Achieving Price Transparency for Consumers: A Toolkit for Hospitals
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Price Transparency
Introduction

Consumers and their families deserve useful information about the price of their hospital care. And demand for understandable price information will only increase as patients shoulder an increasing proportion of their health care costs.

America’s hospitals are committed to being more transparent, not only about the price but the quality of care, so that patients can be more involved in and make informed decisions about their health care. But more can, and should, be done to share meaningful health care information with the public. The American Hospital Association (AHA) and our members stand ready to work with policymakers on innovative ways to build upon existing efforts at the state level and share information that helps consumers make better choices about their health care.

Forty-two states now report information on hospital charges or payment rates and make that information available to the public. The Centers for Medicare & Medicaid Services (CMS) posts on its website average hospital-specific charges per patient and average Medicare payments for the most common diagnosis-related groups (DRGs), as well as 30 ambulatory procedures. Additionally, the Affordable Care Act (ACA) requires that hospitals report annually and make public a list of hospital charges for items and services.

Many state, regional and metropolitan hospital associations have provided guidance to help hospitals comply with these requirements. This resource is not intended to replace those materials. Instead, it can serve as a guide to help you assess how your organization is doing and learn from others through case examples and sample tools.

The AHA recently participated in a multi-stakeholder task force to address price transparency, convened by the Healthcare Financial Management Association (HFMA). A key element of the group’s approach and final report was that different price transparency frameworks are needed for different groups. The taskforce agreed that for insured patients, health plans should be the main source of price information; for uninsured and out-of-network patients, providers should be the main source of price information. The task force issued a report that included a set of principles, as well as specific action steps, required to achieve greater transparency. In addition, they issued a guide to help consumers better understand health care pricing (both the report and guide are included in the resources section – see Resources, pages 5.23 and 5.49).

While consumers are seeking price information, it should not be provided in a vacuum. Patients also deserve easy-to-understand quality and safety information to help them make informed health care decisions. Hospitals must prioritize price transparency to better understand what patients experience. Conduct a secret shopper exercise within your organization. Consider a transparency ombudsman to coordinate activities in a thoughtful and helpful way. Technology cannot tell the entire story. It requires training, scripting and direct communication. This information is important
not only to patients, but to employers, insurers, physicians and providers as they all work to ensure consumers receive the best quality health care at the best value.

The issue of transparency is a familiar one to hospitals. The AHA has spent more than a decade advocating transparency in all areas to strengthen community trust and allow hospitals to reaffirm their rightful place as a valued and vital community resource that merits broad support. The AHA Board of Trustees created a Statement of Principles and Guidelines (see Resources, page 5.75) related to hospital billing and collections rooted in transparency and updated them to account for the ACA requirements. The Principles and Guidelines include themes that are echoed in the recent HFMA report: information on the price of care should be easy to understand, use and access. Separately, the board also tasked hospitals to find the best ways to share meaningful pricing information with consumers and challenged them to present information in a way that:

1. Is easy to access, understand and use;
2. Creates common definitions and language describing hospital price information for consumers;
3. Explains how and why the price of patient care can vary;
4. Encourages patients to include price information as just one factor, along with quality and safety, when making decisions about hospitals and health plans; and
5. Directs patients to more information about financial assistance with their hospital care.

As consumers take on greater responsibility for the cost of their care, hospitals have a responsibility to communicate with consumers upfront, sharing meaningful information and demonstrating caring and trust.

For additional background materials, visit www.aha.org/billing.

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**Common Definitions – Courtesy HFMA**

**Charge.** The dollar amount a provider sets for services rendered before negotiating any discounts. The charge can be different from the amount paid.

**Cost.** The definition of cost varies by the party incurring the expense:
- To the patient, cost is the amount payable out of pocket for health care services.
- To the provider, cost is the expense (direct and indirect) incurred to deliver health care services to patients.
- To the insurer, cost is the amount payable to the provider (or reimbursable to the patient) for services rendered.
- To the employer, cost is the expense related to providing health benefits (premiums or claims paid).

**Price.** The total amount a provider expects to be paid by payers and patients for health care services.

**Out-of-pocket payment.** The portion of total payment for medical services and treatment for which the patient is responsible, including copayments, coinsurance and deductibles.
Price transparency is a complex issue that is important to not just patients but to everyone involved – hospitals, insurers, physicians, providers, employers, etc. Moving towards price transparency that is truly patient-centered will be a multi-step process that requires the participation of all parties. For hospitals, a good place to start is with the action items below.

1. Put yourself in the shoes of the consumer.

If patients need price information from your hospital today, where do they go for it? What will they find? Take time to conduct your own self-assessment (see page 2.1). Call your billing office, visit your website or conduct a “secret shopper” experiment (Resources, page 5.3) to determine how well your organization communicates price information to interested consumers.

2. Train your staff.

Communicating price transparency takes both knowledge and sensitivity. There should be a process for how phone calls are handled, and staff should be scripted to ensure information is consistently provided and applicable caveats are included. For example, staff should:

- Emphasize that prices provided are estimates;
- Alert patients that changes may occur depending on a patient’s health or if complications occur;
- Note what is and what is not included in the estimate (e.g., physician fees); and
- Tell patients what other bills they may receive.

While it is important to have specific staff members designated and trained to fulfill this role, it is just as important to ensure all staff who interact with patients, including nurses, social workers and receptionists, have a general understanding of your pricing policies and know where to direct patients with questions. Be sure that switchboard operators especially understand where to forward consumers that ask for pricing information.
3. **Make information meaningful.**

- Price information needs to be tailored to the individual consumer.
- Tell consumers how much they will pay out of pocket for care (regardless if they are insured or uninsured).
- Hospitals should link to insurance company information on discounts, where available.
- Share consumer-specific information on coinsurance and deductibles.

Many vendor tools exist that can help hospitals set up systems to pull this information together.

4. **Know how your information compares to others in its accessibility and usefulness — not just other hospitals, but the growing number of alternative sites of care, such as walk-in clinics, ambulatory surgery centers, imaging centers, etc.**

Consumer expectations for meaningful price information are growing, and many providers — hospitals and others — are stepping up to the plate. Hospitals need to be aware of whether and how others are making price information accessible and then assess how their information compares.

5. **Tap into your community for help.**

Many hospitals have working or advisory groups made up of patient advocates, as well as past patients or family members. Engage this group in your price transparency efforts and enlist them to be secret shoppers. Ask them how you are doing, listen to their suggestions and use their feedback to refine your approach.
Price Transparency
Self-Assessment
How to Use this Self-Assessment

The ability of every hospital to offer consumers information about the expected price of their care is essential in order to maintain public trust and accountability. It can be challenging because price varies due to a number of factors, including private insurance contracts; care the hospital must subsidize, such as caring for the poor, burn and neonatal units, and teaching and research; as well as an individual patient’s course of care.

This self-assessment is designed to offer a basic framework that hospital leaders can use to evaluate how far they are along the journey of price transparency and consider whether they are successfully communicating such efforts to their patients and communities. It is not intended to be a benchmark against the performance of others. Rather, it should be used to help promote the effective implementation of policies and practices that support price transparency and public trust.

Answer the series of questions to assess your current practices and to stimulate thinking about overall organizational activities. Alongside each question are three boxes: “Yes,” “No” and “More needs to be done.”
## Self-Assessment Checklist

<table>
<thead>
<tr>
<th>1. Has your organization conducted a “secret shopper” experiment both within your own facility, as well as with other organizations, to determine how well price information is communicated?</th>
<th>Yes</th>
<th>No</th>
<th>More needs to be done</th>
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<td>O</td>
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<th>2. Do you proactively communicate price information, as well as information about your billing process, charity care and financial assistance policies, in a way that is easy to understand and culturally appropriate?</th>
<th>Yes</th>
<th>No</th>
<th>More needs to be done</th>
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<td>O</td>
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<th>3. Is your organization’s price information easily accessible and presented in a way that is understandable to and usable by the general public? Including:</th>
<th>Yes</th>
<th>No</th>
<th>More needs to be done</th>
</tr>
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<tbody>
<tr>
<td>Made available in the languages that are used most often in your community</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Accessible via your website or immediately upon request</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Shared with outside community organizations</td>
<td>O</td>
<td>O</td>
<td>O</td>
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<tr>
<td>Available via online calculator/price estimator</td>
<td>O</td>
<td>O</td>
<td>O</td>
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<tr>
<th>4. Does your hospital have specially trained staff available to answer patient and family questions about estimated prices and provide additional explanations about how price may vary from estimates depending on the patient’s care requirements?</th>
<th>Yes</th>
<th>No</th>
<th>More needs to be done</th>
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<td>O</td>
<td>O</td>
<td>O</td>
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<tr>
<th>5. Do all staff involved in patient and family interactions (nurses, receptionists, as well as billing staff) receive general training on your hospital’s price information, including how to connect patients and families with specially trained hospital staff who are knowledgeable about hospital charges, billing practices and financial assistance policies?</th>
<th>Yes</th>
<th>No</th>
<th>More needs to be done</th>
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## Self-Assessment Checklist

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<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>More needs to be done</th>
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<tbody>
<tr>
<td>6.</td>
<td>Do your financial counselors follow a specific script or guide when sharing price information with patients to ensure consistency?</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>7.</td>
<td>Does your hospital offer patients a range of information as it relates to potential prices? Specifically:</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td></td>
<td>• Estimated prices specific to that patient’s coverage</td>
<td>O</td>
<td>O</td>
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<tr>
<td></td>
<td>• Out-of-pocket estimates (copays, coinsurance, deductibles)</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td></td>
<td>• Out-of-network prices, if applicable</td>
<td>O</td>
<td>O</td>
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<tr>
<td>8.</td>
<td>Does your website and/or staff offer disclaimers about the limitations of the price estimates given? Specifically:</td>
<td>O</td>
<td>O</td>
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<tr>
<td></td>
<td>• That prices are only an estimate and will vary based on the individual’s course of care</td>
<td>O</td>
<td>O</td>
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<tr>
<td></td>
<td>• What is and what isn’t included (e.g., prices for associated physician services)</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td></td>
<td>• Any out-of-pocket costs</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td></td>
<td>• Applicable out-of-network fees</td>
<td>O</td>
<td>O</td>
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<td></td>
<td>• Insurer-specific information</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>9.</td>
<td>Does your hospital offer average procedure prices and information about whether a patient may qualify for financial assistance? Specifically through:</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td></td>
<td>• Your website</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td></td>
<td>• Your staff</td>
<td>O</td>
<td>O</td>
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# Self-Assessment Checklist

<table>
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<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>More needs to be done</th>
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| **10.** Does your hospital partner with others to offer pricing resources/price estimates to patients/the community? Including:  
  - External vendors  
  - State and/or metropolitan hospital association  
  - Insurance companies  
  - Physician groups or ancillary care providers | O | O | O |
| **11.** Does your organization provide quality data to consumers along with price information?  
  - Is that information also shared with providers? | O | O | O |
| **12.** Do you have plans to expand current pricing transparency efforts? | O | O | O |
| **13.** Do you have a process/feedback loop to evaluate how your organization is doing in price transparency?  
  - Do you have a consumer advisory group involved in the process? | O | O | O |
Case Examples
Augusta Health
Fishersville, Virginia

224 beds
56,530 ED visits
11,173 inpatient admissions

Impetus for Initiative: Four years ago, Augusta Health began its transparency initiative to improve the patient experience. It uses a team of financial counselors to proactively reach out to each patient who has a scheduled service and provide pricing information, including the expected out-of-pocket obligation, ahead of time. Augusta Health uses a commercial vendor, Recondo Technology, to develop the pricing information. Recondo ties together chargemaster pricing data with the terms of the hospital’s various insurance contracts to estimate an average price for each service specific to each payer. Augusta Health’s registration system connects to insurance company databases so the out-of-pocket estimate provided to patients reflects the current status of coinsurance, copayments and deductibles.

Augusta Health carefully scripts financial counselors to clearly communicate with patients that the information provided includes just the expected obligation for the hospital portion of the service and is only an estimate. Financial counselors also discuss options for payment and financial assistance. Training is extensive because of the sensitive nature of the conversation.

Community response has been positive. Augusta Health not only provides this information to patients with scheduled services, but also to people seeking pricing information prior to scheduling.

Challenges: The biggest challenges in implementing its program were to convince Augusta staff and physicians of the benefits of having this conversation upfront and finding the right individuals for the financial counselor positions.

Contact: Brandy Hoell, Director of Patient Access and Case Management
bhoell@augustahealth.com
540-332-4000
**Baptist Health System**

**A seven-hospital system in Florida**

1,492 beds
292,700 + ED visits
72,681 inpatient admissions

**Impetus for Initiative:** In 2001, Baptist Health began its price transparency initiative to help international, self-pay patients anticipate the cost of procedures before they received care. Originally named the Corporate Pricing Office, the seven-person office is now the Central Pricing Office (CPO) and serves all Baptist Health facilities, including physician offices.

Price estimates include hospital care and facility physician services, such as anesthesiology, pathology and radiology; employed hospital physician fees also are included. Each month, the CPO provides on average 1,400 self-pay price quotes, 2,500 out-of-pocket quotes and receives an additional 2,200 calls for price information.

Though the initiative has expanded, it remains a homegrown system created by the CPO to be as informative as possible for patients. Estimates can be provided for any procedure. Patients needing information on uncommon procedures are called back the same day. Patients who are pre-registered for services receive a letter with details about the services they will receive and what portion of that cost they are responsible for via upfront estimates of out-of-pocket expenses, including copays, coinsurance and deductibles. All other patients receive the information at registration so there are no surprises post-care. Baptist Health collects copays, coinsurance and deductibles upfront. If a patient cannot afford care, they are immediately connected with a financial aid officer who assesses whether the patient may qualify for charity care or other assistance programs.

Baptist Health strives to be precise and believes its community is best served when price information is accurate and based on a specific patient. Prices are not available on the website, and every price estimate requires hospital registration information.

**Challenges:** Many patients with high-deductible plans defer care or avoid going through their insurance because their out-of-pocket costs are higher than if they were a self-pay patient. Pricing for facility- and hospital-based physicians may differ between facilities and that can become an issue for self-pay patients.

**Contact:** Baptist Health System
www.baptisthealth.net
786-596-1960
**Billings Clinic**  
**Billings, Montana**

388 beds  
39,232 ED visits  
14,525 inpatient admissions

**Impetus for Initiative:** Value is key to the organization’s mission and a word they take seriously. The price transparency initiative is part of the Billings Clinic's commitment to transparency in all areas but most specifically quality and price.

Currently, Billings lists the price of its most common procedures on its website for patients to easily find. Most procedures have a price range because complications can occur and patients’ medical situations may vary. Patients unable to find information on the website are encouraged to contact the hospital via phone or web contact form and are connected with the Patient Financial Services department, which can help them with specific questions. Patients without insurance or who are unable to afford services are connected immediately with a representative, who discusses charity care programs and payment options. Billings Clinic staff who work in the Patient Access and the Patient Financial Services departments undergo specialized training that includes price transparency education.

Total charges are broken out into coinsurance and out-of-pocket costs. These can vary greatly, and the Billings Clinic does not have access to the level of insurance detail needed to appropriately inform consumers of their unique responsibilities. Because the Billings Clinic is integrated with most physician services, the price quoted to consumers typically includes all services. There is a new layer of transparency currently underway with an effort to make costs simpler for patients to understand.

**Challenges:** The payment system is not evolving or conducive to price transparency. Many consumers struggle to understand that lower prices from other organizations do not include professional fees, such as radiology or pathology. Billings has worked to ensure staff appropriately communicate how care is delivered and how charges in other organizations may be billed separately.

**Contact:** Connie Prewitt, Chief Financial Officer  
cprewitt@billingsclinic.org  
406-238-2500
Holy Cross Hospital
Part of Taos Health Systems in New Mexico

35 beds
15,869 ED visits
2,286 inpatient admissions

Impetus for Initiative: Today’s patient seeks as much information as possible about their health-related costs. Holy Cross meets that demand through Passport—a newly implemented system that takes chargemaster and patient insurance information and provides every patient who comes through the Registration department with estimated out-of-pocket expenses. Patients also can call for estimates. Holy Cross is working on an online component to Passport, which will make access to this information easier.

While Passport is used almost exclusively by the Registration, Billing and Centralized Scheduling departments, all Holy Cross staff have access to the tool, with between 12 and 18 staff members having received in-depth training and meeting regularly to address any challenges in real time. Passport covers virtually every single procedure offered at Holy Cross. Staff work continually to educate patients and make certain they know that the information they receive is specifically for hospital-related costs.

Holy Cross staff work to identify charity or reduced-fee patients as early as possible and help them find programs that best meet their individual circumstances.

Challenges: Anticipating and accounting for the price of any ancillary services a patient receives is a challenge.

Contact: Peter Hofstetter, Chief Executive Officer
phofstetter@taoshospital.org
575-751-8911
**Littleton Regional Healthcare**  
**Littleton, New Hampshire**

25 Beds  
9,000+ ED visits  
1,259 inpatient admissions

**Impetus for Initiative:** As the number of patients with high-deductible insurance plans began to grow, so too did patient interest in their “first dollar” of expense. In 2012, to meet the growing interest, Littleton Regional Healthcare implemented a hosted contract management system that allows the hospital to provide patients with detailed estimates of their financial responsibility based on insurance provider and procedure. Littleton currently provides estimates for more than 100 procedures and is consistently adding more.

Cost estimates can be found on Littleton’s website or by calling or visiting Littleton’s Patient Financial Services department. Financial Services staff have gone through training, and cost estimate procedures and policies are documented and shared amongst staff. Staff also are equipped with a script to help ensure patient requests are handled uniformly.

In addition to the hospital, Littleton Regional Healthcare runs a 38-member physician group and other provider services, such as anesthesiology. Patients, therefore, receive not only estimated hospital fees, but also estimated professional fees, giving them a complete picture of what a procedure may cost.

**Challenges:** Initially, the cost estimate statement went through several iterations as Littleton revised it to ensure it fit on one page and was written in “everyday” language. An ongoing challenge is making certain all contract information is in its contract management system in order to calculate an accurate estimate.

**Contact:** Nick Braccino, Chief Financial Officer  
nbraccino@lrcares.org  
800-464-7731
North Shore-Long Island Jewish Health System (North Shore-LIJ)

17-hospital system in New York

4,507 beds
673,524 ED visits
254,700+ inpatient admissions

Impetus for Initiative: Prompted by state-based financial assistance laws that New York rolled out in 2002, North Shore-LIJ established its price transparency initiative. A call center provides patients with pricing information for most common procedures and answers questions related to bills received.

A web-based cost estimator was later added, allowing insured patients to get an estimate—including out-of-pocket costs—based upon expected insurance coverage (including the expected deductible). If an estimate is not available via the web-based tool, patients can call the Financial Assistance number and get price information within 24 hours. In fact, more than half of inquiries still come via phone. Over the years, technology has improved and allows direct access to insurer databases so patients receive real-time deductible and copayment amounts. More than 10,000 inquiries have come through the call center and web-estimator combined.

North Shore-LIJ always pairs quality information with price information to give patients a full picture of the care the hospitals provide. As a policy, charges are not listed on the website since the majority of patients do not find such information helpful without knowing their out-of-pocket costs.

Call center staff follow scripts to ensure everyone communicates consistently. Included in all communication—including via web-based cost estimator—is the disclaimer that patients may receive physician bills in addition to a hospital bill.

Challenges: The health care system and its various components are not always easily understood by patients. Separate physician fees for services, such as anesthesia, can be confusing to patients, which challenges North Shore-LIJ staff to proactively communicate and educate patients about what is included in a price estimate.

Contact: Bob Shapiro, Executive Vice President & Chief Financial Officer
bshapiro@nshs.edu
516-465-8162
**North Valley Hospital**  
Whitefish, Montana

25 beds  
7,646 ED visits  
1,550 inpatient admissions  

**Impetus for Initiative:** In response to patient requests, North Valley Hospital began providing basic pricing information in 2010 on common procedures, such as MRIs and CT scans. North Valley recently improved its price transparency capabilities by acquiring price estimator software. Now, patients can receive the estimated out-of-pocket cost for two dozen procedures. Requests for pricing information are received primarily through telephone and in-person inquiries, but the organization is upgrading its cost estimator to include a web-based feature.

