[Alaska Stat. § 18.23.400.]

§ 18.23.400. Disclosure and reporting of health care services, price, and fee information: Electronic Health Information Exchange System

(a) A health care provider shall annually compile a list, including a brief description in plain language that an individual with no medical training can understand, of the 10 health care services most commonly performed by the health care provider in the state in the previous calendar year from each of the six sections of Category I, Current Procedural Terminology, adopted by the American Medical Association and, for each of those services, state

(1) the procedure code;

(2) the undiscounted price; and

(3) any facility fees.

(b) A health care facility in the state shall annually compile a list, including a brief description in plain language that an individual with no medical training can understand, of the 10 health care services most commonly performed at the health care facility in the previous calendar year from each of the six sections of Category I, Current Procedural Terminology, adopted by the American Medical Association and, for each of those services, state

(1) the procedure code;

(2) the undiscounted price; and

(3) any facility fees.

(c) If, in the annual reporting period under this section, fewer than the number of health care services described under (a) or (b) of this section are performed by a health care provider or at a health care facility in the state, the provider or facility shall include in the list required under this section all of the health care services performed by the provider or at the facility from each of the six sections described under (a) or (b) of this section.

(d) A health care provider who provides health care services at a health care facility in a group practice is not required to compile and publish a list under (a) and (e) of this section if

(1) the health care facility where the provider is in a group practice compiles and publishes a list in compliance with (b) and (e) of this section; and

(2) the prices and fees that the provider charges are reflected in the list compiled and published by the health care facility.

(e) A health care provider and health care facility shall publish the lists compiled under (a) and (b) of this section by January 31 each year

(1) by providing the list to the department for entry in the department's database under AS 18.15.360 along with the name and location of the health care provider or health care facility;

(2) by posting a copy of the list

(A) in a font not smaller than 20 points;

(B) in a conspicuous public reception area at the health care provider's office or health care facility where the services are performed;

(C) that includes the address for the department's Internet website;

(D) that may include a statement explaining that the undiscounted price may be higher or lower than the amount an individual actually pays for the health care services described in the list;

(E) that includes a statement substantially similar to the following: "You will be provided with an estimate of the anticipated charges for your nonemergency care upon request. Please do not hesitate to ask for information."; and

(F) that lists any health care insurers with which the health care provider or health care facility has a contract to provide health care services as an in-network preferred provider; and

(3) if the health care provider or health care facility has an Internet website, by posting the list on the website.

(f) The department shall annually compile the lists provided under (a) and (b) of this section by health care service and, where relevant, health care provider and health care facility name and location, post the information on the department's Internet website, and enter the information in the database maintained under AS 18.15.360.

(g) If a patient who is receiving nonemergency health care services requests an estimate from a health care provider, health care facility, or health care insurer of the reasonably anticipated charges for treating the patient's specific condition, the health care provider, health care facility, or health care insurer

(1) shall provide a good faith estimate before the nonemergency health care services are provided and not later than 10 business days after receiving the request;

(2) shall provide the estimate in whichever of the following formats the patient requests: orally, in writing, or by electronic means; if the estimate is provided orally, the health care provider, health care facility, or health care insurer shall keep a record of the estimate;

(3) is not required to disclose the charges for the total anticipated course of treatment for the patient, but if the estimate does not include charges for the total anticipated course of treatment, the estimate must include

a statement explaining that the estimate only includes charges for a portion of the total anticipated course of treatment; and

(4) may provide an estimate that includes a reasonable range of charges for anticipated health care services if the charges for the services will vary significantly in response to conditions that the health care provider, health care facility, or health care insurer cannot reasonably assess before the services are provided.

(h) A good faith estimate provided by a health care provider or health care facility under (g) of this section must include

(1) a brief description in plain language that an individual with no medical training can understand of the health care services, products, procedures, and supplies that are included in the estimate;

(2) a notice disclosing the health care provider's or health care facility's in-network or out-of-network status that is substantially similar to one of the following forms:

(A) "(Name of health care provider or health care facility) is a contracted, in-network preferred provider for ONLY the following plan networks: (list each network or state 'NONE. YOU MAY INCUR OUT-OF-NETWORK CHARGES.')"

