlow/</a>
<b>Colorado</b>	<a href="https://www.comedprice.org">https://www.comedprice.org</a>
<b>Florida</b>	<a href="http://www.floridahealthfinder.gov/">http://www.floridahealthfinder.gov/</a>
<b>Illinois</b>	<a href="http://www.healthcarereportcard.illinois.gov/">http://www.healthcarereportcard.illinois.gov/</a>
<b>Maine</b>	<a href="https://mhd0.maine.gov/healthcost2014/CostCompare">https://mhd0.maine.gov/healthcost2014/CostCompare</a>
<b>Maryland</b>	<a href="http://184.80.193.37/consumerinfo/hospitalguide/hospital_guide/cost_report.html">http://184.80.193.37/consumerinfo/hospitalguide/hospital_guide/cost_report.html</a>
<b>Massachusetts</b>	<a href="http://hcqcc.hcf.state.ma.us/">http://hcqcc.hcf.state.ma.us/</a>
<b>Nevada</b>	<a href="http://www.nevadacomparecare.net/">http://www.nevadacomparecare.net/</a>
<b>New Hampshire</b>	<a href="http://www.nhhealthcost.org/about">http://www.nhhealthcost.org/about</a>
<b>Ohio</b>	<a href="http://publicapps.odh.ohio.gov/facilityinformation/">http://publicapps.odh.ohio.gov/facilityinformation/</a>
<b>Utah</b>	<a href="https://health.utah.gov/myhealthcare/monahrq/index.html">https://health.utah.gov/myhealthcare/monahrq/index.html</a>
<b>Vermont</b>	<a href="http://www.dfr.vermont.gov/insurance/insurance-consumer/2012-pricing-financial-reports">http://www.dfr.vermont.gov/insurance/insurance-consumer/2012-pricing-financial-reports</a>
<b>West Virginia</b>	<a href="http://www.comparecarewv.gov/">http://www.comparecarewv.gov/</a>

Source: Compiled by Think New Mexico.

In the years since Maine enacted its health care transparency law, 13 other states have launched public health care cost comparison websites and another five states are currently developing them.

One state that has recently joined the health care transparency movement is Arizona, which enacted a law in 2013 requiring hospitals to post online the costs of their 50 most frequent inpatient and outpatient procedures. The Arizona Department of Health currently provides both cost and quality information on a single website, and the quality data is “risk adjusted” to ensure that certain hospitals are not disadvantaged simply because they are treating sicker patients.

Two of New Mexico’s other neighboring states, Colorado and Utah, have also developed user-friendly websites to allow their residents to compare the cost and quality of their health care options.

### Benefits and Requirements of Transparency

Early results from other states illuminate the potential benefits of price transparency, as well as the key elements needed to make it work.

The central goal of transparency is to bring down prices. In 2013, three University of Chicago professors conducted a nationwide study comparing health care costs in states that had established transparency websites with those that had not. They concluded that “price transparency regulations reduce the price charged for common, uncomplicated, elective procedures by an average of approximately 7%.”

For example, hip transplants averaged \$2,800 less in states with price disclosure websites than in states without them. The researchers also tracked the prices over time, and found that sharp price declines consistently corresponded with the time



periods in which the transparency websites went online.

Interestingly, these positive results do not necessarily mean that price transparency is working as it was originally intended, with patients comparison shopping for the best value. Indeed, one argument against transparency tools is that many patients simply won't use them, or won't be able to use them because they lack internet access or have an urgent medical emergency.

Even if no patients ever check an online cost comparison website, it still has a beneficial impact on prices because employers, doctors, health insurers, and other hospitals do visit the websites.

In New Hampshire, which created its health care transparency website shortly after Maine in 2003, a 2013 evaluation found that "the state's actions influenced health care market dynamics—not by stimulating consumer shopping directly, as most policymakers originally had envisioned, but by focusing attention on the wide variation in provider prices and thus helping to foster changes in [insurance plan] benefit design." In one high-profile case, a health insurer was able to use the cost comparison information to negotiate lower prices from the state's most expensive hospital.