North Valley is experiencing an uptick in pricing information requests, most likely due to the increasing number of patients with high-deductible health insurance plans. Additionally, the hospital finds itself serving a significant number of Canadian patients, many of whom are seeking elective procedures not covered by insurance.

While many of the employees in the Admissions and Patient Access departments are involved in providing patients with pricing information, North Valley has a core group of employees who have received specific training. This training includes HFMA price transparency and patient-friendly billing coursework. The communication includes educating patients so they know they are likely to receive other bills (radiology, anesthesiology, etc.).

**Challenges:** The hospital has experienced challenges in ensuring that the price estimator software pulls the correct data and that the various information systems and databases used to compile a price estimate all communicate appropriately. It is important that staff understand from which data the software is pulling.

**Contact:** Jason Spring, Chief Executive Officer  
jspring@nvhosp.org  
406-863-3500
Northcrest Medical Center
Springfield, Tennessee

81 beds
NA  ED visits
NA  inpatient admissions

**Impetus for Initiative:** In response to growing demand, Northcrest Medical Center began its phone-based price transparency initiative in 2011. A plastic surgeon asked for detailed hospital pricing information to provide to his patients, most of whom were receiving services not covered by insurance. At the same time, Northcrest noticed an uptick in requests for pricing information from patients enrolled in high-deductible health plans. These factors prompted Northcrest to assess its cost structure and set prices that covered direct costs, overhead and an adequate margin. The organization is still in the process of building its database of pricing information. At this point, it has more success with outpatient verses inpatient procedures.

Patients calling the hospital for pricing information are referred to patient schedulers who consult a spreadsheet of charges and consider the patient’s insurance coverage in determining what the out-of-pocket expenses will be. The estimate includes physician services, but patients are told they will ultimately receive separate bills for surgery, anesthesia and from other physicians involved in their care. Staff are trained to make it clear that the price is an estimate and may vary depending on the specific course of care. Self-pay patients get an automatic 20 percent discount.

**Challenges:** A significant challenge for Northcrest is understanding its own cost structure so adequate prices can be set. Additionally, some patients are frustrated by the imprecision of the estimate and/or the length of time it takes to get an estimate if the service is not already in the database.

**Contact:** Randy Davis, CEO
Randy_davis@northcrest.com
615-384-1501
St. Joseph Medical Center
Part of an eight-hospital system in Washington

366 beds
NA  ED visits
22,980 inpatient admissions

Impetus for Initiative: St. Joseph Medical Center began its transparency effort in 2011 to provide patients with as much information as possible ahead of time, believing that it helps the organization financially if patients are aware of their obligations upfront.

St. Joseph uses a commercial tool called ClearQuote that combines information on charges and insurer contracted rates with information on the patient’s benefit plan to provide expected out-of-pocket costs at the Current Procedural Terminology (CPT) and Diagnosis-Related Group (DRG) level for all services provided by the hospital. Cost estimates are provided via a call center by a trained staff of Financial Access Counselors. If patients cannot provide adequate information on their insurance plan, Financial Access Counselors will contact the insurance company and call them back with a more accurate quote. If patients are self-pay, they are given the charge for the procedure with a 60 percent self-pay discount. If it is unclear what the CPT code is for the procedure, Financial Access Counselors contact the physician for specific information and call the patient back. Through ClearQuote, St. Joseph also provides written estimates to patients when they present for services.

Training is ongoing and extensive due to the sensitivity of this type of patient interaction. Financial Access Counselors are scripted to make clear that the quote is an estimate and that the actual patient obligation may be more or less depending on the specific course of care. Staff are trained to tell the caller that the quotes do not include physician services. Patients needing information on charity care are transferred to Patient Financial Advocates. Feedback has been positive, and St. Joseph staff feel providing price transparency has improved patient loyalty.

Challenges: Patients rarely have CPT-level information on what services they are receiving. It can be a challenge to make it clear to patients that the quote is an estimate and that the final price may be higher or lower depending on the actual course of care.

Contact: Lorraine Parker, Patient Access Manager
LorraineParker@fhshealth.org
253-426-4101
Sample
Web-Based Tools
Baptist Memorial Health Care, Memphis, Tennessee – Expense Navigator

Consumers can use the free, online Expense Navigator form to estimate out-of-pocket costs associated with a health care service.

The estimated costs provided do not include physician charges (for example, pre-procedure office visits, surgeon, anesthesiologist, radiologist, pathologist, consulting physicians, emergency room physicians, etc.). The estimated cost is not a guarantee of insurance coverage. Consumers are encouraged to check with their insurance company to best understand benefits for the service chosen.

http://www.baptistonline.org/expense-navigator/
FAIR Health, National – Consumer Cost Lookup

This medical cost estimator lets consumers estimate the cost of thousands of medical procedures, searchable by zip code. It is designed to help consumers plan for expenses, and also shows how much patients are likely to pay if care is needed while uninsured.

http://fairhealthconsumer.org/medicalcostlookup.php
**Geisinger Health System, Danville, Pennsylvania – MyEstimate**

The MyGeisinger.org website incorporates tools to help patients meet their health care needs quickly and conveniently by providing a secure, confidential and efficient way to view health information anywhere internet access is available. There are many beneficial features of MyGeisinger.org including:

**Viewing:**
- Online medical record including lab results
- Account balances, with online billpay
- Health and fitness information

**Communicating with your doctor’s office for:**
- Prescription renewals
- Appointment requests
- Medical advice for non-urgent questions or concerns

Additionally, MyChart Mobile is an application (app) that provides a MyGeisinger user with secure access on their mobile device to frequently used features of MyGeisinger, such as messaging providers, viewing individual and family medical records, upcoming and past appointments and test results.

http://www.geisinger.org/patients/business_services/estimator/
HealthPartners, Bloomington, Minnesota – Cost of Care

HealthPartners allows consumers to compare provider costs for common conditions, treatments and services as well as estimate medical costs for specific treatments via a Cost Calculator.

https://www.healthpartners.com/empower/costofcare/
Maine Health Data Organization – Maine HealthCost

Maine Health Data Organization collects data on health care claims for Maine residents. The HealthCost web tool presents the average cost of specific medical procedures at more than 50 different high-volume health care facilities and hospitals around the state. Although an individual’s particular out-of-pocket cost for a procedure depends on a number of factors, the cost compare function provides an overall idea of a procedure’s average cost by facility.

https://mhdo.maine.gov/healthcost2014/
Maricopa Integrated Health System, Phoenix, Arizona – CopaCare Estimate

Maricopa provides web-accessible charts that outline both price and financial assistance policies, as well as direct pricing information for both inpatient and outpatient services. The tools were developed to give patients an estimate of prices for the health system’s most common procedures.

http://mihs.org/patient-information/price-and-financial-policy
Spectrum Health, Grand Rapids, Michigan – Priority Health

Spectrum Health found that more people were calling with questions about how much certain procedures cost. This is a result of more people having high-deductible health plans or health savings accounts in which they have direct responsibility for their health care costs. Also, the number of uninsured individuals continues to increase.

The information provided on its website provides a general idea of the prices for common inpatient, outpatient and diagnostic procedures. A final bill from Spectrum Health will vary depending on the actual services provided, existing health conditions that may impact the procedure and specific insurance coverage.

http://www.spectrumhealth.org/AveragePrices
Pricing information provided is based on the average hospital charge for a specific service. The website does not provide information about what a consumer may pay for health care. Consumers are encouraged to contact their insurance company to determine the specific amount one may be expected to pay based upon an individual’s insurance policy. Consumers select county and city, then select a service finding cost information at a single hospital or comparing pricing at up to four facilities.

http://www.wahospitalpricing.org/

**Welcome to WSHA Hospital Pricing**

This website allows health care consumers to receive basic, facility-specific information about services and charges provided in Washington hospitals.

The information being displayed is based on the average hospital charge for a specific service. This website does not provide information about what you will pay for your health care. You need to contact your insurance company to determine the specifics about what you will be expected to pay based upon your insurance policy.

**How to use the Washington Hospital Price System**

**STEP ONE: Select a Hospital**

Select a hospital by choosing a county or city from the drop-down menu. Your selection will reveal another drop-down menu that lists all hospitals in that county or city. On the results page you will be given the opportunity to select up to three hospitals for comparison.

**STEP TWO: Select Service**

Using the menu below, select the type of service that you would like to view for the hospital you selected. Note, this system only includes information about inpatient services, or those that require a stay in the hospital. There is not currently a database in Washington State that covers outpatient services like those that occur in emergency rooms or a doctor’s office.

**STEP THREE: Receive the Results**

After you select a specific type of service, the following information will be displayed:

- The name, address and telephone number of the hospital you selected.

- The number of discharges, the average length of stay, and information about the average and median charges for (1) the selected hospital; (2) all hospitals in the selected county; (3) all hospitals with similar patient volume as the selected hospital; and (4) all Washington hospitals. Please note that the charges listed are for hospital services only. They do not include physician charges such as those for a surgeon or anesthesiologist.

- Overall information about charges and payments to the selected hospital from different types of insurers.
Wisconsin PricePoint System

Provided through the Wisconsin Hospital Association Information Center, PricePoint has been collecting data since 2004. It provides complete, accurate and timely data about charges and services provided by Wisconsin hospitals and ambulatory surgery centers. PricePoint also is licensed to 10 other states.

http://www.wipricepoint.org/
Resources
AHA
Secret Shopper Exercise
This exercise enables hospital leaders to get a shared sense of the challenges consumers face in trying to access hospital price information.

Consumers are taking a more active role in seeking information about the price of health care services. Become a “secret shopper” for two health care services provided by your hospital or a hospital in your health system and then repeat the process for one health care service provided by an independent, non-hospital provider of the same service.

Hopefully, as a result, you will have a better sense of the challenges consumers face trying to access health care price information, as well as how that might differ across various provider types.

1. Place two anonymous calls to your hospital or a hospital in your health system. Start with the general phone number to see where the patient gets directed. You may want to make the call from a phone outside the hospital if you have caller ID or even ask someone to place the calls for you. This is also a good opportunity to engage trustees and/or your consumer advisory group in your price transparency efforts by asking them to participate in the exercise.

❖ Tell the person who answers the phone that you are looking for price information, and ask for the price of a different hospital service for each call. Once you are in the right place, present yourself as an uninsured patient. Suggest that you do not qualify for reduced prices and are interested in the full charge amount. Please ask for information on the price of the following services:

A magnetic resonance imaging (MRI) of one shoulder; and total knee replacement.

(Note: if your hospital does not provide these services, feel free to choose an inpatient and outpatient example of your choice.)

❖ Take notes on the process and response you get. How was your request handled? What area of the organization were you directed to? What kind of information was offered? How many times was your call transferred? How many minutes did it take you to get an answer? Did the hospital employee note that you might receive bills from other providers, such as a radiologist, surgeon or anesthesiologist for the same services? Did hospital personnel offer any information on financial assistance policies? Please remember, this is an opportunity to identify some of the challenges consumers face and understand how we can better serve them and is not intended to single out the responsiveness of individual employees.
AHA Secret Shopper Exercise

2. **Place a third anonymous call to an independent, non-hospital provider (e.g., imaging center.)**
   Ask for the price of an MRI of one shoulder. Again take notes on the process, focusing on the differences in how the calls were handled by your hospital and by the other provider.

3. **Move the findings to staff discussions and take action.** This exercise is only as valuable as it is actionable. Meet with staff to talk about the secret shopper exercise and open up a dialogue about what’s working and what can be improved. Leave these discussions with a plan for how you will move forward.
Preparing for Price Transparency:
A Five-Point Checklist

Courtesy Healthcare Financial Management Association
As your organization prepares to offer price information to patients and other care purchasers, make sure you have addressed these five essential points.

1. Secure board and executive team support of price transparency. Working to implement price transparency will require dedication of organizational time and resources, as well as communication with external stakeholders, therefore it is important that leadership fully supports the effort.

2. Identify a reasonable starting point. Lower-priced, high-demand services will likely be of greatest interest to price-sensitive patients and are a good starting point for transparency efforts.

3. Consider how care purchasers will access the information you provide. Price information might be publicly posted on a website, made available on a password-protected website (e.g., for health plan members), or made available in response to an inquiry submitted via website or made by phone. However you plan to provide access to price information, make sure that patients can easily find out how to get it.

4. Identify other information sources that will help patients assess the value of the services you provide. Consider, for example, linking price information to relevant and publicly reported quality or patient safety scores.

5. Be prepared to explain healthcare pricing. Healthcare prices vary for different care purchasers and payers. Medicare and Medicaid programs set the prices they will pay providers, for example, while providers and health plans negotiate prices for insured patients based on such factors as anticipated volume of business and the cost to the provider of making the service available. As prices become more transparent, be prepared to explain why prices may be different for different care purchasers.
Patient Financial Communication
Best Practices

Courtesy Healthcare Financial Management Association
Patient Financial Communications Best Practices

These common-sense best practices bring consistency, clarity, and transparency to patient financial communications, and outline steps to help patients understand the cost of services they receive, their insurance coverage, and their individual responsibility.
For more information, go to hfma.org/communications.

1. Section 1—Emergency Department

NOTE: All practices must comply with EMTALA and all other Federal, State and Local regulations affecting the Emergency Department

1.1. Discussion participants: The patient or guarantor will have these discussions with properly trained registration or discharge representative for routine scenarios; financial counselor or supervisor for non-routine / complex scenarios. Patient should be given the opportunity to request a patient advocate, designee or family member to assist them in these discussions.

1.2. Setting for discussions: No patient financial discussions will occur before patient is screened and stabilized. Once a patient has been stabilized, in accordance with EMTALA, the following timings and locations are appropriate for financial discussions.

1.2.1. Emergent Patients: Discussions will occur during the discharge process. The discussion can also occur during the medical encounter as long as patient care is not interfered with and the patient consents to these conversations in order to expedite discharge.

1.2.2. Patients who do not have an emergency medical condition: Following the medical screening, provider representative will have a discussion with the patient during the registration or discharge process. The discussion can also occur during the medical encounter as long as patient care is not interfered with and the patient consents to these discussions in order to expedite discharge.

1.3. Registration, insurance verification, and financial counseling discussions: No patient financial discussions will occur before patient is screened and stabilized, in accordance with EMTALA.

1.3.1. Registration: The provider organization will first gather basic registration information including demographics, insurance coverage, as well as determining the potential need for financial assistance.

1.3.2. Provision of care: Patient will be informed that their ability to pay will not interfere with treatment of any emergency medical conditions. Uninsured patients will be informed the goal of collecting information is to identify paying solutions or financial assistance options that may assist them with their obligations for this visit.

1.3.3. Insurance verification: Once screening has occurred and the patient is stabilized, the provider organization will review insurance eligibility information with the patient to ensure information accuracy.

1.3.4. Financial counseling: If appropriate, patient is referred to a financial counselor and/or offered information regarding the provider’s financial counseling services and assistance policies.
1.4. **Patient share and prior balance discussions:** These discussions will occur once the provider organization has fulfilled the previous best practice requirements. Interactions will not interfere with patient care, and will focus on patient education. During patient share and prior balance discussions, the provider representative will:

1.4.1. **Patient share discussions:**

1.4.1.1. Provide a list of the types of service providers that typically participate in the service both verbally and if the patient requests, in writing.

1.4.1.2. Inform patient that actual costs may vary from estimates depending on actual services performed or timing issues with other payments affecting the patient’s deductible.

1.4.1.3. If appropriate, ask the patient if they are interested in receiving information regarding payment options.

1.4.1.4. If appropriate, ask the patient if they are interested in receiving information regarding the provider’s financial assistance programs.

1.4.2. **Prior balance discussions:**

*NOTE:* Balance resolution discussion occurs on prior balances that are being pursued for collection by provider, collection agency or other organization. There will be many scenarios where patients will not have prior balances.

1.4.2.1. Discuss with patient the services that led to the prior balance, including the dates of service and the resulting prior balance. Upon the patient’s request, provide the patient a written list of the services provided, dates of service and the resulting prior balance.

1.4.2.2. Ask the patient if they are interested in receiving information regarding payment options.

1.4.2.3. Ask the patient if they are interested in receiving information regarding the provider’s supportive financial assistance programs.

1.4.2.4. Proactively attempt to resolve prior balances through insurance and financial assistance programs.

1.5. **Balance resolution:** Once the provider organization has fulfilled the best practice steps as outlined above, it is appropriate to inquire about how the patient would like to resolve the balance for the current service and any prior balance the patient may have, as well as informing the patient of the timing of collection activity.

1.6. **Summary of care documentation:** During the discharge process, the patient will receive, in writing, information regarding the provider’s supportive financial assistance programs, and a summary of the potential financial implications for the services rendered, including a phone number to call with questions.
2. Section 2—Time of Service (Outside the ED)

2.1. **Discussion participants:** The patient or guarantor will have these discussions with properly trained registration or discharge representative for routine scenarios; financial counselor or supervisor for non-routine / complex scenarios. Patient should be given the opportunity to request a patient advocate, designee or family member to assist them in these discussions.

2.2. **Setting for discussion:** Provider organization will have discussion with patient during the registration or discharge process in a location that does not disrupt patient flow. The discussion can also occur during the medical encounter as long as patient care is not interfered with and the patient consents to these discussions in order to expedite discharge.

2.3. **Registration, insurance verification, and financial counseling discussions:** Provider organizations will maintain a thread of pre-registration discussions that occurred with the patient. If pre-registration discussions took place, these discussions will not occur again.

2.3.1. **Registration:** The provider organization will first gather basic registration information including demographics, insurance coverage, as well as determining the potential need for financial assistance.

2.3.2. **Insurance verification:** The provider organization will review insurance eligibility details with the patient to ensure information accuracy. Uninsured patients will be informed the goal of collecting information is to identify paying solutions or financial assistance options that may assist them with their obligations for this visit.

2.3.3. **Financial counseling:** If appropriate, patient is referred to a financial counselor and /or offered information regarding the provider’s financial counseling services and assistance policies.

2.4. **Provision of care:** Provider organizations will have clear policies on how to interact with patients with prior balances choosing to have elective or non-elective procedures. They will also have clear definitions for elective and non-elective procedures. These policies will be made available to the public.

2.4.1. **Elective services (As defined by the provider):**

2.4.1.1. **Patient share discussions:** Patients have the obligation to make satisfactory payment arrangements before receiving care.

2.4.1.2. **Prior balance discussions:** Patients with prior balances will be informed by the provider organization if the provider’s policies regarding prior balances mean the service will be deferred.

2.4.2. **Non-elective services (As defined by the provider):**

2.4.2.1. Patients will be informed that ability to resolve patient share or any prior balances will not affect provision of care.

2.5. **Patient share and prior balance discussions:** Discussions will not interfere with patient care, and will focus on patient education. During patient share and prior balance discussions, the provider representative will:
2.5.1. **Patient share discussions:**

2.5.1.1. Provide a list of the types of service providers that typically participate in the service both verbally and if the patient requests, in writing.

2.5.1.2. Inform patient that actual costs may vary from estimates depending on actual services performed or timing issues with other payments affecting the patient’s deductible.

2.5.1.3. If appropriate, ask the patient if they are interested in receiving information regarding payment options.

2.5.1.4. If appropriate, ask the patient if they are interested in receiving information regarding the provider’s financial assistance programs.

2.5.2. **Prior balance discussions:**

*Note:* Balance resolution discussion occurs on prior balances that are being pursued for collection by provider, collection agency or other organization. There will be many scenarios where patients will not have prior balances.

2.5.2.1. Discuss with patient the services that led to the prior balance, including the dates of service and the resulting prior balance. Upon the patient’s request, provide the patient a written list of the services provided, dates of service and the resulting prior balance.