(B) "(Name of health care provider or health care facility) is a contracted, in-network preferred provider for your insurance plan."; or

(C) "(Name of health care provider or health care facility) is NOT a contracted, in-network preferred provider for your insurance plan. YOU MAY INCUR OUT-OF-NETWORK CHARGES.";

(3) the procedure code for each health care service included in the estimate;

(4) any facility fees, along with an explanation of the facility fees; and

(5) the identity, or suspected identity, of any other person that may charge the patient for a service, product, procedure, or supply in connection with the health care services included in the estimate, along with an explanation of whether the charges are included in the estimate.

(i) A health care provider or health care facility that provides a good faith estimate to a patient under (g) and (h) of this section or a health care insurer that provides a good faith estimate to a patient under (g) of this section is not liable for damages or other relief if the estimate differs from the amount actually charged to the patient.

(j) The requirement for a health care facility to provide a good faith estimate of reasonably anticipated charges for nonemergency health care services under (e)(2)(E), (g), and (h) of this section does not apply to a health care facility that is an emergency department.

(k) A health care provider or a health care facility that fails to comply with the requirements of (a) — (e), (g), or (h) of this section or a health care insurer that fails to comply with the requirements of (g) of this section is liable for a civil penalty not to exceed $10,000 for each violation. The department may impose a penalty

(1) for failure to comply with (a) — (e) of this section of not more than $100 for each day of noncompliance after March 31; or

(2) for failure to provide a good faith estimate under (g) or (h) of this section of not more than $100 for each day of noncompliance.

(l) A health care provider, health care facility, or health care insurer penalized under (k) of this section is entitled to a hearing conducted by the office of administrative hearings under AS 44.64.

(m) A municipality may not enact or enforce an ordinance that is inconsistent with or imposes health care price or fee disclosure requirements in addition to the requirements under this section or regulations adopted under this section.

(n) In this section,
(1) "department" means the Department of Health and Social Services;

(2) "facility fee" means a charge or fee billed by a health care provider or health care facility that is in addition to fees billed for a health care provider's professional services and is intended to cover building, electronic medical records system, billing, and other administrative and operational expenses;

(3) "health care facility" means a private, municipal, or state hospital, psychiatric hospital, emergency department, independent diagnostic testing facility, residential psychiatric treatment center as defined in AS 47.32.900, kidney disease treatment center (including freestanding hemodialysis units), office of a private physician or dentist whether in individual or group practice, ambulatory surgical center as defined in AS 47.32.900, free-standing birth center as defined in AS 47.32.900, and rural health clinic as defined in AS 47.32.900; "health care facility" does not include
(A) the Alaska Pioneers' Home and the Alaska Veterans' Home administered by the department under AS 47.55;

(B) an assisted living home as defined in AS 47.33.990;

(C) a nursing facility licensed by the department to provide long-term care;

(D) a facility operated by an Alaska tribal health organization; and

(E) a hospital operated by the United States Department of Veterans Affairs or the United States Department of Defense, or any other federally operated hospital or institution;

(4) "health care insurer" has the meaning given in AS 21.54.500;

(5) "health care provider" means an individual licensed, certified, or otherwise authorized or permitted by law to provide health care services in the ordinary course of business or practice of a profession;

(6) “health care service” means a service or procedure provided in person or remotely by telemedicine or other means by a health care provider or at a health care facility for the purpose of or incidental to the care, prevention, or treatment of a physical or mental illness or injury;

(7) “nonemergency health care service” means a health care service other than a health care service that is immediately necessary to prevent the death or serious impairment of the health of the patient;

(8) “patient” means an individual to whom health care services are provided in the state by a health care provider or at a health care facility;

(9) “third party” means a public or private entity, association, or organization that provides, by contract, agreement, or other arrangement, insurance, payment, price discount, or other benefit for all or a portion of the cost of health care services provided to a recipient; “third party” does not include a member of the recipient’s immediate family;

(10) “undiscounted price” means an amount billed for a service rendered without complications or exceptional circumstances; “undiscounted price” does not include a negotiated discount for an in-network or out-of-network service rendered or the cost paid by a third party for that service.