Similarly, a 2013 study by the American Medical Association found that when doctors at Johns Hopkins Hospital in Baltimore were given information about the prices of diagnostic tests, they ordered 9.1% fewer tests for their patients. This is significant since reducing the unnecessary use of tests can help reduce overall health care costs—and in most cases, doctors have no information about the costs of tests when they order them.

In the instances where transparency initiatives have not been as successful in cutting costs, the fundamental flaw was that quality information (like patient outcome data) was not presented alongside prices. As the New Hampshire transparency report explained: "without meaningful quality information, price transparency does not allow purchasers or consumers to assess overall value when choosing providers."

Naturally, patients are interested in receiving the highest quality health care, and very few patients understand that in the bizarre world of health care pricing, more expensive care is not necessarily better. (In fact, as we described in the previous section, in some cases higher priced care may actually be lower quality.)

Unless quality ratings are clearly displayed alongside price, transparency may actually increase prices as people select higher-priced providers out of the erroneous belief that they provide higher quality care.

The good news is that if health care cost and quality information are presented side-by-side in an easy-to-interpret format, consumers do tend to choose the highest-value option (i.e., the best quality health care offered at the lowest cost).

Another benefit of quality reporting is to encourage hospitals to compete to improve quality.

In 1989, the New York State Health Commission required that hospitals publicly report their death rates from a common heart operation (coronary artery bypass grafts). Hospitals also reported the complexity of the cases, allowing the state to adjust the data and make the comparison fair. The first

year that the data was reported, there was a wide quality variation: death rates from the procedure ranged from 1 out of 100 patients at the best hospital to nearly 1 out of 5 at the worst.

Many New York hospitals objected strongly to the release of this data, but it had the intended effect: hospitals with high death rates made major changes and improved their performance. Hospitals began competing to offer the best outcomes and in the first four years after reporting began, statewide deaths from the procedure fell by 41% to the lowest level in the nation. The rate has continued to improve in the years since.

As hospitals improve quality, that in turn helps to keep costs lower. A 2006 study in Pennsylvania, which has been reporting hospital quality for over two decades, found that the average cost of hospitalization when no infection occurred was \$8,311, but if the patient acquired an infection, the cost spiked to \$53,915. The state began publishing hospital infection rates that year, and by the end of 2007 the statewide hospital-acquired infection rate had fallen by 7.8%, saving millions of dollars—as well as lives.

A key challenge with quality measures is making sure that they are truly reflective of the quality of care, because best practices for medical treatment are constantly evolving in response to new data (e.g., a new study may show that a test or treatment thought to be effective actually isn't). It is also essential to ensure that quality measures are designed and reported in a way that does not disincentivize hospitals from treating the sickest patients.

However, the bottom line is that if reliable, risk-adjusted quality metrics are reported alongside prices in a format that patients and their doctors can easily access and understand, health care transparency can have a real impact on controlling costs.

### Achieving Transparency in New Mexico

Notwithstanding New Mexico's failing grade from the Health Care Incentives Improvement Institute, there have been several recent efforts to increase health care transparency.

The largest initiative is that of the Centers for Medicare and Medicaid Services (CMS), which now provides information about hospital charges,

Example of Well-Designed, User-Friendly Presentation of Health Care Price and Quality Information									
		Consumer Ratings of Provider				Provides Excellent Quality of Care			Your Price
BEST VALUE	Provider A	★	★			★	★		\$20
	Provider B	★	★	★	★	★	★	★	\$150
	Provider C	★	★	★		★	★		\$180
	Provider D	★	★			★	★	★	\$510

Source: Based on an example from Pacific Business Group on Health. "PBGH Policy Brief: Price Transparency." 2013. The data in the "provides excellent quality of care" column would be based on the relevant quality metrics.

Medicare payments, and quality indicators on the federal “Hospital Compare” website. (This is the source of the information used to create the chart on page 13 of this report.)

Along with the federal data, there has also recently been a proliferation of free and subscription-based services designed to provide cost comparison information to consumers and employers, by organizations such as New Choice Health, FAIR Health, Health Care Bluebook, and Castlight Health.

Quality data is also increasingly available. Along with the information on the federal Hospital Compare website, the Robert Wood Johnson Foundation has funded the creation of the New Mexico Coalition for Healthcare Quality’s Hospital Snapshots, which provide comparative quality information about Albuquerque’s hospitals.