2.5.2.2. If appropriate, ask the patient if they are interested in receiving information regarding payment options.

2.5.2.3. If appropriate, ask the patient if they are interested in receiving information regarding the provider’s supportive financial assistance programs.

2.5.2.4. Proactively attempt to resolve prior balances through insurance and financial assistance programs.

2.6. **Balance resolution:** Once the provider organization has fulfilled the best practice steps as outlined above, it is appropriate to inquire about how the patient would like to resolve the balance for the current service and any prior balance the patient may have, as well as informing the patient of the timing of collection activity.

2.7. **Summary of care documentation:** During the registration or discharge process, the patient will receive in writing, information regarding the provider’s supportive financial assistance programs, and a summary of the potential financial implications for the services rendered, including a phone number to call with questions.

3. **Section 3—Advance of Service**

3.1. **Discussion participants:** Appropriately trained provider representatives will have these discussions with the patient or guarantor. Patient should be given the opportunity to request a patient advocate, designee or family member to assist them in these discussions.
3.2. **Setting for discussion:** Discussions will occur using the most appropriate means of communication for the patient. These discussions may take place via:
- Outbound contact to patient in advance of a scheduled service.
- Inbound contact from patient inquiring about their upcoming service.
- Scheduling / Contact center when appointment is made.

3.3. **Timing of discussion:** A reasonable attempt will be made for discussions with patients to occur as early as possible, taking place before a financial obligation is incurred up to the point at which care is provided. Timely discussions will ensure patients understand their financial obligation and providers are aware of the patient’s ability to pay and/or source of payment.

3.4. **Registration, insurance verification, and financial counseling discussions:** Provider organizations will maintain a thread of pre-registration discussions that occurred with the patient. If pre-registration discussions took place, these discussions will not occur again.

3.4.1. **Registration:** The provider organization will first gather basic registration information including demographics, insurance coverage, as well as determining the potential need for financial assistance.

3.4.2. **Insurance verification:** The provider organization will review insurance eligibility with the patient to ensure information accuracy. Uninsured patients will be informed the goal of collecting information is to identify paying solutions or financial assistance options that may assist them with their obligations for this visit.

3.4.3. **Financial counseling:** If appropriate, patient is referred to a financial counselor and/or offered information regarding the provider’s financial counseling services and assistance policies.

3.5. **Provision of care:** Provider organizations will have clear policies on how to interact with patients with prior balances choosing to have elective or non-elective procedures. They will also have clear definitions for elective and non-elective procedures. These policies will be made available to the public.

3.5.1. **Elective services (As defined by the provider):**

3.5.1.1. **Patient share discussions:** Patients have the obligation to make satisfactory payment arrangements before receiving care.

3.5.1.2. **Prior balance discussions:** Patients with prior balances will be informed by the provider organization if the provider’s policies regarding prior balances mean the service will be deferred.

3.5.2. **Non-elective services (As defined by the provider):**

3.5.2.1. Patients will be informed that ability to resolve patient share or any prior balances will not affect provision of care.

3.6. **Patient share and prior balance discussions:** Interactions will not interfere with patient care, and will focus on patient education. During patient share and prior balance discussions, the provider representative will:
3.6.1. **Patient share discussions:**

3.6.1.1. Provide a list of the types of service providers that typically participate in the service both verbally and if the patient requests, in writing.

3.6.1.2. Inform patient that actual costs may vary from estimates depending on actual services performed or timing issues with other payments affecting the patient’s deductible.

3.6.1.3. If appropriate, ask the patient if they are interested in receiving information regarding payment options.

3.6.1.4. If appropriate, ask the patient if they are interested in receiving information regarding the provider’s financial assistance programs.

3.6.2. **Prior balance interactions discussions:**

*Note:* Balance resolution discussion occurs on prior balances that are being pursued for collection by provider, collection agency or other organization. There will be many scenarios where patients will not have prior balances.

3.6.2.1. Discuss with patient the services that led to the prior balance, including the dates of service and the resulting prior balance. Upon the patient’s request, provide the patient a written list of the services provided, dates of service and the resulting prior balance.

3.6.2.2. If appropriate, ask the patient if they are interested in receiving information regarding payment options.

3.6.2.3. If appropriate, ask the patient if they are interested in receiving information regarding the provider’s supportive financial assistance programs.

3.6.2.4. Proactively attempt to resolve prior balances through insurance and financial assistance programs.

3.7. **Balance resolution:** Once the provider organization has fulfilled the best practice steps as outlined above, it is appropriate to inquire about how the patient would like to resolve the balance for the current service and any prior balance the patient may have, as well as informing the patient of the timing of collection activity.

4. **Section 4—All Settings**

4.1. Compassion, patient advocacy and education should be part of all patient discussions.

4.2. Providers should have standard language to guide staff on the most common types of patient financial discussions.

4.3. Where appropriate, provider organizations should utilize face-to-face discussions to facilitate one-time resolution.
4.4. Availability of supportive financial assistance should be communicated to patients. Provider organizations should communicate and make financially supportive policies available to the community.

4.5. Service provider should take initiative to communicate with patient.

4.6. All personnel engaging in patient financial discussions (e.g., registration staff, financial counselors, financial clearance representatives and customer service staff) will receive annual training on the following:

- Patient Financial Communications Best Practices
- Financial assistance policies
- Common coverage solutions for the uninsured and underinsured
- Customer service

4.7. Provider organizations should ensure broader education and awareness of the PFI Best Practices throughout their organization.

4.8. Provider organization should include the perspective of a patient when developing standard language used in patient financial discussions.

4.9. Providers should regularly survey their patients to assess performance against the PF Best Practices. Results should be shared with staff and leadership for continuous improvement opportunities.

4.10. Communication should be understandable by the patient.

4.11. Communication should include verification of patient information (mailing address, phone numbers, email, etc.) and the patients’ preferred methods for future communication.

4.12. Providers should have technology that gives financial representatives up-to-date information about patient balances and financial obligations.

4.13. In all patient financial discussions, patient privacy should be respected and conversations should occur in a location and manner that are sensitive to the patient’s needs.

4.14. Elective procedures should be defined by individual provider organizations to ensure patients are properly informed regarding their financial obligations.

4.15. Providers should have a toll-free number that is widely publicized that patients can call to receive assistance in financial matters and concerns they may have.

4.16. Provider organizations will have clear policies regarding the handling of patients with prior balances. These policies will be made available to the public.

4.17. Patient discussions will focus on steps toward amicable resolution of financial obligations.
Section 5—Measurement Criteria
Following are criteria for evaluating the effectiveness of patient financial communications in a healthcare organization. HFMA offers a recognition program so organizations can demonstrate their implementation of the practices.

1. Training program evaluation
   a. All staff, including Patient Access, Financial Counseling and Customer Service dealing with patient financial discussions should go through training on an annual basis.
   b. Evidence that training occurred is presented to the Executive Leadership Team on an annual basis.
   c. Training can be provided through a variety of forums (e.g. Web-based or in-person).
   d. Training can be provided by qualified resources (internal or external) as deemed appropriate by a designated quality officer (e.g. Compliance, Quality, or Human Resources).
   e. Training must cover:
      i. Patient Financial Communications Best Practices specific to the staff role
      ii. Financial assistance policies
      iii. Available patient financing options
      iv. Alternative solutions for the uninsured
      v. Standard language to be used in patient discussions
      vi. Laws and regulations (e.g. EMTALA, FDCPA, TCPA, etc.) specific to the staff role

2. Process compliance evaluation
   a. Ensure provider organization is compliant with the Best Practices through annual observation, monitoring and tracking of results.
   b. The evaluation will be comprehensive and cover all relevant parts of the Patient Financial Communications Best Practices:
      1. Best Practice Scenario 1 – Patient Financial Communications in the ED
         1. Registration
         2. Patient Share
         3. Prior Balance
      2. Best Practice Scenario 2 – Patient Financial Communications in Advance of Service
         1. Registration
         2. Patient Share
         3. Prior Balance
      3. Best Practice Scenario 3 – Patient Financial Communications at the Time of Service (Outside the ED)
         1. Registration
         2. Patient Share
         3. Prior Balance
      4. Best Practice Scenario 4 - Best Practices for all Patient Financial Interactions
   c. Process compliance evaluation can be performed by any organization independent of the department being audited (e.g. internal audit, compliance, quality or a 3rd party).
   d. A report containing the results of the process evaluation is presented to the Executive Leadership Team on an annual basis.

3. Technology evaluation
   a. Ensure technology is in place to support informing the patient of the following:
      i. Verification of insurance eligibility for current services
      ii. Verification of existing prior balance within organizational control
iii. Estimated cost of the current services and the consumer responsibility portion
   a. A report containing the results of the technology evaluation is presented to the Executive Leadership Team on an annual basis.
   b. The technology evaluation can be performed by any qualified individual or organization (e.g. technology, compliance, quality or a 3rd party).

4. Feedback process and response evaluation
   a. Ensure process is in place to regularly solicit input and receive feedback from key stakeholders in compliance with Patient Financial Communications Best Practices (e.g. community, patient surveys, physicians)
   b. Ensure process is in place to measure and respond to input and feedback received
   c. Ensure provider organization has an escalation process for patient complaint resolution
   d. A report detailing the feedback and response process that is in place and a summary of the feedback and responses that have been exchanged is presented to the Executive Leadership Team on an annual basis.

5. Executive level metrics reporting evaluation
   a. Ensure process is in place to consolidate the reports from the 4 areas listed above into an overall Compliance Report and presented to the executive leadership team on an annual basis.
Price Transparency in Health Care

Report from the HFMA Transparency Task Force
Price Transparency in Health Care

Report from the HFMA Price Transparency Task Force
# HFMA Price Transparency Task Force

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<tr>
<th>Name</th>
<th>Title</th>
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<tbody>
<tr>
<td>Therese Allison</td>
<td>Consumer</td>
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<td>Peter Angood, MD</td>
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<td>Leah Binder</td>
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## Advisory Capacity

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EXECUTIVE SUMMARY

As patients face increased exposure to healthcare costs, they have an urgent need for meaningful and transparent price information. To bring this about, all stakeholders should be committed to providing or using price, quality, safety, and other information that patients and other care purchasers need to make informed healthcare decisions. This report focuses on the issue of price transparency, while affirming the need for that information to be presented in the context of other relevant information. The definitions shown in the sidebar below are used in this report to distinguish among charge, cost, and price, and among different stakeholders and stakeholder interests.

GUIDING PRINCIPLES AND POLICY CONSIDERATIONS

To be effective, price transparency must offer clear information that is readily accessible to patients and enables them to make meaningful comparisons among providers. It will also require a collaborative effort among providers, care purchasers, and payers to identify and develop the information and tools that will be most useful to patients. The following statements represent the task force’s consensus on basic principles that should guide efforts to achieve these goals. These guiding principles informed the task force’s recommendations.

• Price transparency should empower patients and other care purchasers to make meaningful price comparisons prior to receiving care.
• Any form of price transparency should be easy to use and easy to communicate to stakeholders.
• Price transparency information should be paired with other information that defines the value of services for the care purchaser.
• Price transparency should ultimately provide patients with the information they need to understand the total price of their care and what is included in that price.
• Price transparency will require the commitment and active participation of all stakeholders.

Common Definitions

Charge, Cost, and Price

Charge. The dollar amount a provider sets for services rendered before negotiating any discounts. The charge can be different from the amount paid.

Cost. The definition of cost varies by the party incurring the expense:
  • To the patient, cost is the amount payable out of pocket for healthcare services.
  • To the provider, cost is the expense (direct and indirect) incurred to deliver healthcare services to patients.
  • To the insurer, cost is the amount payable to the provider (or reimbursable to the patient) for services rendered.
  • To the employer, cost is the expense related to providing health benefits (premiums or claims paid).

Price. The total amount a provider expects to be paid by payers and patients for healthcare services.

Stakeholders

Care purchaser. Individual or entity that contributes to the purchase of healthcare services.

Payer. An organization that negotiates or sets rates for provider services, collects revenue through premium payments or tax dollars, processes provider claims for service, and pays provider claims using collected premium or tax revenues.

Provider. An entity, organization, or individual that furnishes a healthcare service.

Other Definitions

Out-of-pocket payment. The portion of total payment for medical services and treatment for which the patient is responsible, including copayments, coinsurance, and deductibles.

Price transparency. In health care, readily available information on the price of healthcare services that, together with other information, helps define the value of those services and enables patients and other care purchasers to identify, compare, and choose providers that offer the desired level of value.

Value. The quality of a healthcare service in relation to the total price paid for the service by care purchasers.
The task force also recognizes that price transparency may have unintended consequences that may need to be addressed as greater transparency takes hold. These include the impacts of transparency on price negotiations within the business-to-business marketplace between health plans and providers and on providers’ ability to provide societal benefits.

RECOMMENDATIONS FOR PRICE TRANSPARENCY FRAMEWORKS

Because care purchasers’ information needs and sources vary, the task force recommends different price transparency frameworks for different care purchaser groups.

Insured patients. Health plans should serve as the principal source of price information for their members. Along with other suppliers of price information, health plans should innovate with different frameworks for communicating price information to insured patients.

Transparency tools for insured patients should include some essential elements of price information, including:

- The total estimated price of the service
- A clear indication of whether a particular provider is in the health plan’s network and information on where the patient can try to locate a network provider
- A clear statement of the patient’s estimated out-of-pocket payment responsibility
- Other relevant information related to the provider or the specific service sought (e.g., clinical outcomes, patient safety, or patient satisfaction scores)

Patients should be alerted to the need to seek price information from out-of-network providers. To ensure valid comparisons of provider price information, health plans and other suppliers of such information should make transparent the specific services that are included in the price estimate. The task force also recommends that government agencies should develop similar transparency frameworks for beneficiaries of public programs such as Medicare and Medicaid.

Uninsured and out-of-network patients. The provider should be the principal source of price information for uninsured patients and patients who are seeking care from the provider on an out-of-network basis.

Price transparency frameworks for uninsured and out-of-network patients should reflect the following basic considerations.

- Providers should offer an estimated price for a standard procedure without complications and make clear to the patient how complications or other unforeseen circumstances may increase the price.
- Providers should clearly communicate preservice estimates of prices to uninsured patients and patients seeking care on an out-of-network basis.
- Providers should clearly communicate to patients what services are—and are not—included in a price estimate. If any services that would have significant price implications for the patient are not included in the price estimate, the provider should try to provide information on where the patient could obtain this information.
- Providers should give patients other relevant information (e.g., clinical outcomes, patient safety, or patient satisfaction scores), where available.

Employers. Fully insured employers should continue to use and expand transparency tools that assist their employees in identifying higher-value providers.

Self-funded employers and third-party administrators should work to identify data that will help them shape benefit design, understand their healthcare spending, and provide transparency tools to employees.

Referring clinicians. Referring clinicians should help a patient make informed decisions about treatment plans that best fit the patient’s individual situation. They should also recognize the needs of price-sensitive patients, seeking to identify providers that offer the best price at the patient’s desired level of quality.

CONCLUSION

Patients are assuming greater financial responsibility for their healthcare needs and in turn need information that will allow them to make informed healthcare decisions. Price is not the only information needed to make these decisions, but it is an essential component. Based on the recommendations in this report, the task force calls upon all stakeholders to join in a concerted effort to provide the price information that patients and other care purchasers require.
INTRODUCTION

The movement toward transparency in the U.S. healthcare system has been slow and not entirely steady, posing challenges to patients and other care purchasers, providers, and health plans alike. It is time to build on the successes of early adopters and promote transparency throughout the healthcare system.

To bring this about, all stakeholders should be committed to providing or using price, quality, safety, and other information that patients and other care purchasers need to make informed healthcare decisions. This report focuses on the issue of price transparency, while affirming the need for that information to be presented in the context of other relevant information.

Why transparency matters now. Long an issue for uninsured patients, the lack of price information is becoming a significant issue for insured patients as well. Among those covered by employer-sponsored insurance, employee-cost sharing has been growing quickly.¹

At the time of this report, newly insured patients gaining coverage through the state and federal marketplaces mandated by the Affordable Care Act are also expected to take on high deductibles with what are expected to be the most popular bronze and silver plan options.² As patients face increased exposure to healthcare costs, they have an urgent need for meaningful and transparent price information. Patients are being asked to act as consumers in a marketplace in which price—a fundamental driver of consumer behavior—is often unknown until after the service they purchase has been performed.

Achieving a more transparent system is a multi-stakeholder issue and requires consensus among hospitals, physicians, and other care providers; the pharmaceutical and medical device industries; commercial and governmental payers; employers; patients and consumer advocates; and regulatory agencies to develop a workable, meaningful solution. A task force representing most of these stakeholders came together to produce this report (see a list of task force members on the inside front cover).

Audiences for this report. The primary audience for this report is industry stakeholders in provider, payer, and purchaser settings that this report calls upon to take specific actions to increase the transparency of healthcare prices. This report is also intended for use by other audiences—including federal and state legislators and policy makers, members of the media, and patients—that can benefit from an understanding of the issues and definitions of key terms related to price transparency in their efforts to shape public policy, influence public opinion, provide information on the healthcare system, or seek informed access to healthcare services.
COMMON DEFINITIONS

The following definitions represent the task force’s consensus on distinctions among charge, cost, and price, and among different stakeholders and stakeholder interests. In most instances, comments that offer background information on the defined term or a discussion of the rationale follow each definition.

CHARGE, COST, AND PRICE

**Charge.** The dollar amount a provider sets for services rendered before negotiating any discounts. The charge can be different from the amount paid.

Medicare or Medicaid beneficiaries, privately insured patients, and uninsured patients who qualify for financial assistance rarely pay full charges. Uninsured patients who do not qualify for financial assistance may be asked to pay full charges, but often ultimately pay a lower price. In the absence of accessible, more accurate information on prices, however, charges continue to be used in academic studies, policy reports, and the media as a proxy for price. Indeed, Section 2718 of the Affordable Care Act requires that “[e]ach hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital’s standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act.”

While there has been an historical relationship between charges and prices for healthcare services, that relationship has become less relevant as new payment models have emerged.

For hospitals, several factors have contributed to the widening gap between charges and the prices paid by most patients. The relationship of Medicare outlier payments to charges has put significant upward pressure on charges; as noted in a recent report from the Center for Medicare & Medicaid Services’ Office of Inspector General: “Although hospital charges do not affect the Medicare payment amount on most ... claims, hospital charges directly affect whether a hospital receives an outlier payment and, if so, the amount of payment.”

Upward pressure on charges also resulted from Medicare’s shift to fixed price, diagnosis-related group payments, as providers turned to payment from charge-based indemnity plans to help offset losses on Medicare. As commercial insurers also began to move away from charge-based contracting, even more pressure was put on charges for the remaining payers who still made charge-based payments (in FY12, for example, just under 20 percent of not-for-profit hospitals’ net patient revenues came from percent-of-charges contracts).

There are significant differences between charges and prices, both with respect to hospital services and with respect to services delivered by other providers. Physicians who treat Medicare beneficiaries are paid according to the Medicare physician fee schedule, for example, and negotiate payment rates with health plans for privately insured patients. But billed charges (often described as “standard rates”) for uninsured or out-of-network patients are often significantly higher than the price paid by Medicare or health plans for the same service. In some instances, patients do not even know they have received care from an out-of-network physician until after the fact, as scheduling a procedure at an in-network hospital does not guarantee that physician services received as part of that procedure (which are billed separately) will be in-network.

**Cost.** The definition of cost varies by the party incurring the expense—patient, provider, insurer, or employer.

- **To the patient,** cost is the amount payable out of pocket for healthcare services, which may include deductibles, copayments, coinsurance, amounts payable by the patient for services that are not included in the patient’s benefit design, and amounts “balance billed” by out-of-network providers. Health insurance premiums constitute a separate category of healthcare costs for patients, independent of healthcare service utilization.
- **To the provider,** cost is the expense (direct and indirect) incurred to deliver healthcare services to patients.
- **To the insurer,** cost is the amount payable to the provider (or reimbursable to the patient) for services rendered.
- **To the employer,** cost is the expense related to providing health benefits (premiums or claims paid).