Yet there is no single site that brings together all the scattered data, and no public site that includes payment information from private insurers and uninsured patients.

One reason why this data is not available is due to the gag clauses in many contracts between hospitals and insurers. Because of the obstacle that gag clauses pose to health care transparency, in 2012 California joined a handful of other states in enacting a law outlawing them.

New Mexico already prohibits insurance contracts from including gag clauses that would silence doctors from telling patients about treatment options that their insurance plans do not cover. In order to make health care transparency possible, this provision should be expanded to abolish gag clauses that prevent the disclosure of health care prices.

Once gag clauses are outlawed in New Mexico, insurers and health care providers can begin to make their pricing information available to patients, alongside relevant, risk-adjusted quality indicators. The logical place to begin is with hospitals and the outpatient facilities and physicians’ groups that they own. Bills from hospitals and the facilities they own are the largest single piece of health care spending and are also the largest source of medical inflation according to a 2013 study in the *Journal of the American Medical Association*.

We would also recommend that all disclosures follow the procedures recommended by the American Medical Association to ensure accuracy, primarily by providing doctors with an opportunity to review and correct the data before it is made public. With these safeguards, the cost and quality data could be posted on a single user-friendly public website, perhaps overseen by the New Mexico Department of Health.

**To summarize, we recommend enacting legislation prohibiting gag clauses in contracts between insurers and health care providers and requiring that hospitals or insurers disclose health care pricing and payment information to the New Mexico Department of Health. That price information would be posted on a user-friendly website alongside relevant, risk-adjusted quality indicators. As far as possible, the prices should be inclusive (i.e., include facility fees, physician fees, and test costs) and be bundled by procedure so that patients can easily interpret and understand the information.**

## Going Beyond Transparency

Removing the blindfold and making health care prices and quality transparent would go a long way toward making New Mexico's health care market work like other markets.

Yet implementing this reform requires answering one very fundamental question: what price should be posted?

Most other states that post health care information on public websites include either the average prices paid by all payers, or the hospital charge-master prices, which only uninsured and out-of-network patients are actually charged. Seeing these average rates can help patients get an idea of which hospitals tend to be more expensive than others on average, but they do not actually inform a particular patient what he or she will pay for a specific procedure at a specific hospital.

It would be unworkably complex to attempt to disclose every possible price that patients might pay under the current system, since prices differ from insurer to insurer, but there is one way that transparency could truly give patients and their doctors the information they need to make informed health care decisions: if every patient paid the same rate for the same service from the same hospital.

## One Price for Everyone

Charging every patient the same price for the same procedure at the same provider is not a new idea.

Ten years ago, Harvard Business School professor Michael Porter and University of Virginia Business School professor Elizabeth Olmsted Teisberg co-authored an article which they later expanded into a book titled, *Redefining Health Care*. In their



Cartoon by Bob Englehart, reprinted by permission of the Hartford Courant.

analysis, Porter and Teisberg found that the current structure of the health care market made it impossible for providers to compete in the areas that matter: improving quality and lowering cost.

Instead, the current competition focuses on market share. On the one hand, large hospital chains are able to demand higher prices from insurers. On the other, dominant insurers are able to demand deep discounts for their members and force hospitals to shift the costs of care to members of smaller insurers and the uninsured.

As Porter and Teisberg write, these discounts are unjustifiable because "the cost of treating a medical condition has nothing to do with who the patient's employer or insurance company is," and the uninsured patients who are least able to afford it often end up stuck with the highest bills.

Porter and Teisberg proposed an alternative: "Providers would charge the same price to any patient for addressing a given medical condition, regardless of the patient's group affiliation. Providers could and would set different prices from their competitors, but that pricing would not vary simply because one patient was insured by



Aetna, another covered by Blue Cross, and another self-insured. Payers could negotiate, but price changes would have to benefit all patients, not just their own."

The idea of ending price discrimination has been embraced by other health care economists, who often describe the reform as an "all-payer" rate system, since all payers would pay the same prices. These experts note that Germany and Switzerland have had all-payer rate systems for many years, and they point to the example of one U.S. state that has demonstrated an impressive track record of keeping prices in check by prohibiting price discrimination.

In 1971, Maryland's legislature enacted a bill designed to curb the rapid growth in its health care costs. The state ended the practice of allowing hospitals to provide discounts to insurers and instead required them to charge a single price to

everyone, based on a price schedule set by a state commission created for that purpose.

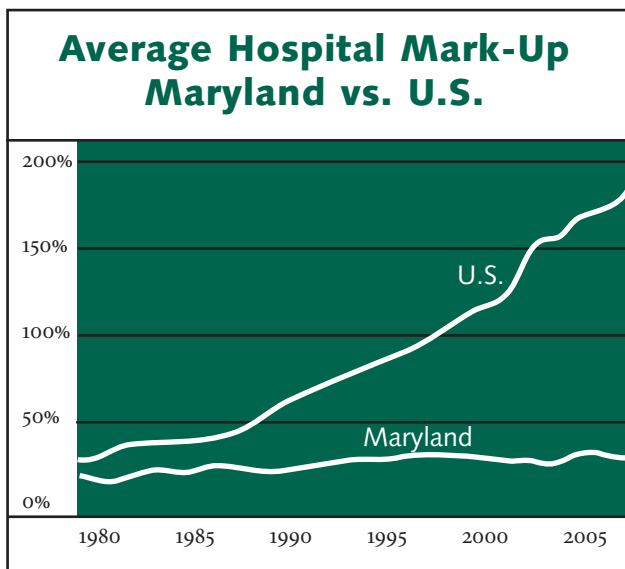
The commission required the hospital price schedule to satisfy three principles: (1) The total costs of all services offered by a hospital must be reasonable; (2) The aggregate revenues of a hospital must be reasonably related to its aggregate costs; and (3) Rates must be the same for all purchasers of hospital services.

When Maryland's new system took effect in 1974, the state's costs per hospital admission were about 24% above the national average. By 2005, those costs were 5% below the national average. If the state's health care costs had grown at the national average during that time period, total spending would have been \$40 billion higher.

### Ending Price Discrimination in New Mexico

Ending price discrimination does not require the sort of heavy-handed government price setting that occurs in Maryland. Rather than having a state agency set prices, we recommend a market-based system in which prices are determined by the hospitals themselves, because they, not the government, know what they need to charge to cover their costs and keep their doors open. Each hospital would set its own prices, so they would still vary from hospital to hospital, but not from patient to patient receiving the same procedure in a single hospital.

To determine its price schedule, a hospital would negotiate with insurers similar to the way they do today; the primary difference would be that all insurers would be at the table together, and the resulting prices would be the same for all payers and fully transparent.



Graph shows the average mark-up of hospital charges over actual costs. Source: American Hospital Association annual statistics, 1980–2007.

Ideally, sitting alongside the insurers at the negotiation table would be representatives from Medicare and Medicaid. These two programs cover about half of New Mexico's residents, and the rates they pay are low. Although Medicare aims to pay the full cost of any given medical procedure, on average hospitals only receive about 94.6% of the cost of treating Medicare recipients. Similarly, Medicaid only pays an average of 89% of the cost of treatment according to a 2010 report by the American Hospital Association.

In Maryland, the state successfully negotiated a waiver with the federal government so that Medicare and Medicaid pay the same rate as every other payer (the waiver is currently being updated). This makes an enormous difference for hospitals serving disproportionately low-income or elderly populations, and we would recommend that New Mexico seek a similar waiver.

Although dealing with large federal bureaucracies is always daunting, we would note that New Mexico has received three major Medicaid waivers since 2000, including the recent Centennial Care waiver. Nationwide, there are 37 active Medicaid waivers allowing states to experiment with innovative payment programs that have the potential to increase efficiencies and decrease overall health care costs.

Because both the federal government and state government contribute to Medicaid, increasing the Medicaid reimbursement rate would mean that the state's Medicaid costs would increase in the short term as well (for every \$1 that the federal government spends on Medicaid in the state, New Mexico pays about 44 cents). However, over time the cost savings from implementing these reforms should more than balance out that increase.