Because the definition of cost varies according to the party in question, this report will minimize the use of the term “cost.” When the term must be used—to describe, for example, the
direct and indirect costs a provider incurs to deliver healthcare services—the party to whom the cost applies will be specified. When referring to the costs incurred by a patient or other care purchaser for healthcare services, this report will use the terms “payment” or “price.”

**Price.** The total amount a provider expects to be paid by payers and patients for healthcare services.

The price of healthcare services often differs depending on whether the patient has insurance coverage or is eligible for financial assistance.

For an insured patient, the price for healthcare services is the rate negotiated for services between the payer and the provider, including any copayments, coinsurance, or deductible due from the insured patient.

For an uninsured patient, price is first determined by eligibility for financial assistance. If the patient qualifies for financial assistance, the price is reduced according to the terms of the provider’s financial assistance policy, provided that the patient works with the provider to supply the documentation necessary to establish financial need.9

If an uninsured patient has the financial means to pay for the services rendered, the price could be as much as the provider’s full charge for the services, although the patient and the provider may negotiate a discount from the charge.

**STAKEHOLDERS**

**Care Purchaser.** Individuals and entities that contribute to the purchase of healthcare services.

In general, the patient is the principal care purchaser. Other important care purchasers include private employers and public-sector healthcare purchasers such as state employee and retiree agencies that contribute to employees’ purchase of health insurance and the cost of actual healthcare claims, including through self-funded health plans.

**Payer.** An organization that negotiates or sets rates for provider services, collects revenue through premium payments or tax dollars, processes provider claims for service, and pays provider claims using collected premium or tax revenues.

Examples include commercial health plans (also known as insurers), third-party health plan administrators, and government programs such as Medicare and Medicaid.

**Provider.** An entity, organization, or individual that furnishes a healthcare service.

Examples of providers include (but are not limited to) hospitals, health systems, physicians and other clinicians, pharmacies, ambulance services, ambulatory surgical centers, rehabilitation centers, and skilled nursing facilities.

Under the healthcare payment system in place at the time of this report, each provider typically prepares its own bill for the patient and the patient’s insurance carrier (if applicable) for the services the provider renders. An inpatient hospital procedure, for example, typically results in a bill from the hospital for the services it provides and a bill from multiple physicians on the hospital’s medical staff (e.g., anesthesiologist, radiologist, surgeon, etc.). If rehabilitation or skilled nursing services are delivered by another provider or providers following the inpatient stay, the provider(s) also bills separately for services rendered. Patients, in other words, may receive different services from different providers, and are typically asked to pay separately for each provider’s services. Also, as not all providers are under contract with insurers, varying payment arrangements are common. New payment methods such as bundled payment and

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**About Balance Billing**

Balance billing occurs when a healthcare provider bills a patient for charges (other than copayments, coinsurance, or any amounts that may remain on the patient’s annual deductible) that exceed the health plan’s payment for a covered service. In-network providers are contractually prohibited from balance billing health plan members, but balance billing by out-of-network providers is common.
population-based payment are encouraging providers to move toward more “all-inclusive” pricing models that combine the services of multiple providers into a single price.

OTHER DEFINITIONS

**Out-of-pocket payment.** The portion of total payment for medical services and treatment for which the patient is responsible, including copayments, coinsurance, and deductibles. Out-of-pocket payment also includes amounts for services that are not included in the patient’s benefit design and amounts for services balance billed by out-of-network providers.

For insured patients, out-of-pocket payment can be affected by a number of variables beyond the copayments, coinsurance, or deductibles specified in the patient’s health plan’s summary of benefits and coverage. The use of an out-of-network provider, for example, can significantly increase the amount of an out-of-pocket payment. Out-of-pocket payment for insured patients thus depends on the specifics of each patient’s benefit design and on the contracting status of the relevant providers.

For uninsured patients, out-of-pocket payment can rise to the full charge for a service, although as noted earlier, patients rarely pay full charges today.

**Price transparency.** In health care, readily available information on the price of healthcare services that, together with other information, helps define the value of those services and enables patients and other care purchasers to identify, compare, and choose providers that offer the desired level of value.

The intended outcome of price transparency is to provide patients and other care purchasers with the information they need to make an informed choice of provider. Price transparency is just one component of the information that care purchasers need to make this choice; the quality and safety of services a provider delivers, for example, are other important components of the information a care purchaser needs.

**Value.** The quality of a healthcare service in relation to the total price paid for the service by care purchasers.

Although the basic definition of value seems straightforward, it is complicated by the fact that value is ultimately the determination of the individual stakeholder. Quality, for example, can comprise elements of access and convenience, patient safety, patient satisfaction, patient experience, adherence to clinical guidelines and evidence-based medicine, and clinical outcomes. Patients will likely weigh these elements differently—one patient may put the highest priority on convenient access, for example, while another may put the highest priority on the provider’s safety record. The price a patient is willing to pay will vary in relationship to the patient’s preferences.

Given that value is the determination of the individual stakeholder, a goal of transparency should be to provide the right information on key elements of price, quality, and other relevant information to enable patients and other care purchasers to choose a provider that best fits their definition of value.
GUIDING PRINCIPLES FOR PRICE TRANSPARENCY

To be effective, price transparency must offer clear information that is readily accessible to patients and enables them to make meaningful comparisons among providers. It will also require a collaborative effort among providers, care purchasers, and payers to identify and develop the information and tools that will be most useful to patients. The following statements represent the task force’s consensus on basic principles that should guide efforts to achieve these goals.

**Principle 1.** Price transparency should empower patients to make meaningful price comparisons prior to receiving care. It should also enable other care purchasers and referring clinicians to identify providers that offer the level of value sought by the care purchaser or the clinician and his or her patient.

**Relevance.** Price transparency is most immediately relevant for healthcare services that can be scheduled in advance, enabling the patient, other care purchaser, or referring clinician to identify providers, therapies, or treatments that offer the desired combination of price and quality. But price transparency is ultimately relevant for all healthcare services. Employers with self-funded health plans, for example, need price information across a provider’s services, as well as prices for pharmaceutical, medical device, and other treatment options, to make informed decisions on benefit design for their employees.

**Differences in information needs.** Patients, other care purchasers (e.g., employers), and referring clinicians are different audiences with different information needs. A patient may be seeking a particular service within a particular budget (with parameters, for example, such as a deductible or copayment or individual financial resources). An employer may be trying to identify providers that can consistently deliver a desired level of value to an insured population. And a referring clinician may be focused primarily on identifying a provider that can best meet the particular clinical needs of the patient within the parameters of the patient’s insurance coverage or ability to pay.

**Principle 2.** Any form of price transparency should be easy to use and easy to communicate to stakeholders.

**Ease of use and access.** Ease of use is most important with respect to individual patients, who in most instances will not have the same in-depth understanding of the healthcare system that other care purchasers do. But all stakeholders should have easy access to the information that will enable them to make informed decisions on provider choice.

**Communication methods.** The manner in which price information is communicated to stakeholders can have a significant impact on how that information is used. Individual patients, for example, may equate low price with low quality. In one study of 1,400 adult employees, price information that was presented through the number of dollar signs (with "$" representing low price and "$$$" representing high price) led a significant number of employees to use low price as a proxy for low quality. But when a star ranking system was used to rate providers as “being careful with my healthcare dollars,” employees in the study were significantly more likely to choose a lower-price provider. Any system of price transparency will likely need to experiment with the most effective means of communicating price information to various audiences.

**Principle 3.** Price transparency information should be paired with other information that defines the value of services for the care purchaser.

**Quality as a component of value.** Price alone is not sufficient to enable patients and other care purchasers to make an informed choice of providers. As noted in this report’s definition of value, information on quality—comprising a range of factors from patient satisfaction and experience to adherence to clinical standards and evidence-based medicine to patient safety and clinical outcomes—is needed to ensure that a provider offers the desired level of value.

**Quality models and metrics.** This report’s focus is on price transparency, but the task force urges organizations involved in defining the quality of healthcare services to seek consensus.
on models and appropriate quality metrics that will provide patients and other care purchasers with ready access to relevant information in addition to price when making their healthcare decisions.

**Principle 4.** Price transparency should ultimately provide patients with the information they need to understand the total price of their care and what is included in that price.

**Effects of fragmentation.** At the time of this report, a dominant fee-for-service payment system has led to fragmentation of healthcare delivery, and a unit of care is typically provider-specific. Patients may need to purchase units of care from multiple providers to treat a condition or have a procedure done. They may also need to pay separately for pharmaceuticals or medical devices. As a result, it can be difficult for patients to obtain price estimates for everything that will be needed as part of the treatment or procedure. A hospital, for example, may be able to provide a price for the services it will render as part of an inpatient procedure, but not for the services of physicians who will be involved in the procedure, for the pharmaceuticals that are prescribed post-discharge, or for a post-acute care facility that provides rehabilitation services.

**Benefits of new payment and care delivery models.** New payment and care delivery methods are beginning to reshape how a unit of care is defined. As an example, the Center for Medicare and Medicaid Innovation, which was created by the Affordable Care Act, has launched a Bundled Payments for Care Improvement initiative that asks providers—including, depending on the model, hospitals, physicians, and post-acute care facilities—to define a single price for a set of services that make up an episode of care. Other initiatives, such as the Pioneer Accountable Care Organization (Pioneer ACO) model, are moving toward population-based payment, which will pay providers in the ACO a certain amount per assigned Medicare beneficiary to manage the care of the ACO’s assigned beneficiary population. Commercial health plans are developing similar models for bundled and population-based payment. If successful, these models should provide patients and other care purchasers with significantly greater clarity on both the services included within a unit of care and the total price for those services.

**Information sources for insured patients.** Health plans have the most comprehensive understanding of price in today’s healthcare marketplace, and are best situated to provide price information to their members. Many health plans already offer tools that provide price and quality information to their members. There are also a growing number of independent vendors that use data from health plans and/or employers in web- and telephonic products to inform employees about price. To provide the most helpful price information, these tools should be tied to the specifics of an individual’s benefit design and include information on applicable copayments, coinsurance, or deductible requirements. They should also assist members in identifying in-network providers and identify any impact that selection of an out-of-network provider is expected to have on the patient’s responsibility for payment.

**Information sources for uninsured patients.** Uninsured patients will likely face a greater challenge obtaining information on the total price of care in today’s marketplace. Many states have enacted legislation that encourages or mandates greater transparency although, to the extent these efforts rely on charge data, they may be of limited usefulness for patients seeking price information. As noted earlier, today’s fragmented healthcare system also makes it difficult for any single provider to furnish prices for all providers, treatments, and therapies that may be involved in caring for a patient, although these capabilities are expected to develop as new payment methods take hold. In the meantime, providers should strive to offer patients assistance in identifying additional providers from whom the patient should seek price information.

**Parameters of price estimates.** Price information will likely take the form of an estimate or price range, given that unexpected complications may increase the price of care. Providers should make clear that they are providing estimated prices for a standard procedure or service, describe what is included in the estimate, and indicate who will pay for any services related to unexpected complications. Some providers have begun to distinguish between avoidable complications, such as a hospital-acquired condition, and unavoidable complications, such as a complication arising from a comorbidity that was not evident prior to a procedure, covering the price of care related to treatment of an avoidable complication.
As providers grow more sophisticated in their pricing capabilities, they should ideally be able to identify common complications associated with a procedure or service, the likelihood of such complications, estimates of the price for treating any such complications, and information on the process by which any significant deviations from the price estimate will be reconciled. In some emerging payment models, such as bundled payment or population-based payment, the risks and associated costs of complications will already be built into the price of care.

**Importance of comparable data.** All care purchasers have a strong interest in better understanding total price of care. Comparable data on price, quality (including readmission and complication rates), and utilization can help identify high-quality, cost-effective providers to help inform patient choice, benefit design decisions, and clinical referrals. Again, in today’s marketplace, health plans are the best source of this data for their enrollees.

**Principle 5.** Price transparency will require the commitment and active participation of all stakeholders.

The healthcare payment system is complex. There are many different sources of price and quality information, many different benefit designs for patients that are insured, and an increasing variety of payment models and quality indicators. Given these complexities, providers, payers, patients, and other care purchasers should work together to define and provide the price and quality information that care purchasers need to make informed provider choices. Transparency efforts should also remain flexible to adapt to changing healthcare payment and delivery models.
While the task force supports greater price transparency, it also recognizes the potential for unintended consequences that may need to be addressed as greater transparency takes hold. This section addresses two significant issues that will require monitoring and, potentially, policy solutions: the impact of transparency on prices in different markets and payment environments and the impact of transparency on the provision of societal benefits.

**POTENTIAL IMPACT OF TRANSPARENCY ON PRICES**

As this report has indicated, price transparency can take a variety of forms depending on such factors as for whom the price information is intended and the information needs of that intended audience. Moreover, a variety of submarkets exist within the broader healthcare marketplace. Most prices for commercially insured patients, for example, are the product of private negotiations between health plans and providers in a business-to-business marketplace. Certain areas of health care are becoming, or already are, more like a retail marketplace, including the market for elective procedures such as Lasik eye surgery or cosmetic surgery. Recent trends in consumer-driven and value-based insurance design are moving “commodity services” such as lab work, imaging, and screening tests, as well as some procedures, more toward a retail model. And new payment models are potentially reshaping how care will be delivered and priced. Price information needs—and the impact of price transparency—might vary significantly among different markets and payment environments.

**TRANSPARENCY IN THE BUSINESS-TO-BUSINESS MARKETPLACE**

Among the unique features of the U.S. healthcare marketplace is the existence of a business-to-business marketplace between providers and private health plans. For a typical hospital, this marketplace determines payments that make up approximately one-third of the hospital’s total revenue.

**Risk of price inflation.** From a consumer perspective, as a general rule, the more transparency the better. But within a business-to-business marketplace, some healthcare economists and the federal antitrust enforcement agencies have noted that public transparency of negotiated rates could actually inflate prices by discouraging private negotiations that can result in lower prices for some buyers. Providers, for example, may have less incentive to offer lower prices to certain payers if they know other payers in the market will demand similar rates. They may also have less incentive to offer lower prices if they think this will set off a price war with other providers in the market. Within the privately insured market, these considerations suggest that an approach to transparency that emphasizes out-of-pocket payments for insured patients instead of full transparency of negotiated rates may be preferable.

**Evidence for price reduction.** In other contexts, evidence suggests that price transparency may help lower prices. This effect has been noted in pilot programs involving reference pricing, one of several payment models that have emerged in recent years as alternatives to fee-for-service payment. Reference pricing sets a limit on the amount that, for example, a large employer with a self-funded plan will pay for healthcare services purchased by its employees. (This price limit establishes the reference price.) The employer communicates to employees a list of the providers who have agreed to accept the reference price (or less) for their services. If an employee chooses a provider who has not accepted the reference price, the employee is responsible for the amount the provider charges above the reference price.

The Safeway chain of grocery stores launched a reference pricing pilot in 2009 to address market variations in price for screening colonoscopies that, in one regional market, varied from $848 to $5,984 for the same procedure. Safeway set a reference price of $1,500 for the facility and provided employees with a list of physicians who used the facilities that charged less than the $1,500 limit. (The physicians were paid according to a uniform fee schedule that had little variation across facilities.) The success of the pilot led to nationwide expansion of the program in 2010, with the reference price reduced to $1,250. If a provider cannot lower its costs for providing a reference-priced service, it may raise its prices on other services to help mitigate the impact of meeting the reference price. Employers and other care purchasers should be sensitive to the potential for cost shifting when focusing on price reductions for a particular service.

**Need for impact monitoring.** The above examples suggest that price transparency may have varying impacts on prices...
depending on such factors as the context in which price transparency is introduced, the means by which price information is communicated to stakeholders, and the nature of the information that is communicated. As the healthcare industry develops frameworks for price transparency, it should remain sensitive to these factors and carefully monitor the impacts on prices of any price transparency frameworks that are introduced into the marketplace.

PROVISION OF SOCIETAL BENEFITS
One goal of price transparency is to make the healthcare system more efficient, encouraging providers to focus on maximizing the efficiency of their operations and reducing their internal cost structure so they can better compete on price. In some instances, however, providers offer services (e.g., a Level I trauma center) or programs (e.g., a strong teaching and research mission) or serve low-income, indigent, or rural populations to address community or societal needs but may not produce a profit or positive margin, regardless of improved efficiencies.18,19

As noted in one analysis of this problem, “until the political system is willing to level the playing field by explicitly paying for under- and unfunded services, market changes such as price transparency and specialization, although beneficial in their own right, could have severe negative consequences.”20 This is not an argument against price transparency, but a reminder that any system of price transparency should be implemented with full awareness of these potential consequences, which may require policy solutions to ensure the continued provision of services such as those described above.
RECOMMENDATIONS FOR PRICE TRANSPARENCY FRAMEWORKS

While all care purchasers share a common need for greater price transparency, the framework for different care purchasers varies according to such factors as the most important information needed and the source of that information. This section outlines the task force’s recommendations for price transparency frameworks for different groups of care purchasers.

PRICE TRANSPARENCY FOR PATIENTS

Recommendation 1. Because health plans will, in most instances, have the most accurate data on prices for their members, they should serve as the principal source of price information for their members.

As noted earlier in this report, many health plans have already developed or are in the process of developing web-based or telephonic transparency tools for their members. These tools have the potential to benefit both patients and health plans, providing patients with needed information while strengthening the health plan’s value to its members. Employers with self-funded health plans have the option of working with health plans (which often serve as third-party administrators for self-funded plans) or other vendors in developing transparency tools for insured employees and their dependents.

Recommendation 2. Health plans and other suppliers of price information should innovate with different frameworks for communicating price information to insured patients.

Health plans and other transparency tool vendors should be encouraged to continue to innovate with different transparency frameworks to see which are the most effective in communicating with patients.

Recommendation 3. Transparency tools for insured patients should include some essential elements of price information.

Building on the features of existing price transparency tools, essential elements of price information for insured patients include the total estimated price of the service, the provider’s network status, and the patient’s estimated out-of-pocket responsibility, along with other available provider- and service-specific information.

Total estimated price of the service. This is the amount for which the patient is responsible plus the amount that will be paid by the health plan or, for self-funded plans, the employer. The amount will necessarily be an estimate for several reasons. The patient, for example, may use additional services not included in the estimate or the physician may code and bill for a service different from the service for which the patient sought an estimate.

The price estimate for in-network services is a communication between the health plan and the insured patient and should follow the form of an explanation of benefits, representing the total estimated price (i.e., the plan’s negotiated rate for the service) as a dollar amount, not as a percent discount from charges, to avoid confusing the patient. For services received from out-of-network providers, because the provider’s pricing information is not available to the health plan, the health plan can only provide information about the benefit structure for that type of out-of-network care (e.g., a 20 percent co-insurance obligation).

Network status. The tool should provide a clear indication of whether a particular provider is in network and information on where the patient can try to locate an in-network provider, such as a list of in-network providers that offer the service.

Out-of-pocket responsibility. Another essential element is a clear statement of the patient’s estimated resulting out-of-pocket payment responsibility, tied to the specifics of the patient’s health plan benefit design, including coinsurance and the amount of deductible remaining to be met (as close to real time as possible).

Other relevant information. Information related to the provider or the specific service sought (e.g., clinical outcomes, patient safety, or satisfaction scores) should be included where it is available and applicable. This information should clearly communicate what has been measured and to whom the measurement pertains (e.g., to the facility, the physician, etc.).
Recommendation 4. Insured patients should be alerted to the need to seek price information from out-of-network providers.

The price of healthcare services for an insured patient can vary significantly depending on whether the services are provided by an in-network or an out-of-network provider. If a provider is out-of-network, the patient may face a higher coinsurance payment or be responsible for the out-of-network provider’s entire bill, depending on the patient’s benefit design. This issue can arise in a variety of situations, as described below.