Even if the state does not receive a federal waiver, having New Mexico's hospitals charge all private payers the same price would still be transformative. It would eliminate the current cost-shifting from large insurers onto small insurers and uninsured patients, and it would save money by simplifying the billing system for both hospitals and insurance companies.

The only exceptions to the single price schedule would be for those uninsured patients who lack the means to pay for their care. In these instances, hospitals need the flexibility to forgive bills that will never be paid, and some of those costs will still be shifted to the rest of the payers because they will be factored into the price schedule.

However, if price discrimination is eliminated, the costs will be shared equally among all other participants—ideally including the federal payers as well as private, which does not currently occur. In addition, as we discussed in the introduction, the number of uninsured New Mexicans has fallen dramatically over the past year and continues to drop, so this should be less and less of a concern in the future.

**We recommend enacting legislation ending price discrimination and requiring that New Mexico's hospitals each develop a single price schedule for their procedures and charge those prices to all payers (with the exception of uninsured patients who are unable to pay them). We also recommend that the state seek a federal waiver so that Medicaid and Medicare would pay the same rates as privately insured and uninsured patients.**

## HOW STAKEHOLDERS BENEFIT FROM THESE REFORMS

### Patients and Employers

Patients are the stakeholders who suffer the most from the opaque and discriminatory system of health care pricing. It is not surprising, then, that patients stand to benefit the most from a system that makes prices simple and transparent, allowing them to comparison shop for the best quality at the lowest price and bringing down costs overall.

A growing mountain of research illustrates the potential for cost savings from increasing health care transparency. In May of 2014, the West Health Policy Center published a report examining the cost savings that would result from making health care pricing more transparent to patients, employers, physicians, and policymakers. Based on data from existing transparency initiatives, West Health found that savings would total \$95–100 billion annually if transparency reforms were implemented nationwide.

**Given the relative size of New Mexico's population, this would mean an annual savings of about \$626 million for New Mexicans, or \$318 per New Mexican per year.**

Going beyond transparency and ending price discrimination will yield even more savings. Professor Joseph White of Case Western Reserve University explains that abolishing price discrimination “saves money not only directly through the prices, but indirectly through limiting administrative costs.” He notes that because discriminatory pricing is so complicated, it is extremely expensive to administer: “This [price] variation increases costs



Photo courtesy iStock, image #19788597.

in the U.S. both for insurers (who must keep track of all the different prices from all the different plans they manage for all the different providers) and for caregivers (who have to maintain elaborate billing operations to deal with the insurers).” Those costs are passed on to patients and the employers who provide insurance for their workers.

About 31% of every dollar spent on health care in the U.S. goes to administration. According to a comprehensive 2012 report by the Institute of Medicine, excess administrative costs account for 13% of national health care spending — totaling \$190 billion in 2009. **Based on New Mexico's share of the U.S. population, that administrative waste costs New Mexico employers and patients about \$1.1 billion annually (\$550 per New Mexican per year).**

Because of all these unnecessary costs, increasing transparency and ending price discrimination is not a zero-sum reform that benefits patients and employers at the cost of other stakeholders. In fact, these reforms will benefit doctors, hospitals, insurers, and New Mexico taxpayers as well.

## Doctors, Nurses, & Health Care Professionals

Without access to information on the prices of various treatments, doctors lack an essential tool they need to fully advise their patients about the best course of treatment—one that will help them without causing harm like making it difficult for patients to afford food, pay utility bills, or keep their homes.

Three physicians expressed this idea in an article in the October 2013 edition of the *New England Journal of Medicine*, writing: “patients burdened by high out-of-pocket costs from cancer treatment reduce their spending on food and clothing to make ends meet or reduce the frequency with which they take prescribed medications...Because treatments can be ‘financially toxic,’ imposing out-of-pocket costs that may impair patients’ well-being, we contend that physicians need to disclose the financial consequences of treatment alternatives just as they inform patients about treatments’ side effects.”

These same concerns prompted a group of doctors to found the nonprofit organization Costs of Care, which works to empower health care professionals with cost and quality information. The group estimates that doctors “ultimately determine how 90% of healthcare dollars are spent,” and argues that providing them with price information will help control health care costs.