Intentional. If a patient seeks care from an out-of-network provider (based, for example, on that provider’s reputation) and contacts the health plan for assistance, the health plan should continue to clearly explain what percentage (if any) of out-of-network provider charges the plan will cover, and describe any other significant out-of-network benefit plan issues (e.g., a “reasonable and customary rate of reimbursement” limit on what the health plan will pay). The health plan should also inform the patient that—if the patient intentionally seeks care from an out-of-network provider—it is the patient’s responsibility to independently obtain price information from that provider.

Inadvertent. In another situation, a patient may schedule a procedure at an in-network provider but receive services as part of that procedure from an out-of-network provider. A typical example is a patient who chooses an in-network hospital or ambulatory surgical center for the procedure but receives services from an out-of-network provider (such as a pathologist, radiologist, or anesthesiologist). In this case, the in-network provider should, to the extent possible, inform the patient of the need to also check the network status of physicians who will be involved in the procedure.

For example, if the in-network provider furnishes a pre-service estimate to the patient, the estimate should note that individual physician services will be billed separately and that the patient should confirm the network status of the physicians. The in-network provider may not know which individual physicians will be providing services to the patient during the procedure, but will typically know which medical groups have been engaged to provide these services. The patient should be provided with the names of these medical groups so the patient can confirm the groups’ network status with his or her health plan and understand the possible financial implications in advance of the procedure.

Emergency. In a third situation, a patient needs emergency medical care and is taken to the nearest emergency department. The patient will have no advance opportunity to identify the network status of any providers involved in his or her emergency care. This is a situation that may well need a policy solution to balance the interests of patients, health plans, and providers.

Recommendation 5. To ensure valid comparisons of provider price information, health plans and other suppliers of such information should make transparent the specific services that are included in the price estimate.

Suppliers of price information should make sure that price estimates are accompanied by explanations of what services are included in such estimates, as well as the impact of differences in network status on such estimates, to help patients make valid comparisons among providers. For example, when comparing prices associated with receiving an imaging service, the patient should be informed if the estimate includes the facility costs associated with taking the image and the radiologist’s fee for the professional reading.

Recommendation 6. The provider should be the principal source of price information for uninsured patients and patients who are seeking care from the provider on an out-of-network basis.

Price transparency for the uninsured is subject to a substantial and expanding number of laws at both the federal and state levels and it is the first responsibility of providers to ensure that policies and practices adhere to these legal requirements. Regardless of legal requirements, however, it is in a provider’s best interest to be proactive in its approach to price transparency. A growing number of patients face significant financial responsibility for healthcare services and are becoming increasingly price sensitive. As consumer price sensitivity has intensified, so too has media attention to healthcare prices. Providers that can speak accurately and confidently about their prices will be
better positioned to succeed in this environment than providers that can only refer back to their charge schedule.

**Recommendation 7.** Providers should develop price transparency frameworks for uninsured patients and patients receiving care out of network that reflect several basic considerations.

There are several basic considerations that providers should take into account when developing price transparency frameworks.

**Clarify the limitations of the estimate.** Prices in most instances will take the form of an estimate; that is, provide a price for a standard procedure without complications and make clear to the patient the services included in the price and how complications or other unforeseen circumstances may increase the price. New payment models such as bundled payment, described earlier in this report, may enable providers to set firm prices for certain procedures. As noted, some providers are covering the price of care related to avoidable complications within the provider’s control so that the estimated price to the patient does not increase in these situations.

**Serve as the primary price information resource for these groups.** Providers should clearly communicate preservice estimates of prices to uninsured patients and patients seeking care on an out-of-network basis. Federal and state laws define basic requirements for communicating prices to patients who are eligible for financial assistance. Beyond that, the provider should, at a minimum, offer clear information on how a patient can obtain price estimates and ensure that the patient can easily reach someone who can address such requests.

Providers should consider which approaches are most useful in providing information to uninsured patients in their markets, including the possible use of web and mobile technologies to respond to queries from an uninsured patient or provide information about the price of a particular service. A national steering committee of experts including patients, hospitals, physicians, payers, and others have developed a set of patient financial communication best practices (available at hfma.org/communications) that providers should refer to when developing or reviewing their patient communication practices.

**Identify inclusions and exclusions.** Providers should clearly communicate to patients what services are and are not included in a price estimate. If any services that would have significant price implications for the patient are not included in the price estimate, the provider should try to provide information on where the patient could obtain this information.

**Offer other relevant information.** Providers should give patients other relevant information, where available. The task force notes that some states have begun to make both price and quality data available on public websites and encourages all states to furnish such information on providers. A number of public and private organizations also offer public access to data on patient outcomes, safety, and patient satisfaction or credentialing information on providers who have met certain quality benchmarks. The price estimate that a provider gives to patients can reference and provide links to various reliable websites where the provider knows relevant information is available.

**Recommendation 8.** Transparency tools for beneficiaries in Medicare health plans or Medicaid managed care programs should follow this task force’s recommendations for patients with private or employer-sponsored insurance coverage.

Beneficiaries of federal and state healthcare programs, including Medicare and Medicaid, will have different sources for price information depending, for example, on the Medicare option they have chosen (e.g., traditional Medicare or Medicare Advantage) or the structure of Medicaid within their state (e.g., whether the state has a Medicaid managed care plan).

For Medicare beneficiaries enrolled in Medicare Advantage or another Medicare health plan, and for Medicaid beneficiaries in a Medicaid managed care program, the health plan or company administering the program will be the best source of price information. Medicare health plans and companies administering Medicaid managed care programs should provide beneficiaries with transparency information and tools similar to those described for patients with private or employer-sponsored insurance coverage on page 13.
Recommendation 9. The Centers for Medicare & Medicaid Services and state administrators of Medicaid programs should develop user-friendly price transparency tools for traditional Medicare and Medicaid beneficiaries.

Traditional Medicare beneficiaries pay a percentage of Medicare-approved amounts for many healthcare services and also are responsible for certain deductibles (e.g., the Part B deductible) and payments for certain prescription drugs and medical devices and supplies. The Centers for Medicare & Medicaid Services (CMS) has taken steps toward greater quality transparency through its Hospital Compare website (www.medicare.gov/hospitalcompare).

The task force urges CMS to add user-friendly price transparency functions to the website, similar to those that are being developed by health plans, to assist traditional Medicare beneficiaries in better understanding their out-of-pocket responsibilities and to assist them in locating high-value providers. Although information on Medicare-approved payments is publicly available, the task force notes that this information in its current format can be difficult for Medicare beneficiaries to locate and understand.

Recommendation 10. To supplement information provided by CMS and state administrators of Medicaid programs, providers should offer information on out-of-pocket payment responsibilities to traditional Medicare and Medicaid beneficiaries upon a beneficiary’s request.

While CMS is developing price information and tools, traditional Medicare beneficiaries should contact providers for information on their out-of-pocket payment responsibilities for scheduled services. Medicaid beneficiaries who are not in a Medicaid managed care program should also contact providers for information on their out-of-pocket payment responsibilities.

PRICE TRANSPARENCY FOR EMPLOYERS

Employers’ transparency needs include helping employees understand, first, what their out-of-pocket payments will be under an employer-sponsored health plan and, second, how much the employer is paying for employees’ care.

State-Supported Transparency Website Recommendations

Public, state-supported websites that provide information on the price and quality of care for providers within a state can provide a valuable resource, especially for uninsured patients who do not have access to transparency tools offered by health plans or other transparency vendors, and for patients who are seeking care at an out-of-network provider.

Consistent with the task force’s overall guidance and recommendations, the task force recommends that state-supported transparency websites should:

- Enable patients to make meaningful price comparisons among providers prior to receiving care
- Be easy for patients to access and use
- Experiment with the most effective means of communicating price information to patients
- Pair price information with other information comprising a range of factors (e.g., patient satisfaction and experience, provider compliance with clinical standards and evidence-based medicine, patient safety, and clinical outcomes) to help patients identify providers that offer the desired level of value
- Emphasize, to the extent data are available, the average amount paid for services instead of the average amount charged
- Conform with the U.S. Department of Justice and Federal Trade Commission’s Statements of Antitrust Enforcement Policy in Health Care

In particular, if the price information offered on a state-supported transparency website is based in whole or in part on prices negotiated between health plans and providers, that information must be sufficiently aggregated so that recipients of the information cannot identify specific negotiated prices.
Recommendation 11. Fully insured employers should continue to use and expand transparency tools that assist their employees in identifying higher-value providers.

The task force agrees that the framework for employer price transparency will vary depending on whether the employer offers its employees a fully-insured or a self-insured plan. When an employer purchases health insurance for its employees from a health plan (fully insured), it does not need to know the rates negotiated between the health plan and providers. Employers in this instance should, however, expect that the health plan will provide its employees with transparency tools that enable employees to understand their out-of-pocket payment responsibilities and provide price, quality, and other relevant information that help employees identify higher-value providers.

Recommendation 12. Self-funded employers and third-party administrators (TPAs) should work to identify data that will help them shape benefit design, understand their healthcare spending, and provide transparency tools to employees.

Employers that offer their employees self-funded plans directly pay the claims for their employees’ care. A self-funded employer may use a health plan or other third-party administrator to administer the plan, but the employer bears the risk. In this instance, employers and TPAs should identify information that can help the employer make informed decisions on benefit design for its employees, understand how its funds are being spent, and provide transparency tools for its employees.

PRICE TRANSPARENCY FOR REFERRING CLINICIANS

Clinicians who refer patients for diagnostic testing, specialist or acute care, or other healthcare services can play a significant role in communicating price information to patients. There are indications that clinicians are increasingly willing to take on this role. The results of a Bain & Company survey from 2011 indicated that more than 80 percent of physicians “agree” or “strongly agree” that bringing healthcare costs under control is part of their responsibility. Other studies suggest that presenting physicians with price information leads them toward more careful consideration of the need for tests, although, as appropriate, information on the quality of patient care is the main driver of clinician decisions. As discussed below, changes in payment and care delivery have begun and should continue to encourage clinicians to make use of this information.

Recommendation 13. Referring clinicians should help patients make informed decisions about treatment plans that best fit the patient’s individual situation. They should also recognize the needs of price-sensitive patients, seeking to identify providers that offer the best price at the patient’s desired level of quality.

Most clinicians will encounter more price-sensitive patients as exposure to higher deductibles and other forms of patient cost-sharing increases. At the time of this report, resources such as the Choosing Wisely campaign (www.choosingwisely.org), a collaborative effort of more than 50 specialty societies, are helping clinicians and their patients make informed decisions about appropriate treatment plans to meet the patient’s individual situation.

When a treatment plan has been decided upon, clinicians will need price information to help their patients find providers that best meet the patient’s clinical and financial needs. For insured patients, the clinician will typically want to refer the patient to his or her health plan as the best source of information. To address the needs of uninsured patients, clinicians should request that providers to whom they refer patients make price information available to help in referral decisions. In non-emergent situations, the clinician should provide the patient with a list of providers so that the patient can obtain and compare price information from them before the referral decision is made.

Clinicians who assume some degree of financial risk for managing a patient’s total cost of care under new payment models (including shared savings models and global or capitated payment models) may need some information on the cost of care provided by others treating that patient. The specific information required will depend on the type of financial risk assumed by the clinician, the ways in which attribution is handled, and the clinician’s relationship with other providers delivering care (e.g., whether they are part of the same ACO). The relevant stakeholders should determine the best way to ensure that clinicians have the information necessary for making such decisions.
CONCLUSION

The lack of price transparency in health care threatens to erode public trust in our healthcare system, but this erosion can be stopped. Patients are assuming greater financial responsibility for their healthcare needs and in turn need the information that will allow them to make informed healthcare decisions. Price is not the only information needed to make these decisions; as this report has noted, price must be presented in the context of other relevant information on the quality of care. But it is an essential component. The time for price transparency in health care is now.

The work of this task force is highly encouraging. Stakeholders representing the distinct and at times disparate perspectives of patients, providers, payers, and employers have engaged in frank and constructive discussions of stakeholder needs and capabilities and have reached consensus on specific recommendations to achieve a more transparent healthcare pricing system. But this report is only a starting point: It is now incumbent upon all industry stakeholders to act on these recommendations in a concerted effort to provide the price information that will give patients the ability to make informed care decisions and, in the process, continue to earn their trust.
ENDNOTES

1. The percentage of workers enrolled in an employer-sponsored plan with an annual deductible of $1,000 for individual coverage grew from 19 percent to 38 percent from 2006 to 2013 for firms of all sizes. At smaller firms (employing 3 to 199 workers), the growth was even more dramatic, going from 16 percent to 58 percent within the same time period. See Kaiser Family Foundation, 2013 Employer Health Benefits Survey, Aug. 20, 2013. Available at kff.org/report-section/2013-summary-of-findings.

2. As of Feb. 1, 2014, the Department of Health and Human Services’ Office of the Assistant Secretary for Planning and Evaluation (ASPE) indicated that 62 percent of enrollees on the marketplaces selected silver plans, 19 percent selected bronze plans, 12 percent selected gold plans, and 7 percent selected platinum plans. An additional 1 percent selected catastrophic coverage. See ASPE Issue Brief, Health Insurance Marketplace: February Enrollment Report, Feb. 12, 2014. An analysis of plans offered on the marketplace in six states indicated that, for a non-subsidized silver plan, the average deductible is $2,590 (reflecting a range of $1,500 to $5,000 in the plans studied). See Avalere Health, Despite Lower Than Expected Premiums, Exchange Consumers Will Face High Cost-Sharing Before the Out-of-Pocket Cap, Oct. 1, 2013.

3. For example, the U.S. Government Accountability Office (GAO) sought price information on selected procedures from 39 providers (19 hospitals and 20 primary care physician offices) as part of a 2011 report on healthcare price transparency. Of those providers that were willing to provide a price estimate for a full knee replacement surgery, the estimate ranged from about $33,000 to about $101,000. See GAO, Health Care Price Transparency: Meaningful Price Information Is Difficult for Consumers to Obtain Prior to Receiving Care, Sept. 2011.

4. As explained in the “Common Definitions” section of this report, there is a critical distinction between charges (the dollar amount a provider sets for services rendered before negotiating any discounts) and prices (the total amount a provider expects to be paid). See pages 5 and 6 of this report.

5. At the Dec. 12, 2013, public meeting of the Medicare Payment Advisory Commission (MedPAC), MedPAC staff noted that overall Medicare margins for hospital inpatient and outpatient services from 2011 to 2012 remained steady at minus 5.4 percent. MedPAC staff also noted that, if current law remains in effect, they expect that even more efficient providers will have negative margins on Medicare payments by 2015. See pp. 67–71 of the meeting transcript at www.medpac.gov/meeting_search.cfm?SelectedDate=2013-12-12%2000:00:00.0

6. For example, a study of actual prices paid by uninsured patients in California hospitals from 2001 to 2005 showed that they paid prices similar to those of Medicare patients. See Melnick, G. A., and Fonkych, K., “Hospital Pricing and the Uninsured: Do the Uninsured Pay Higher Prices?” Health Affairs, March–April 2008, pp. w116–w122.


9. Note that section 501(r) of the Internal Revenue Code, which was added by the Affordable Care Act, limits the price that not-for-profit hospital organizations can request for emergency or other medically necessary care provided to an uninsured patient who qualifies for financial assistance to no more than amounts generally billed to insured patients for these services.


12. The National Conference of State Legislatures, for example, has identified 31 states that have enacted legislation regarding transparency and disclosure of health costs. See www.ncsl.org/research/health/transparency-and-disclosure-health-costs.aspx.

13. Since 2008, the Centers for Medicare & Medicaid Services has identified categories of hospital-acquired conditions for which extra payment is denied if the condition is acquired during hospitalization.

14. Geisinger’s ProvenCare model, for example, covers the price of any follow-up care if a patient eligible for a ProvenCare procedure experiences an avoidable complication within 90 days of the procedure.

15. For a summary of the federal antitrust agencies’ concerns regarding provider exchanges of price information, see the U.S. Department of Justice and Federal Trade Commission, Statements of Antitrust Enforcement Policy in Health Care, Statement 6, Aug. 1996.


19. For an analysis of the costs to academic medical centers and teaching hospitals of maintaining their teaching and research missions, as well as providing standby capacity for medically complex patients, see L. Koenig, A. Dobson, S. Ho, et al., “Estimating the Mission-Related Costs of Teaching Hospitals,” Health Affairs, Nov. 2003, pp. 112-122.


21. A provider has a similar and important responsibility to alert patients or potential patients if the provider knows it is not in the patient’s network.

22. A number of states have attempted policy solutions for this issue. For an overview of the different approaches and their strengths and weaknesses, see Hoadley, J., Lucia, K., and Schwartz, S., Unexpected Charges: What States Are Doing About Balance Billing, California HealthCare Foundation, April 2009.

23. Price estimates for home remodeling provide a useful comparison, in that they can involve a significant financial commitment and are subject to any unknown complications unique to the home (e.g., presence of asbestos or defective plumbing) that may arise after remodeling begins.


25. In a controlled study at The Johns Hopkins Hospital, clinicians (physicians and nonphysicians) who ordered lab tests through a computerized physician order entry system (CPOE) showed a decrease in the number of tests per patient day ordered when fee data for the test was presented in the CPOE. See Feldman, L.S., Shihab, H.M., Thiemann, D., et al., “Impact of Providing Fee Data on Laboratory Test Ordering: A Controlled Clinical Trial,” JAMA Internal Medicine, May 27, 2013, pp. 903-908.

26. A study of California physicians participating in capitated health plans indicated that while physicians are willing to refer patients to more distant hospitals for a lower price with similar quality, they are not willing to accept lower quality for a lower price. See Ho, K., and Pakes, A., Hospital Choices, Hospital Prices and Financial Incentives to Physicians, National Bureau of Economic Research Working Paper No. 19333, Aug. 2013.
PARTICIPATING ORGANIZATIONS

HFMA wishes to thank these organizations for their participation in the development of this report.
With more than 40,000 members, HFMA is the nation’s premier membership organization for healthcare finance leaders. HFMA builds and supports coalitions with other healthcare associations and industry groups to achieve consensus on solutions for the challenges the U.S. healthcare system faces today. Working with a broad cross-section of stakeholders, HFMA identifies gaps throughout the healthcare delivery system and bridges them through the establishment and sharing of knowledge and best practices. Our mission is to lead the financial management of health care.
Understanding Healthcare Prices:
A Consumer Guide

Courtesy Healthcare Financial Management Association
Understanding Healthcare Prices: A Consumer Guide
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If you’re like many Americans, you don’t know what an emergency department visit or an operation costs until a bill from a healthcare provider or a letter from your health insurance plan comes in the mail. We realize this uncertainty can be stressful and can make it hard to plan your personal or household finances. That’s why we developed this guide. This guide can help you if:

▶ You want to know where to get answers to your questions about healthcare prices
▶ You would like to compare prices for a particular service among providers
▶ You want to better understand, plan, and manage your out-of-pocket healthcare costs
▶ You are covered by a high-deductible health plan

PRICE MATTERS. From the smallest purchases, like a package of gum, to the biggest ones, like a car or a house, you typically know what things cost before you buy them. But when it comes to health care, knowing your cost up front is not always easy. Estimating how much it will cost to “fix” a person will never be like estimating the cost of fixing a refrigerator. It’s not always easy to predict what is needed to treat an illness or restore a person’s health.

But knowing the price you will be expected to pay for your care is more important today than ever. Health plans are designed to include more cost-sharing with their members than they were years ago. One purpose of cost-sharing is to encourage people to make better healthcare choices. When consumers share the cost of their health care, they may be less likely to choose care that is of limited benefit to them.
QUALITY MATTERS TOO. Of course, the price of health care is not the only consideration. Although this guide focuses on prices, learning about the quality of your health care is critical as well. Price does not necessarily relate to the quality of care. More expensive does not mean better care!

PRICE IS LINKED TO INSURANCE COVERAGE. The price you pay for a healthcare service depends on the health insurance you have, for several reasons.

First, if you have insurance, you and your health plan share your healthcare costs. The specifics of your health plan coverage, including your deductible, copayment, and coinsurance, determine how much of your healthcare costs you will pay, and how much your health plan pays.

Second, health plans have different networks of doctor, hospitals, and other healthcare professionals. When you choose a doctor or hospital, you will want to know if the providers you are considering are in your health plan’s network. And you’ll want to know how your out-of-pocket costs will be affected if you use an out-of-network provider. When you receive care from a network doctor or hospital, you typically pay a lower price. If you go out of the network, you usually have to pay a higher price. (Read more about this on page 11.) Your health plan can provide more information.

Finally, your health plan may have price information for many different providers in your network. A hospital can provide information about its own prices but it usually doesn’t have price information for other hospitals or the services of other providers who may be involved in your care.

It’s easy to see that healthcare pricing can be complicated. So what questions should you ask to get a price estimate? And who has the answers? Read on.

Making Informed Healthcare Choices

In health care, more is not always better. For example, sometimes it’s a better choice to wait and see if a health problem, such as back pain, improves on its own or with medication. In general, if your doctor recommends surgery, consider visiting another doctor to get a second opinion and consider your alternatives.

Overall, it’s important to work closely with your doctor to choose care that is supported by evidence showing it works for patients like you, does not repeat other tests or procedures you have already received, won’t harm you, and is truly necessary. That’s how Choosing Wisely®, a group effort by more than 50 medical specialty societies, defines wise treatment choices. Visit www.choosingwisely.org, for tools that will help you talk with your doctor and make better decisions about situations ranging from allergy testing to end-of-life care.
For Consumers with Health Insurance Coverage

For purposes of this guide, health insurance is a category that includes everyone who is covered under a health insurance plan that’s not sponsored by a government agency. Many people under age 65 get health insurance through an employer. Others buy their own insurance through the individual insurance market or the new Insurance Marketplace (also known as insurance exchange) created by the Affordable Care Act, the national healthcare reform law.

Your health insurance plan can be a resource for information about healthcare prices. This section of the report is designed to help you work with your doctor and your health plan to get price information.

How to Get an Estimate When You Can Plan Ahead

Situations when you can schedule healthcare services ahead of time offer the best opportunities to take financial considerations into account. For example, you can plan ahead when you choose to have elective surgery, such as a knee replacement. In those situations, start by asking your doctor for specific information about the care you will receive before you request an estimate.

GET THE SPECIFICS. When you visit the doctor, ask for the technical name of the procedure you will be having, the insurance codes, a list of tests you may need beforehand, and information about follow-up care that is likely to be needed afterward. For example, ask whether you are likely to need care in a rehabilitation unit or facility before you’re ready to return home, or whether you will need physical therapy or occupational therapy after your surgery. Sometimes, the only follow-up care needed is a visit to the doctor. (See the list on page 6 for more examples of questions to ask your doctor.)

Insurance Codes: What You Need to Know

Your healthcare providers and your health insurance plan use several types of codes to communicate with each other about payment. The codes are designed to make sure that billing and payment are handled the right way. To get a price estimate, you should have the following code information:

- **ICD-9 or ICD-10 code.** The International Classification of Diseases codes identify your health condition or diagnosis. For example, 250.0 means diabetes with no complications; 493.0 is the ICD-9 code for asthma.

- **CPT® code.** Current Procedural Terminology (CPT) codes are numbers that are often used on medical bills to identify the charge for each service and procedure billed by a provider to you and/or your health insurance plan. For example, the six CPT codes 99460–99465 are for newborn care services; 99281–99288 are CPT codes for emergency department services.

- **HCPCS code (say “Hickpicks”).** Medicare uses these codes in place of CPT codes. If you don’t have Medicare, you don’t need to know these codes.

Before you ask your health insurance plan for a price estimate, ask your provider to supply the code numbers that relate to the service or procedure you plan to receive. In many instances, the exact code is not known until the procedure is performed. Because thousands of codes are in use, the codes may not be available at the time of your request. Your doctor or hospital may need to follow up with you to provide this information.

Also, few of the online price information tools available today include price information for all of these codes. Often, online information is available only for common tests and procedures.
Questions to Ask Your Doctor Before Elective Surgery

Imagine that your friend Mary has been diagnosed with gall stones. She has already talked with her doctor about her treatment options. Together, Mary and her doctor decide that Mary’s gall bladder should be removed sometime in the next few weeks. Her doctor could perform the surgery at one of two hospitals in the area. He says they are both “good hospitals” and he’ll schedule the surgery as soon as he gets the go-ahead from Mary. You know that Mary is almost as worried about the effect on her budget as she is about the surgery itself. How can Mary find out what her out-of-pocket cost will be? Here are some questions Mary can ask her doctor before she contacts her health plan for an estimate.

<table>
<thead>
<tr>
<th>Question</th>
<th>Likely Answers</th>
<th>Tips</th>
</tr>
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<tbody>
<tr>
<td>What is the exact name of the procedure?</td>
<td>Laparoscopic cholecystectomy</td>
<td>Ask the doctor to clearly print the name of the procedure. Correct spelling is important and many surgery names sound similar.</td>
</tr>
<tr>
<td>What ICD-9 or ICD-10 codes will be used?</td>
<td>One or more codes</td>
<td>Your health plan pays healthcare providers based on these diagnosis codes, which the doctor’s office or hospital will provide to them. The coding system will eventually be updated from ICD-9 to ICD-10, which is much more detailed than ICD-9. At that time, the code numbers will change.</td>
</tr>
<tr>
<td>What is the CPT® code for this procedure?</td>
<td>One or more five-digit codes</td>
<td>CPT codes are the billing codes that are used by providers—usually for physician services—throughout the United States.</td>
</tr>
<tr>
<td>What tests will I need before the surgery?</td>
<td>Blood tests</td>
<td>Ask for specifics about which blood tests will be ordered.</td>
</tr>
<tr>
<td></td>
<td>Diagnostic imaging tests, such as a CT scan or ultrasound</td>
<td>Ask the doctor if you have a choice of facilities for getting these tests done. Check with your health plan before you have the test to find out where your out-of-pocket cost will be lowest.</td>
</tr>
<tr>
<td>Will other doctors be involved in my care and bill me for their services?</td>
<td>A pathologist, a radiologist, and an anesthesiologist may be involved in your care.</td>
<td>Even if your surgeon and the hospital are in your health plan’s network, other doctors involved in your hospital care may not be. (For more information, see page 11.)</td>
</tr>
<tr>
<td>What kind of anesthesia will I receive?</td>
<td>General anesthesia</td>
<td>Many surgeries will involve care by an anesthesiologist and other doctors who may or may not be part of your health plan’s network. (For more information, see page 11.)</td>
</tr>
<tr>
<td>After my surgery, will I go right home from the hospital?</td>
<td>After you are discharged from the hospital, you should be able to go directly home.</td>
<td>Although it is unlikely after gall bladder surgery, after some operations, you may need care in a rehabilitation unit or skilled nursing facility for a while. Or you may need home health care. Your health plan can provide information about coverage and prices. (The cost of medication you take at home is rarely included in price estimates.)</td>
</tr>
<tr>
<td>What medications and follow-up care will I need?</td>
<td>You may need to take [name of medication] for [period of time] after your surgery.</td>
<td></td>
</tr>
<tr>
<td>What else should I know about—such as potential complications—that might affect the cost of the procedure?</td>
<td>In a few cases, the minimally invasive gall bladder surgery has to be changed to an “open” cholecystectomy, which may or may not be more expensive.</td>
<td>You and your doctor should already have discussed this when you talked about the risks and benefits of the surgery. If not, be sure to ask questions about the open procedure before the day of surgery. Having a different procedure (or an additional procedure) is likely to change the cost. And if you need to stay overnight in the hospital for any reason, that is generally more expensive than an outpatient procedure.</td>
</tr>
</tbody>
</table>
REQUEST THE ESTIMATE. After your doctor gives you the specifics, look to your health plan for a price estimate.

First, visit your health plan’s website. Some health plan websites have price information available online.

If you haven’t created an account on the plan website, you will need to do so, because the price information health plans provide is generally available only to health plan members.

Once you are logged into the member portion of the website, look for an interactive tool designed to help members view and compare healthcare prices, taking individual cost-sharing circumstances into consideration. These tools may allow you to plug in the information you have received from your doctor and quickly find the estimated cost of common services or procedures offered by providers in your network. If you are not sure whether your plan offers these tools or where to find them on your plan’s website, some plans offer online “live chat” assistance that can help.

If the information you need is not available online, you need help finding or using the information, or you just prefer to talk with a person directly, call the health plan’s customer service number, which is usually listed on the back of your insurance ID card, during the plan’s business hours. Have your insurance card available when you call.

Once you receive an estimate, print or save a copy (if you get the estimate online) or ask to have a copy mailed or emailed to you. You may need to refer to it later after you receive a bill.

KNOW THE LIMITATIONS OF THE ESTIMATE. The price estimate should include the following specific information.

- The total price of your care and the portion of that price that you are expected to pay
- What is included in the estimate
- What is not included in the estimate. For example, the estimate may not include:
  - Medications prescribed for your use after you leave the hospital
  - Medical devices or home medical equipment
  - Care at a rehabilitation facility or home health care after you leave the hospital
  - Services provided by doctors, such as anesthesiologists, radiologists, and pathologists
- The network status of the specialist, hospital, or other providers you are considering. Choosing an out-of-network provider can result in much higher, out-of-pocket cost to you. Your health plan will not be able to provide price estimates for care from out-of-network providers beyond your copayment amounts and coinsurance percentages. (See page 11 for more information.)

In many cases, your health plan can provide separate information about the costs of care you may need after leaving the hospital, once your doctor gives you an idea of what services (such as rehabilitation care) to expect.

There is always a chance that the bill you receive will turn out to be higher than the estimate. See the sidebar on page 9 for information about your options in that situation.
CONSIDER OTHER RESOURCES. Your employer may be another resource for healthcare price information. Some employers make online price transparency tools or call centers available to their employees. Ask your human resources department for more information. Also, some states, such as Maine and Massachusetts, have public resources such as websites that offer price estimates or average prices for common tests and procedures.

BE AWARE THAT SOME SERVICES ARE NOT COVERED. You are responsible for paying the full amount of any healthcare products or services that are not covered by your health plan, such as Lasik surgery to improve vision, cosmetic surgery, and over-the-counter medications. To get price information for these, you should contact the provider or the retail outlet directly. In general, providers of products and services that are not typically covered by health insurance are used to working with consumers who are seeking information on pricing and payment plans.

Noncovered services don’t count toward the annual out-of-pocket maximum under your health plan. However, some of these services may qualify for payment through a flexible spending account, health savings account, or health reimbursement account offered by some employers. Contact your human resources department for more information.
Ask Your Health Plan About Pre-Approval

You may need pre-approval (sometimes called pre-authorization or prior authorization) from your health plan before you have surgery or receive certain other healthcare services. Through the pre-approval process, your health plan confirms medical necessity—in other words, that the service is appropriate for your condition.

As a healthcare consumer, it is important to understand which services require pre-approval. If you receive care without first obtaining a required pre-approval, your health plan may not cover your claims. Pre-approval may be required for a variety of services, such as CT scans or MRI scans, not just for surgery. When in doubt, call your health plan to find out whether pre-approval is needed. If your health plan requires pre-approval for a particular service, that's a step you need to take whether or not you request a price estimate.

What to Do When the Bill Is Higher than the Estimate

If you receive a bill that is higher than you expected, first, take a deep breath. Then, take the time to compare the specifics of the estimate with those on the bill. At that point, you'll be ready to call your doctor’s office or the hospital's patient financial services department to get more information and find out what options are available to you. For best results, take a constructive, solution-oriented approach to the conversation and expect the other person to do the same. When you call, keep in mind that you may be asked to supply a copy of the estimate. Here are some questions to ask.

▶ Can you tell me why the bill is higher than the estimate? Maybe you had tests, procedures, or other services beyond those included in the estimate or you stayed in the hospital longer than expected.

▶ May I have a clear bill with an easy-to-understand summary of the services? Although doctors and hospitals make every effort to send clear, accurate bills, mistakes can happen. Don’t hesitate to ask about any charges that you don’t understand or that don’t seem right.

▶ Am I eligible for a discount? Each hospital has its own policies about financial assistance, which are typically available on the hospital’s website or upon request, along with application materials. In some cases you may be able to negotiate a lower price even if you choose not to apply for formal financial assistance.

▶ Is a payment plan available? You may request an extension of the due date or an interest-free payment plan. Or your doctor or hospital may suggest a payment plan offered by an independent company, such as a bank, credit union, or credit card company. Be sure you understand all of the terms and conditions before you enter into any credit agreement. And ask for written documentation.
What to Know About Emergency Care

In a medical emergency, life-saving care always comes before payment and insurance considerations, including any unpaid hospital bills for previous care.

YOUR RIGHT TO RECEIVE CARE. A federal law known as EMTALA (the Emergency Medical Treatment and Active Labor Act) gives everyone the right to be treated for an emergency medical condition, regardless of their ability to pay. This law helps protect patients who are uninsured as well as those who have Medicare, Medicaid, or private insurance. (EMTALA applies to all hospitals that accept Medicare, which includes most hospitals in the United States.) Other federal, state, and local laws may provide additional safeguards to your right to emergency care.

YOUR PAYMENT RESPONSIBILITIES. It is important to realize that having a right to emergency care does not mean the care is free. A hospital’s regular policies about prices, billing, payment, and eligibility for financial assistance still apply. Those financial discussions take place after you have been screened and stabilized in the emergency department (ED). A financial counselor will talk with you or your representative (such as a family member) as you’re getting ready to leave the ED, during the discharge process.

OUT-OF-NETWORK CHARGES IN THE ED. In the past, some health insurance plans limited payment for ED services provided outside of a plan’s network. Or they required you to get your plan’s prior approval for emergency care at hospitals outside its network.

Under the Affordable Care Act, health plans can’t require higher copayments or co-insurance for out-of-network ED services provided in a hospital ED. The new rules also don’t allow health insurance plans to require that you get prior approval before seeking ED services from a provider or hospital outside your plan’s network. (However, there are exceptions for health insurance plans that were created or issued before March 23, 2010.)

BALANCE BILLING. If you visit an ED that is not in your plan’s network, although the health plan can’t require higher copayments or co-insurance, you may be responsible for the difference between the amount billed by the provider for out-of-network ED services (which could be considered “list price”) and the amount paid by your health plan. Why? Because there is not an established rate that has been agreed upon by the provider and health plan for the services, and therefore payment by the health plan to the provider may not be agreeable to the provider. This is sometimes referred to as balance billing. Ask your health plan about your coverage for out-of-network emergency care before you need it, so you’ll be prepared if an emergency arises.
Know Before You Go

You’ve probably seen the terms “in-network” and “out-of-network” on your insurer’s website and in your plan description. But, what do these terms mean? And how do they affect how much you have to pay for your care?

Your plan contracts with a wide range of doctors, as well as specialists, hospitals, labs, radiology facilities, and pharmacies. These are the providers in your “network.” Each of these providers has agreed to accept your plan’s contracted rate as payment in full for services.

That contracted rate includes both your insurer’s share of the cost, and your share. Your share may be in the form of a copayment, deductible, or co-insurance. For instance, your insurer’s contracted rate for a primary care visit might be $120. If you have a $20 copayment for primary care visits, you will pay $20 when you see a doctor in your network. Your insurer will pick up the remaining $100.

If you go outside your network, it’s a different story. You will likely pay more if you go “out-of-network” for your care. That’s because:

▶ Providers outside your network have not agreed to any set rate with your insurer, and may charge more.
▶ Your plan may require higher copayments, deductibles and co-insurance for out-of-network care. So, if you normally have to pay 20 percent of the cost of the service in-network, you may have to pay 30 percent out-of-network. Often, you’ll have to pay that plus any difference between your insurer’s allowed amount and what the provider charges.
▶ Your plan may not cover out-of-network care at all, leaving you to pay the full cost yourself.

Your costs for out-of-network care also depend on your type of plan:

▶ In a health maintenance organization, or HMO, you generally have to pay the full cost of any out-of-network care, except for emergencies.
▶ In a preferred provider organization (PPO) or point-of-service (POS) plan, you will usually have to pay:
  — A higher deductible than in-network and or a higher copayment
  — Plus a higher percentage co-insurance, which is a percentage of the “allowed amount”
  — Plus, the full difference between the allowed amount and your provider’s actual rate, which could be much higher

These costs can add up quickly, even for routine care. If you have a serious illness, it can mean tens of thousands of dollars more.

So, when you need care, it’s important to find out if all of your providers are in your plan’s network.
In-Network and Out-of-Network Care

In-Network and Out-of-Network Costs in Action: An Example
First, let’s look at in-network costs. Say you visit a provider who usually charges $1,000 for a service. But, that provider is in your plan’s network. That means they have agreed to accept your insurer’s contracted rate—say, $500—rather than the amount they normally charge. How much will you have to pay?

In-Network Costs for Different Types of Health Plans

<table>
<thead>
<tr>
<th></th>
<th>HMO In-Network</th>
<th>POS In-Network</th>
<th>PPO In-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider’s Usual Charge</td>
<td>$1,000</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>Your Plan’s Contracted Rate</td>
<td>$500</td>
<td>$500</td>
<td>$500</td>
</tr>
<tr>
<td>Your Cost Sharing</td>
<td>$10 copayment</td>
<td>$10 copayment</td>
<td>20% co-insurance</td>
</tr>
<tr>
<td>Your Plan Pays to the Provider</td>
<td>$490 ($500 - $10)</td>
<td>$490 ($500 - $10)</td>
<td>$500 x 80% = $400</td>
</tr>
<tr>
<td>You Pay to the Provider</td>
<td>$10</td>
<td>$10</td>
<td>$500 x 20% = $100</td>
</tr>
</tbody>
</table>

Now, let’s say you visit a provider outside your network for the same service. The provider still charges $1,000—and this time, they do not have any agreement with your insurer to accept a lower rate.

In this case, your insurer will base their share of the cost on the allowed amount for that service. This is the most money that they consider to be a fair and reasonable cost, based on what other providers in the area charge. It is not necessarily the same as your plan’s contracted rate. In this case, let’s say the allowed amount is $800.

So, what does that mean for you?

Out-of-Network Costs for Different Types of Health Plans

<table>
<thead>
<tr>
<th></th>
<th>HMO Out-of-Network</th>
<th>POS Out-of-Network</th>
<th>PPO Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider’s Charge</td>
<td>$1,000</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>Your Plan’s Allowed Amount</td>
<td>$0</td>
<td>$800</td>
<td>$800</td>
</tr>
<tr>
<td>Your Cost Sharing</td>
<td>100%</td>
<td>30% of the allowed amount plus the difference between the allowed amount and provider’s charge</td>
<td>30% of the allowed amount plus the difference between the allowed amount and provider’s charge</td>
</tr>
<tr>
<td>Your Plan Pays the Provider</td>
<td>$0</td>
<td>70% of $800 - $560</td>
<td>70% of $800 - $560</td>
</tr>
<tr>
<td>You Pay to the Provider</td>
<td>$1,000 (100%)</td>
<td>30% of $800 - $240 plus $1,000 - $800 = $200</td>
<td>30% of $800 = $240 plus $1,000 - $800 = $200</td>
</tr>
<tr>
<td>Your Total Cost</td>
<td>$1,000</td>
<td>$440</td>
<td>$440</td>
</tr>
</tbody>
</table>

Going out-of-network for this sample service could cost you hundreds of dollars more.

Your plan’s actual provisions may be different from those we have used in the examples. Be sure to check your plan booklet, your insurer’s website, or call your insurer so you can be sure you understand how your plan works.
Why Go Out-of-Network?
So, why would you go out of network? There are some very good reasons. If you or a loved one is facing a serious illness, you may want more options than are available in your network. Sometimes that means using a hospital that does not participate in your plan, or a specialist who is not a part of your network.

Also, patients often go out-of-network without intending to do so. There are two common reasons:

▶ Your primary care physician refers you to a specialist who is not in your network.
Don’t assume that your primary care physician knows the details of your plan. If you need a referral, remind your doctor what insurance coverage you have, and ask him or her to refer you to a specialist in that plan. When you call to make an appointment with that provider, ask the office staff to confirm that the doctor is in your network.