Beyond helping them provide better care for their patients, some physicians view transparency as an important tool to promote the high quality and competitive prices of their services. For example, a Denver doctor interviewed for a radio story on Colorado’s health care transparency initiative said that he was looking forward to having access to information about how much other doctors in the city were charging and the complication rates from

their procedures because he expected that his practice would compare favorably on both measures.

Finally, doctors and other health care professionals stand to benefit from the administrative cost savings of these reforms. In 2010, there were five health care administrators for every doctor in the U.S., according to the Bureau of Labor Statistics. This high ratio is due in large part to the complexity of health care billing in our current system.

If the system were simplified by ending price discrimination, some of the millions of dollars being spent on administrative overhead could instead be directed to doctors and other health care professionals, like nurses. One reason for New Mexico’s critical doctor shortage is the fact that physician salaries in the state are about 13% below the national average.

## Hospitals

As the Arizona legislature debated its price transparency law in early 2013, one Phoenix hospital decided not to wait for the state to act. The 578-bed Maricopa Integrated Health System hospital



Illustration by S. Harris, courtesy Cartoonstock, image #shr0835.



began posting prices for bundled packages of care in March of 2013. In doing so, the hospital re-evaluated its chargemaster and cut its rates by about 50%.

Since posting its prices, the hospital has seen a substantial reduction in uncompensated care, and it has attracted more patients who are shopping around for the best deals; for example, the hospital is now delivering an additional 50–60 babies a month.

Here in New Mexico, Holy Cross Hospital in Taos launched its own transparency initiative in August of 2014. Using data it has collected on the costs of its procedures, as well the details of each patient's insurance policy, the hospital aims to give every patient an up-front price estimate before a procedure is performed. One motivation for the hospital is that giving patients this information may help reduce the amount of unpaid bills.

The American Hospital Association (AHA) itself has long supported price and quality transparency, so long as the information is accurate and presented in a way that is understandable by patients. As AHA President Rich Umbdenstock told the *Wall Street Journal*, hospitals “are absolutely in favor of price transparency.” Having access to this information allows hospitals to better market themselves to patients and empowers them to determine if their prices and quality are competitive or should be adjusted.

Ending price discrimination is a more significant shift for hospitals than increasing transparency, since many feel they need high chargemaster prices in order to cover their costs and not leave any money on the table. Yet as economist Uwe Reinhardt points out, although the idea of shifting

health care costs to wealthier patients in order to cover the shortfalls from those who can least afford it make sense in theory, it simply doesn't occur in practice, as the highest prices fall on low-income uninsured patients.

Some of the heaviest burdens on New Mexico's hospitals, particularly those serving the state's rural communities, result from uncompensated care and underpayments by Medicare and Medicaid. A single price schedule that Medicare and Medicaid agree to follow would staunch the flow of red ink at so many of these hospitals, and even a price schedule that only applies to private payers could be designed to better cover the costs of uncompensated care than today's byzantine pricing system.

Finally, like doctors and patients, hospitals would benefit from the savings that would result from reducing the administrative complexity of the billing process with a uniform price schedule. These are dollars that could be reinvested in their doctors, nurses, and medical equipment, as well as helping to cover the cost of charity care.

## Health Insurers

The health insurers are on the other side of the administrative swamp: they too are spending lots of money negotiating many different pricing deals with different hospitals and managing payments for a wide variety of policies. Like hospitals, they are beginning to unite behind transparency efforts, and they also stand to realize savings from a simplified, non-discriminatory billing system.

But if insurers can no longer negotiate special pricing deals with hospitals, what would they compete on?

The answer to this question can be found in Maryland, which has a healthy and competitive private insurance market despite the fact that insurers in that state have not been able to negotiate pricing deals with hospitals in four decades. An analysis of Maryland's insurance market concluded that once insurers face a level playing field of prices, they are able to compete to improve the quality of their services or their own internal efficiency, which can lead to lower premiums.

As business school professors Porter and Teisberg put it: "The administrative complexity of dealing with multiple prices [for the same procedure] adds costs with no value benefit. The dysfunctional competition that has been created by price discrimination far outweighs any short-term advantages individual system participants gain from it, even for those participants who currently enjoy the biggest discounts."