You can also call your insurer or visit their website to find a doctor in your network. Make sure you are choosing from the provider directory for your type of plan (many insurers offer HMO, PPO, and POS options which may have different networks).

▶ You receive care at an in-network hospital—and then get a bill.
While your hospital may participate in your health plan, some providers at that hospital, like anesthesiologists or radiologists, might not. If you have a serious illness, many providers will be involved in your treatment. Inpatient surgery will require a surgeon, an operating room, anesthesia, medication, the hospital room and board, and more. All of these will have separate charges, and all will contract separately with insurers.

Before you schedule a service or procedure, ask if all the providers who will be treating you at the hospital are in your network.

What About Emergencies?
What happens if you suffer a heart attack? Waiting to get care in an emergency is dangerous and can even be life-threatening. So, many plans cover some portion of emergency care no matter where you are, even out of their network area. Once your condition is stable, you will generally be moved to an in-network provider for follow-up care.

But remember, that only applies to real emergencies. You should never go to the emergency room for routine care that you could receive in a doctor’s office or clinic. Emergency department visits cost more than regular doctor’s visits, and insurers often won't pay the same amount to the provider if it's not a true emergency.

That means you’ll be left with a big bill. Plus, you’ll get better, more personalized care from your own doctor, and you won’t have to wait for hours in the ED.

If you’re not sure what constitutes an emergency, or what emergency costs are covered, ask your insurer.

Your Action Plan: Don’t Get Surprised by the Bill
There are times when going outside your network for care is simply unavoidable. But, the choice should be up to you, and you should make that choice an informed one. Follow these tips to help manage your costs:

▶ Ask your provider to refer you in-network first unless there is a specific reason why you want to go out-of-network.

▶ Before scheduling an appointment with a new provider, ask if they participate in your plan (and your network through that insurer—PPO, POS, or HMO).

▶ If you’re having a complex procedure, like a surgery, ask your doctor if all your providers participate, from the hospital to the lab to the anesthesiologist. Your doctor may be able to change your care to in-network providers for these services.

▶ If you choose to go out-of-network, ask the provider’s staff how much he or she will charge before your visit. Then, talk to your health plan to find out how much of the cost your plan will cover.

And most importantly—remember that you are your own best advocate. Speaking up and asking questions up front will help you avoid being surprised at what you may owe.
Tradional Medicare, sometimes called original Medicare, includes Part A for hospital insurance and Part B for medical insurance. Some people choose coverage under Part C, Medicare Advantage, instead of traditional Medicare. Medicare Advantage plans are typically HMOs or PPOs. (Prescription medication coverage is also available through Medicare Part D.)

If you are covered by a traditional Medicare plan, you pay a percentage of Medicare-approved amounts for many healthcare services. You are also responsible for deductibles and payments for prescription medications, medical devices, and supplies.

Medicare has a website designed to help consumers get information about how hospitals compare in terms of quality (www.medicare.gov/hospitalcompare). But the prices Medicare pays to doctors and hospitals—which affect the prices consumers will be responsible for paying—are not easy for consumers to find online. And Medicare does not pay the same amount to all doctors and hospitals in the country—it pays different amounts based on the costs in a local area.

LEARN ABOUT YOUR MEDICARE COVERAGE. There are several ways to access information about Medicare coverage, benefits, and prices.

▷ Go online or call Medicare. Visit the Medicare website at www.mymedicare.gov or call 800-MEDICARE (800-633-4227) and talk to a customer service representative. Those who use a special device for the hearing or speech-impaired (TTY) should call 877-486-2048.

▷ Read the Medicare & You handbook. This handbook is published every year by the government’s Medicare agency. It’s available online at www.medicare.gov/medicare-and-you. If you prefer to receive a paper handbook, you may request one by calling 800-MEDICARE (800-633-4227).

▷ Use your state’s Medicare counseling service. Check out the information provided by your state’s State Health Insurance Assistance Program (SHIP). SHIP is a free health benefits counseling service for Medicare beneficiaries and their families or caregivers. It is funded by federal agencies and is not affiliated with the insurance industry. The SHIP phone number and website contact information for each state is available at www.seniorsresourceguide.com/directories/National/SHIP.

▷ View your doctor and hospital as information resources. Call your doctor’s office or a hospital’s patient financial services department. They can provide an estimate of your out-of-pocket costs for many common services and procedures, with specific information about:
  — What is included in the estimate
  — What is not included in the estimate (such as medications prescribed for your use after you leave the hospital, medical devices or home medical equipment, and care at a rehabilitation facility or home health care after you leave the hospital).

Your doctor or hospital also may be able to provide contact information for companies or suppliers that provide items or services which are not included in the estimate, so you can contact those companies or suppliers for price information.

VIEW YOUR MEDIGAP PLAN AS A RESOURCE. Some people have a health insurance policy designed to go along with traditional Medicare coverage. These policies are known as supplemental or Medigap policies. Medigap policies can help pay your share (coinsurance, copayments, or deductibles) of the costs of Medicare-covered services. Some Medigap policies also cover certain items that Medicare does not cover. If you have a Medigap policy, your Medigap plan is the best source of price and cost information for you.

VIEW YOUR MEDICARE ADVANTAGE PLAN AS A RESOURCE. If you have coverage through Medicare Advantage, which is provided by nongovernment insurance companies approved by Medicare, contact your Medicare Advantage plan for information about prices. (If you have Medicare Advantage coverage, you don’t need and aren’t eligible for a Medigap policy.)
For Consumers Who Don’t Have Health Insurance

If you don’t have health insurance coverage, learn about your insurance options, find out if you are eligible for financial assistance for hospital care, and request a price estimate before you receive healthcare services.

LEARN ABOUT YOUR INSURANCE OPTIONS. Starting in 2014, millions of Americans became eligible for health insurance through the Insurance Marketplace created by the Affordable Care Act. Depending on your individual and household income, you may qualify for private health insurance or for coverage under Medicaid, or your children may qualify for coverage under the Children’s Health Insurance Program (CHIP). Both Medicaid and CHIP cover millions of families with limited income. For more information, see the sidebar or visit healthcare.gov. Also, your healthcare provider can help you find out if you qualify for any of these programs.

FIND OUT IF YOU ARE ELIGIBLE FOR FINANCIAL ASSISTANCE. You may apply for financial assistance provided directly by a hospital for hospital care, based on the hospital’s eligibility criteria for free or discounted care. Many people without insurance are eligible to receive free or discounted care.

REQUEST A PRICE ESTIMATE. In addition to helping you determine your eligibility for health insurance and financial assistance, the financial representative can provide an estimate of your out-of-pocket costs for many common services and procedures, with specific information about:

▶ What is included in the estimate
▶ What is not included in the estimate (such as medications prescribed for your use after you leave the hospital, medical devices or home medical equipment, and other providers’ services that may be involved in your care, such as a rehabilitation facility or home health care after you leave the hospital)
▶ The total price of your care

About the Insurance Marketplace

The Insurance Marketplace is a new way to find quality health insurance coverage. It can help if you don’t have coverage now or if you have it but want to look at other options.

When you use the Insurance Marketplace, you’ll provide some information about your household size and income to find out if you can get a subsidy to help you pay your monthly premiums for private insurance plans. You’ll learn if you qualify for assistance with out-of-pocket costs. And you’ll see all the health plans available in your area so you can compare them side-by-side and pick the plan that’s right for you. The Marketplace will also tell you if you qualify for free or low-cost coverage available through Medicaid or the Children’s Health Insurance Program. Most Americans are eligible to use the Marketplace.

Open enrollment for 2014 in the Insurance Marketplace is over. But if you had a change in family status (for example, marriage or the birth of a child) or you lost other health insurance coverage, you may qualify to apply soon after such a “qualifying event” occurs. Open enrollment for 2015 coverage begins on Nov. 15, 2014. For more information, visit healthcare.gov or call 800-318-2596.
Doctors, hospitals, health plans, and consumer groups agree that it should be easier for consumers to get the healthcare price information they need. That’s why these groups are working together to improve price transparency, which is just another way of saying that prices should be clear. As a starting point, these groups have agreed on a set of guiding principles, as shown in the exhibit below. As a healthcare consumer, you have an important role to play in improving the price information that is available to you and millions of other consumers across the country. One of the ways you can help is to make your voice heard. If your health plan, doctor, or hospital is providing the price information you need, let them know that you used this information in making decisions. If the information falls short, please offer your suggestions and feedback. Together, we can make information about the cost of health care more accessible to all.

### Guiding Principles for Improving Price Information

<table>
<thead>
<tr>
<th>Guiding Principle</th>
<th>What That Means for You</th>
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<tbody>
<tr>
<td>Price transparency should empower patients to make meaningful price comparisons prior to receiving care. It should also enable other care purchasers and referring clinicians to identify providers that offer the level of value sought by the care purchaser or the clinician and his or her patient.</td>
<td>You should have information that enables you to make meaningful price comparisons before you buy a healthcare service. The information should also allow doctors and other healthcare professionals to identify providers that can best meet your needs.</td>
</tr>
<tr>
<td>Any form of price transparency should be easy to use and easy to communicate to stakeholders.</td>
<td>Price information should be easy for you to use and understand.</td>
</tr>
<tr>
<td>Price transparency information should be paired with other information that defines the value of care for the care purchaser.</td>
<td>Along with price information, you should receive information about quality, safety, patient experience, and other aspects of care that are important to you.</td>
</tr>
</tbody>
</table>
| Price transparency information should ultimately provide patients with the information they need to understand the total price of their care and what is included in that price. | You should receive the information you need to understand:  
  ▶ The total price of your care  
  ▶ What is included in that price  
  ▶ What is excluded from that price |
| Price transparency will require the commitment and active participation of all stakeholders. | Hospitals, doctors and other healthcare professionals, and consumers each have a part to play and will need to work together to reach these goals. |

Affordable Care Act
The healthcare reform law—the Patient Protection and Affordable Care Act—enacted in March 2010.

Allowed amount
Maximum amount on which insurance payment is based for covered healthcare services. This may be called “eligible expense,” “payment allowance,” or “negotiated rate.” If your provider charges more than the allowed amount, you may have to pay the difference.

Balance billing
When a provider bills you for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A network provider may not balance bill you for covered services.

Children’s Health Insurance Program (CHIP)
Insurance program jointly funded by state and federal government that provides health coverage to low-income children and, in some states, pregnant women in families who earn too much income to qualify for Medicaid but can’t afford to purchase private health insurance coverage.

Coinsurance
Your percentage share of the costs of a covered healthcare service. This (for example, 20 percent) is based on the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health plan’s allowed amount for an office visit is $100 and you’ve met your deductible, your coinsurance payment of 20 percent would be $20. The health insurance or plan pays the rest of the allowed amount.

Contracted rates
The amounts that health plans will pay to healthcare providers in their networks for services. These rates are negotiated and established in the plans’ contracts with in-network providers.

Copayment
A fixed amount (for example, $15) you pay for a covered healthcare service, usually when you get the service. The amount can vary by the type of covered healthcare service.

Cost sharing
This refers to the ways that health plan costs are shared between employers and employees. Generally, costs are shared in two main ways: through premium contributions and through payments for healthcare services, such as copayments, a fixed amount paid by the employees at the time they obtain services; co-insurance, a percent of the charge for services that is typically billed after services are received; and deductibles, a flat amount that the employees must pay before they are eligible for any benefits.

CPT® code
Current Procedural Terminology (CPT) codes are numbers assigned to medical services and procedures. The codes are part of a uniform system maintained by the American Medical Association and used by medical providers, facilities and insurers. Each code number is unique and refers to a written description of a specific medical service or procedure. CPT codes are often used on medical bills to identify the charge for each service and procedure billed by a provider to you and/or your health plan. Most CPT codes are very specific in nature. For example, the CPT code for a 15-minute office visit is different from the CPT code for a 30-minute office visit. You will see a CPT code on your Explanation of Benefits form (EOB). You can also ask your healthcare provider for the CPT code for a procedure or service you will undergo, or have already received. You may need these codes to receive accurate price estimates. CPT® is a registered trademark of the American Medical Association.
**Definitions**

**Deductible**
The amount you are expected to pay for healthcare services your health plan covers before your health plan begins to pay. For example, if your deductible is $1,000, your plan won’t pay anything until you’ve met your $1,000 deductible for covered healthcare services subject to the deductible. The deductible may not apply to all services, for example, preventive services such as blood pressure screening.

**Elective surgery**
If a surgery is not an emergency, it is considered an elective surgery.

**Explanation of benefits (EOB)**
A statement sent by your health plan after you receive healthcare services from a provider. For each service, it shows the amount charged by the provider, the plan’s allowable charge, the plan’s payment, and the amount you owe. It is not a bill.

**Flexible spending account (FSA)**
An arrangement you set up through your employer to pay for many of your out-of-pocket medical expenses with tax-free dollars. These expenses include insurance copayments and deductibles, and qualified prescription drugs, insulin, and medical devices. You decide how much of your pre-tax wages you want taken out of your paycheck and put into an FSA. You don’t have to pay taxes on this money. There is a limit on the amount you can put into an FSA each year. In 2014, contributions are limited to $2,500 per year. Your employer may set a lower limit.

**Health maintenance organization (HMO)**
A health insurance plan that requires members to get referrals from their primary care doctor for many healthcare services and pre-authorization from the plan for certain services. In general, HMO members must use participating or “in network” providers, except in an emergency. HMO members typically pay only a copayment and need not file claim forms for services they receive within the network.

**Health plan**
The type of health insurance coverage you have, such as a health maintenance organization or a preferred provider organization. Also referred to as health insurance plan or health insurance

**Health reimbursement accounts (HRA)**
An employer-funded group plan from which employees are reimbursed tax-free for qualified medical expenses, up to a certain amount per year. Unused amounts may be rolled over to be used in subsequent years. The employer funds and owns the account. HRAs are sometimes called health reimbursement arrangements.

**Health savings account (HSA)**
A medical savings account available to taxpayers who are enrolled in a high-deductible health plan. The funds contributed to the account aren’t subject to federal income tax at the time of deposit. Funds must be used to pay for qualified medical expenses. Unlike a flexible spending account (FSA), funds roll over year to year if you don’t spend them.

**Healthcare provider**
A doctor or other healthcare professional, hospital, or healthcare facility that is accredited, licensed, or certified to practice in their state, and is providing services within the scope of that accreditation, license, or certification.
**Definitions**

**High-deductible health plan (HDHP)**
A plan that features higher deductibles than traditional insurance plans. High-deductible health plans can be combined with special savings accounts such as health savings accounts or health reimbursement arrangements to allow you to pay for qualified out-of-pocket medical expenses on a pre-tax basis.

**ICD-9 or ICD-10 codes**
The official system of assigning codes to medical diagnoses in the United States. By using these codes, healthcare professionals anywhere in the country can have a shared understanding of a patient’s diagnosis.

**Insurance Marketplace**
A resource where individuals, families, and small businesses can: learn about their health coverage options; compare health plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage. The Insurance Marketplace, also known as an exchange, also provides information on programs that help people with low to moderate income and resources pay for coverage. Visit healthcare.gov for more information.

**Network**
The hospitals and other healthcare facilities, providers, and suppliers your health plan has contracted with to provide healthcare services.

**Noncovered services**
Medical services that are not included in your plan. If you receive non-covered services, your health plan will not reimburse for those services and your provider will bill you, and you will be responsible for the full cost. You will need to consult with your health plan, but generally payments you make for these services do not count toward your deductible. Make sure you know what services are covered before you visit your doctor.

**Out-of-pocket healthcare cost**
Your expenses for medical care that aren’t reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that aren’t covered.

**Out-of-pocket maximum**
The limit on the total amount a health insurance company requires a member to pay in deductible and co-insurance in a year. After reaching an out-of-pocket maximum, a member no longer pays co-insurance because the plan will begin to pay 100 percent of medical expenses. This only applies to covered services. Members are still responsible for services that are not covered by the plan even if they have reached the out-of-pocket maximum for covered expenses. Members also continue to pay their monthly premiums to maintain their health insurance policies.

**Point-of-service plan (POS)**
A type of plan in which you pay less if you use doctors, hospitals, and other healthcare providers that belong to the plan’s network. POS plans also require you to get a referral from your primary care doctor in order to see a specialist.

**Preferred provider organization (PPO)**
A type of health plan that contracts with healthcare providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan’s network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

**Premium**
The amount that must be paid for your health insurance plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

Definitions of contracted rates, CPT® code, HMO, noncovered services, and out-of-pocket maximum are copyright 2014, FAIR Health®, Inc. By permission. All rights reserved.
For More Information

*Choosing Wisely.* Offers lists of questions you and your doctor can use to make decisions about tests and procedures for a wide variety of healthcare situations. www.choosingwisely.org

*Directory of State Health Insurance Assistance Programs, Senior Resource Guide.* This website provides contact information for State Health Insurance Assistance Programs (SHIPs), which provide free help to Medicare beneficiaries who have questions or issues with their health insurance. www.seniorsresourceguide.com/directories/National/SHIP

*FH Reimbursement 101.* A series of online informational guides designed to help consumers better understand the healthcare system and how to use it. Developed by FAIR Health®, Inc. www.fairhealth.org

*Healthcare.gov.* The federal government’s resource for learning about and enrolling in health insurance plans available through the Insurance Marketplace.

*INQUIREhealthcare.* An online resource developed by the Healthcare Incentives Improvement Institute to provide healthcare quality, cost, and safety information to consumers. www.inquirehealthcare.org

*Hospital Compare.* This federal government website has information about the quality of care at over 4,000 Medicare-certified hospitals across the country. You can use Hospital Compare to find hospitals and compare the quality of their care. medicare.gov/hospitalcompare

*MyMedicare.gov.* Medicare’s free, secure online service for accessing personalized information about your Medicare benefits and services. mymedicare.gov
With more than 40,000 members, HFMA is the nation’s premier membership organization for healthcare finance leaders. HFMA builds and supports coalitions with other healthcare associations and industry groups to achieve consensus on solutions to the challenges the U.S. healthcare system faces today. Working with a broad cross-section of stakeholders, HFMA identifies gaps throughout the healthcare delivery system and bridges them through the establishment and sharing of knowledge and best practices. Our mission is to lead the financial management of health care.

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AHA
Hospital Billing and Collection
Statement of Principles
and Guidelines, 2012
HOSPITAL FIELD SUPPORTS BILLING AND COLLECTION GUIDELINES THAT TREAT PATIENTS WITH DIGNITY AND RESPECT

May 30, 2012

The mission of every hospital in America is to serve the health care needs of people in its community – part of that commitment includes treating patients with dignity and respect from the bedside to the billing office. In 2003, the hospital field adopted voluntary principles and guidelines on billing and collections, which incorporate patient-friendly billing practices. Those guidelines address effective communications, financial assistance for those in financial need, applying policies accurately and consistently, making care more affordable for those in need and ensuring fair practices.

The billing and collection guidelines were recently updated [see attachment] because several of its original tenets were incorporated into law at the same time the promise of health insurance coverage was extended to 32 million Americans. The updated guidelines also are a reminder that hospitals and patients are partners who share responsibility for addressing billing issues in a timely, transparent and forthright manner.

The voluntary principles and guidelines underscore hospitals’ commitment to their communities and to ensure conversations about financial obligations don’t impede care. They also are crafted to reflect the hospital field’s immense diversity. Hospitals will need to adapt these guidelines to the needs and expectations of their particular communities. Hospitals also will need to adapt the guidelines to conform with state and local requirements.

The policies and guidelines reflect hospitals’ commitment to their communities and to their mission of caring.
Hospital Billing and Collection Practices
Statement of Principles and Guidelines
Approved by the AHA Board of Trustees
May 5, 2012

The mission of each and every hospital in America is to serve the health care needs of people in their communities 24 hours a day, seven days a week. Their task, and the task of their medical staffs, is to care and to cure. America’s hospitals are united in providing care based on the following principles:

• Treat all patients equitably, with dignity, with respect and with compassion.
• Serve the emergency health care needs of everyone, regardless of a patient’s ability to pay for care.
• Assist patients who cannot pay for part or all of the care they receive.
• Balance needed financial assistance for some patients with broader fiscal responsibilities in order to keep hospitals’ doors open for all who may need care in a community.