### State Taxpayers

As we noted in the introduction to this report, New Mexico taxpayers are currently spending over \$1.7 billion a year on health care costs for state employees, retirees, and Medicaid patients.

California faces a similar challenge at an even larger scale. Seeking some way to reduce its spiraling costs, in 2008 the California Public Employee Retirement System (CalPERS) began collecting pricing data on common medical procedures from hospitals across the state. After learning that the costs of knee and hip replacement surgery varied from \$15,000–\$100,000, and that cost had no correlation to quality, CalPERS informed its members that it would pay only the average price: \$30,000. The agency provided its members with a list of the prices charged by each hospital and informed them that if they wanted to get the

surgery at a facility that charged more, they were free to do so, but they had to pay the difference.

In response to CalPERS' action, 40 of the higher-priced hospitals reduced their prices by as much as 34.3%. Interestingly, even the lower-priced hospitals reduced their costs by an average of 5.6%. State taxpayers saved \$5.5 million on these surgeries in 2011 and 2012, with no loss of quality. Based on its early success, CalPERS is now expanding the program to other elective procedures.

Once New Mexico's hospitals are providing transparent, non-discriminatory pricing, our state employee and retiree health programs will have the tools they need to implement reforms similar to those in California and begin to bring down the unnecessarily high cost of health care.

On the other side of the ledger, the cost of implementing these reforms should be relatively minimal. The New Mexico Health Department can utilize free software developed by the federal Agency for Healthcare Research and Quality to create a searchable, user-friendly website of cost and quality data (this software is being used by Arizona, Utah, Nevada, and Maine, among other states).

A great deal of quality and billing data is already being reported by hospitals to the Department of Health under New Mexico's Health Information System Act. If the prices billed were actually the same as the prices paid, the Health Department would already have most of the information it needs to launch a meaningful health care transparency website for New Mexicans.

## CONCLUSION

In August of 2012, 23 health care experts co-authored a piece in the *New England Journal of Medicine* titled, "A Systemic Approach to Containing Health Care Spending."

Emphasizing the urgent need to slow the growth of medical costs and make health care more affordable, the authors called for ending price discrimination by having health care providers and insurers negotiate rates that would apply to all payers. They called for transparent prices, disclosed alongside quality factors and bundled so that they are easy to understand. They called for a prohibition on gag clauses.

These reforms have support not only from experts, economists, and stakeholders in the health care industry, but also from policymakers across the political spectrum. Variations of the proposals made in this report have been enacted in states ranging from Maryland to Utah.

The status quo is not an option. If New Mexico's health care spending continues to grow at a pace that far outstrips the overall economy, employers and insurers will be forced to continue shifting costs onto individuals and families. The higher their costs, the more likely they are to skip essential medical care or wait to see the doctor until illnesses are advanced and more difficult to treat. The end result will be a sicker, poorer state.

The reforms we propose in this report are common sense measures that will make the health care market more like other free markets for goods and services where prices are transparent and consistent for all customers.

## Think New Mexico's Health Care Affordability Reforms

### ENACT LEGISLATION TO:

- **Require transparency of hospital prices and risk-adjusted quality indicators on a user-friendly public website**
- **Outlaw price discrimination by directing New Mexico's hospitals to charge all payers the same prices, with no discounts except for indigent patients**
- **Prohibit gag clauses in contracts between insurers and health care providers**
- **Seek a federal waiver so that Medicaid will pay the same prices as private payers**

Increasing transparency and ending price discrimination will not solve every problem with New Mexico's health care system. However, they are essential steps toward the goal of a patient-centered system that delivers the most value for every dollar invested in it.

Today New Mexico's health care system bankrupts families, burdens employers and taxpayers, strains hospitals and health care providers, and wastes one out of every three dollars. The time has come for reforms that will reorient the system toward providing high-quality health care that all New Mexicans can afford.

## TAKE ACTION!

Visit [www.thinknewmexico.org](http://www.thinknewmexico.org) and sign up for email alerts to join the fight to increase transparency and end price discrimination in New Mexico's health care!

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