Hospitals’ work is made more difficult by America’s fragmented health care system ... a system that leaves millions of people unable to afford the health care services they need ... a system in which federal and state governments and some private insurers do not meet their responsibilities to cover the costs of caring for Medicare, Medicaid or privately insured patients ... a system in which payments do not recognize the unreimbursed services provided by hospitals ... a system in which a complex web of regulations prevents hospitals from doing even more to make care affordable for their patients. Today’s fragmented health care system does not serve Americans well in many ways.

While most Americans have insurance coverage for their unexpected health care needs, nearly 50 million people do not. Some of these people can pay for the health care they may need, but America’s hospitals treat millions of patients each year who can make only minimal payment, or no payment at all. Until there is adequate insurance coverage for all, America’s hospitals must find ways to both serve and survive.

The following guidelines outline how hospitals can better serve their patients. Hospitals have been following some of these guidelines for years as they work each day to find new ways to best meet their patients’ needs. Those portions of the guidelines included under the Patient Protection and Affordable Care Act (ACA) and required for some hospitals are denoted as follows: (ACA provision). More information on the ACA requirements can be found on the Internal Revenue Service website at: http://www.irs.gov/charities/charitable/article/0,,id=236275,00.html.

Guidelines
Helping Patients with Payment for Hospital Care
Communicating Effectively
• Hospitals should provide financial counseling to patients about their hospital bills and should make the availability of such counseling widely known.
• Hospitals should respond promptly to patients’ questions about their bills and to requests for financial assistance.
• Hospitals should use a billing process that is clear, concise, correct and patient friendly.
• Hospitals should make available for review by the public specific information in a meaningful format about what they charge for items and services.
Helping Patients Qualify for Financial Assistance

- Hospitals should have a written financial assistance policy that includes eligibility criteria, the basis for calculating charges and the method for applying for financial assistance. (ACA provision)
- Hospitals should communicate this information to patients in a way that is easy to understand, culturally appropriate, and in the most prevalent languages used in their communities.
- Hospitals should have understandable, written policies to help patients determine if they qualify for public assistance programs or hospital-based assistance programs.
- Hospitals should widely publicize, e.g., post on the premises and on the website and/or distribute directly to patients, these policies and share them with appropriate community health and human services agencies and other organizations that assist people in need. (ACA provision)

Ensuring Hospital Policies are Applied Accurately and Consistently

- Hospitals should ensure that all financial assistance policies are applied consistently.
- Hospitals should ensure that staff members who work closely with patients (including those working in patient registration and admitting, financial assistance, customer service, billing and collections as well as nurses, social workers, hospital receptionists and others) are educated about hospital billing, financial assistance and collection policies and practices.

Making Care More Affordable for Patients who Qualify for Financial Assistance

- Hospitals should review all current charges and ensure that charges for services and procedures are reasonably related to both the cost of the service and to meeting all of the community’s health care needs, including providing the necessary subsidies to maintain essential public services.
- Hospitals should have policies to limit charges for emergency and other medically necessary care for those who qualify for financial assistance to no more than the amounts generally billed to individuals who have insurance covering such care. (ACA provision)

Ensuring Fair Billing and Collection Practices

- Hospitals should ensure that patient accounts are pursued fairly and consistently, reflecting the public’s high expectations of hospitals.
- Hospitals should have a written collections policy that includes the actions that may be taken in the event of nonpayment and ensures that reasonable efforts are made to determine whether an individual is eligible for financial assistance before undertaking significant collections actions. (ACA provision)
- Hospitals should define the standards and scope of practices to be used by outside collection agencies acting on their behalf, and should obtain adherence to these standards in writing from such agencies.

Hospitals in some states may need to modify the use of these guidelines to comply with state laws and regulations.

Hospitals exist to serve. Their ability to serve well requires a relationship with their communities built on trust and compassion. These guidelines are intended to strengthen that relationship and to reassure patients, regardless of their ability to pay, of hospitals’ commitment to caring.

2012
AHA

Hospital Pricing Transparency,
2006
People deserve meaningful information about the price of their hospital care. Hospitals are committed to sharing information that will help people make important decisions about their health care. Sharing pricing information, however, is more challenging because hospital care is unique. Hospital prices can vary based on patient needs and the services they use; prices reflect the added costs of hospitals’ public service role – like fire houses and police stations – serving the essential health care needs of a community 24 hours a day, seven days a week; and a hospitals’ prices can’t yet reflect important information from other key players like the price of physician care while in the hospital or how much of the bill a patient’s insurance company may cover. But more can, and should, be done to share hospital pricing information with consumers.

**Goal:**
Share meaningful information with consumers about the price of their hospital care

**Objectives:**

- Present information in a way that is easy for consumers to understand and use
- Make information easy for consumers to access
- Create common definitions and language to describe pricing information for consumers
- Explain to consumers how and why the price of their care can vary
- Encourage consumers to include price information as just one of several considerations in making health care decisions
- Direct consumers to additional information about financial assistance with their hospital care

**Roadmap to Price Transparency:**

1) **Federal requirement for states, working with state hospital associations, to expand existing efforts to make hospital charge information available to consumers.**

- 32 states already have statutes requiring hospitals to report pricing information that is made available to the public either by posting to a hospital, hospital association or government Web site, issued in a government or hospital association report, or made available to consumers upon request; five additional states voluntarily do so.
• State efforts on price transparency vary, from making individual hospitals’ master list of charges available to the public (e.g., California), to making pricing information on frequent hospital services available to the public (e.g., Missouri, Florida, Nevada, North Carolina), to making information on all inpatient services available to the public (e.g., Colorado, Kentucky, Oregon, Pennsylvania, Wisconsin).

2) Federal requirement for states, working with insurers, to make available in advance of medical visits, information about an enrollee’s expected out-of-pocket costs.

• This information is especially important to the majority of consumers who already have some type of health insurance coverage. Their likely interest is in knowing the amount for which they personally are financially responsible. This information is provided today to consumers by their insurance company – it is called an “explanation of benefits, or EOB” – but is only given after care is provided. To help inform consumers in advance of their out-of-pocket obligations, insurers could provide an “advance EOB.” This information could be shared with an insured individual by phone or electronically, through an insurer’s Web site. Aetna is currently piloting a project like this for physician services in Cincinnati, OH.

3) Federal-led research effort to better understand what type of pricing information consumers want and would use in their health care decision-making.

We have learned much based on research about what kind of information consumers want about the quality of their health care. But we know less about what consumers may want to know about pricing information. Consumers need different types of price information, depending on whether and how they are insured. The following illustrates different consumer needs:

• Traditional Insurance. Because traditional insurance typically covers nearly all of the cost of hospital care, people with this type of coverage are likely to want information about what their personal out-of-pocket cost would be if they receive care at one hospital versus another.

• HMO Insurance. People who have HMO coverage will have even more specific price information needs. They have agreed, in advance, to adhere to certain limits on their choice of physician or hospital in exchange for broad-based coverage of their health care needs. A person with HMO coverage typically faces no additional cost for care beyond their premium and applicable deductibles and co-payments, but must agree to use physicians and hospitals that are participating in that HMO plan. These individuals likely have little, if any need for specific price information.

• High-Deductible or Health Savings Account (HSA) Insurance. People with HSAs have more interest than a typically insured person in price information.
These types of plans are designed to make consumers more price-sensitive and to encourage consumers to be prudent “shoppers” for the care they need. A typical plan of this type has a deductible of $2,500. But consumers with HSA coverage are likely to be more interested in price information for physician and ambulatory care than for inpatient hospital care for several reasons:

- Many patients admitted to the hospital were first seen on an emergency basis in the hospital emergency department. These are not price-shopping patients, but instead, patients who found themselves in need of emergent care and either came or were brought to the nearest hospital emergency department.

- For patients who are admitted to the hospital for a scheduled or elective procedure, inpatient hospital price information may be less important. That’s because most, if not all hospital admissions result in a cost that exceeds the typical HSA deductible of $2,500, and therefore, are covered by most HSA plans.

- People with HSA coverage may be most interested in comparing prices and shopping for care to be delivered that leads up to meeting their deductible (typically $2,500). People with this type of coverage may be most interested in prices for physician office visits and other ambulatory care for which they are likely to be responsible for paying the full cost.

- **Uninsured Individuals of Limited Means.** People without insurance who have limited means for paying for the health care services they have received need to know how much of their hospital or physician bill they may be responsible for. In the case of hospital care, the information they need must be provided directly by the hospital, after the hospital can ascertain whether a patient may qualify for state insurance programs of which they were unaware, free care provided by the hospital, or other financial assistance.

4) **Hospital-led effort to create consumer-friendly pricing “language” – common terms, definitions and explanations to help consumers better understand the information provided.**

- More can be done to explain pricing information to consumers clearly and consistently. Hospitals will lead an effort to create common terms, definitions and explanations of complex pricing information. This will include sharing innovative and understandable ways for displaying pricing information for use by consumers.
AHA Trendwatch – Price Transparency Efforts Accelerate: What Hospitals and Other Stakeholders Are Doing to Support Consumers
Price Transparency Efforts Accelerate: What Hospitals and Other Stakeholders Are Doing to Support Consumers

Consumers incorporate price information when making most purchasing decisions. While health care services have numerous unique characteristics that make pricing complex and non-uniform across payers, both consumers and providers can benefit from greater price transparency. Knowing the estimated cost and quality of services in advance of receiving care can help patients make informed purchasing decisions, plan for future financial obligations and lessen the burden of unexpected medical bills. Price transparency also can lead to improved quality and efficiency as providers benchmark and improve their performance against peers and national averages. To realize these potential benefits, policymakers and the public increasingly are calling for greater access to information.

Historically, limited access to price information has been felt most acutely by uninsured patients, who face greater exposure to health care expenses. However, consumers increasingly are enrolling in plans with higher levels of deductibles and coinsurance, which require more accurate estimates of out-of-pocket costs. In fact, recent media and policy discussions have illustrated that all patients—not just the uninsured or those with higher deductibles—benefit from timely pricing estimates from insurers and health care providers. Simultaneously, a growing number of price transparency initiatives are emerging at the federal and state levels, and among hospitals, plans and commercial vendors of transparency tools. These public and private resources provide varying levels of detail on price and quality information. They also have varying levels of utility in supporting consumer decision-making. As efforts to improve price transparency evolve, stakeholders will need to address consumers’ increased needs for information and guard against any potential unintended consequences.

Price for services varies by payer and depends on the unique course of care.

Oftentimes, consumers are not aware of the difference between “charges” and “price.” These terms do not have the same definition in the context of health care. Health care charges are based on hospital-established rate lists before the negotiation of any discounts. They include charges for all services, procedures, supplies and drugs that patients receive and are calculated based on a variety of factors, such as direct and indirect costs, regional competitive dynamics, mission and budgetary considerations. Hospital charges serve as a starting point for determining payment rates that are generally heavily discounted. On average, hospitals collect 31 cents for each dollar charged for inpatient and outpatient services.

“You can be a highly educated consumer now and still not understand what bill is going to hit you.”
— Giovanni Colella, M.D., CEO of Castlight Health
Price is defined as the total amount a hospital or another type of provider expects to be paid for a given health care service by both patients and any third-party payer, such as an insurance company. Prices vary depending on provider-payer negotiations and are based on a wide range of factors that influence the cost of care. The cost of care consists of medical expenses such as the surgeon’s time, procedure-related supplies and overhead expenses such as operating room maintenance fees and administrative salaries. Some organizations have higher cost structures due to high-intensity services, such as transplant, trauma, and neonatal intensive care, or mission-related costs such as teaching, research, or care for low-income populations. These added costs translate into higher prices.

The final price for a procedure is contingent on what happens during the course of care. Each patient’s case is unique, making it difficult to predict the exact treatment characteristics ahead of time. For example, surgeons may not know if a tumor can be completely excised or whether it has become attached to a vital nerve bundle or blood vessel until the surgery is in progress. Therefore, creating standard list prices, especially for highly complex procedures, is challenging and can result in over- or under-estimating the cost to the payer and/or patient.

Consumers need information on their anticipated financial obligation in advance of treatment. Regardless of insurance status, price information can help consumers evaluate treatment and provider options and prepare for their share of treatment costs. The privately insured, especially those enrolled in high-deductible health plans (HDHPs), need timely and accurate information on their estimated total out-of-pocket expenses, including deductibles, coinsurance and copayments. Because of the high level of cost-sharing, these patients are more price-sensitive. In fact, this population finds estimates of their out-of-pocket costs more useful than any other kind of health care price information.3 The cost implications of going to an out-of-network provider are also important for privately insured patients; out-of-pocket costs for services rendered by out-of-network providers can be significantly higher than in-network providers.

**Definitions of insurance terms.**

<table>
<thead>
<tr>
<th>Element</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost-Sharing</td>
<td>Methods through which employees share the cost of their health care with their employers. Typically, health care costs are shared through premium contributions, copayments, coinsurance and deductibles.</td>
</tr>
<tr>
<td>Copay</td>
<td>A fixed amount (for example, $20) paid by an enrollee for a covered health care service, usually paid when the individual receives the service. The amount can vary by the type of covered health care service.</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>Enrollee’s percentage share of the costs of a covered health care service. This (for example, 20 percent) is based on the allowed amount for the service provided. Enrollee pays coinsurance, plus any relevant deductibles, for covered services.</td>
</tr>
<tr>
<td>Deductible</td>
<td>The amount an enrollee owes for health care services before the health plan begins to pay. For example, if an individual’s deductible is $1,000, the health plan will not pay anything until he/she has paid $1,000 out-of-pocket for covered health care services. The deductible may not apply to all services.</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>The limit on the total amount a health insurance company requires an enrollee to pay in deductible and co-insurance in a year. After reaching an out-of-pocket maximum, the enrollee no longer pays co-insurance because the plan will begin to pay 100 percent of medical expenses. This only applies to covered services.</td>
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<tr>
<td>High-Deductible Health Plan (HDHP)</td>
<td>An insurance plan with higher deductibles than traditional plans. HDHPs can be combined with health savings accounts or reimbursement programs and allow patients to cover out-of-pocket costs on a pre-tax basis.</td>
</tr>
</tbody>
</table>

Medicare beneficiaries need to understand whether Medicare covers a certain service and their out-of-pocket expense relative to deductibles and coinsurance. For example, traditional fee-for-service Medicare does not provide payment for dental or vision services and requires significant cost-sharing for extended hospital or skilled nursing facility stays. These gaps in coverage can increase out-of-pocket expenses for beneficiaries, prompting many patients in this population to seek supplemental insurance.

The uninsured are solely responsible for their treatment costs and need information on what expenses they will be expected to cover for a physician visit, an episode of care or a procedure. They also need information about the availability of financial assistance or deferred payment options to assist them in making treatment-related decisions.

Irrespective of insurance coverage, it is difficult for patients to get a complete picture of their cost-sharing responsibilities in advance of treatment. A single procedure may involve a broad range of care providers, who may bill patients separately for the same episode of care. For example, receiving an out-of-pocket estimate for a single hip replacement surgery requires aggregating estimates from the hospital, surgeon, anesthesiologist, radiologist and, potentially, a rehabilitation center. The lack of a bundled price for the episode across providers is confusing to patients, most of whom do not know that they need to call different providers to assess their total out-of-pocket expense. This makes it difficult for patients to plan for their portion of treatment costs.

Even when supplied with all related bills post-treatment, insured patients struggle to understand the different types of financial obligations associated with their health insurance plan design. While some patients believe that they understand insurance terms such as deductible, copay, coinsurance and out-of-pocket maximum, one recent study showed that only 14 percent of privately insured patients accurately grasp the concepts. The lack of understanding of benefit design and associated financial obligations creates challenges for beneficiaries and for hospitals. Fifty-seven percent of Americans report allowing medical bills to go to a collections agency and hospitals accrue bad debt if invoices for provided care are not paid.

Section 501(r) of the Affordable Care Act (ACA)

The ACA imposed new patient financial assistance requirements for tax-exempt hospitals, which are now mandated through Section 501(r):

1. Create written financial aid and urgent care policies (effective March 23, 2010)
2. Limit charges for urgent or other necessary care to patients eligible for financial aid (effective March 23, 2010)
3. Make “reasonable efforts” to determine whether patients are eligible for financial aid (effective March 23, 2010)
4. Conduct a community health needs assessment (CHNA) and create an implementation strategy to address identified needs at least once in a three-year period (effective March 23, 2012)

These mandates will be enforced when the Internal Revenue Service (IRS) issues final regulations (proposed regulations were released on June 26, 2012, and April 5, 2013, and the final rule is pending). In the meantime, the IRS notes that “A hospital organization must comply with the statutory requirements of § 501(r), which are already in effect.”

“Health care bills are very confusing and [patients] are getting multiple bills not only from the hospital but from their physicians.”

— George Semko, Vice President of Revenue Cycle at Meritus Health System
Prices without adequate context can be misleading to consumers.

Quality data needs to accompany price information to enable consumers to make informed health care decisions. In fact, a considerable number of consumers equate higher price with higher quality and doubt that high-quality care can be delivered at low cost. Patient beliefs are so powerful that researchers report higher price tags improve patient responses to treatments through the placebo effect. To avoid making health care choices based solely on price, consumers need access to quality data in parallel. Research shows that when consumers are presented with quality data alongside prices, more than 90 percent of consumers will choose providers with low-cost and high-quality scores.

Further, the way that data are reported can make them more or less useful to consumers. Reporting data in tables without clear explanations to describe provider performance is not as valuable to consumers as the use of evaluative comments such as “better than,” “average” or “worse than.” Placing data in the context of what constitutes performance excellence within a metric allows consumers to understand and use data effectively in decision-making. Accordingly, benchmarks are essential as they allow patients to evaluate how an individual hospital ranks against peers and/or against national averages.

**Consumers prefer evaluative, graphical representations of quality and price information.**

Chart 2: Example of Price Data with a Strong Quality Signal

<table>
<thead>
<tr>
<th>Provider</th>
<th>Quality Data</th>
<th>Price Data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Uses treatments proven to get results</td>
<td>Has safeguards to protect patients from medical error</td>
</tr>
<tr>
<td>Dr. Jackson</td>
<td>Worse</td>
<td>Better</td>
</tr>
<tr>
<td>Dr. Lew</td>
<td>Better</td>
<td>Average</td>
</tr>
</tbody>
</table>

* One circle is less careful (higher costs); two circles is somewhat careful (average costs); three circles is very careful (lower costs). Source: Hibbard et al. (2012). An Experiment Shows That a Well-Designed Report on Costs and Quality Can Help Consumers Choose High-Value Health Care.

Many price transparency efforts already exist and are evolving.

There are numerous ongoing initiatives to increase price transparency at the federal and state levels and among hospitals, health plans and commercial vendors of transparency tools. Each stakeholder group has access to unique data sources that underlie their individual price transparency efforts.

**Multi-Stakeholder Initiative**

The Healthcare Financial Management Association (HFMA) released a set of principles and recommendations for price transparency in April 2014. This work was the product of a multi-stakeholder taskforce broadly representative of providers, plans, employers, consumers and others, as price transparency will require the commitment and active participation of all stakeholders. The group recommended that health plans are the best situated to provide information to the insured because they can better provide the consumer with the negotiated rate and expected out-of-pocket costs, but that providers should be the primary source of information for uninsured patients. An accompanying consumer guide provides information to consumers on how to seek pricing information.
Federal Initiatives
The federal government has increased transparency around charge and quality data. Since June 2013, the Centers for Medicare & Medicaid Services (CMS) has published hospital-specific average charges and average Medicare reimbursement rates for the 100 most common inpatient and 30 most common outpatient procedures on the CMS website.\textsuperscript{20} Data for physicians were released in April 2014. While available to the general public, the data have limited use to patients as they are published in an electronic format as a large spreadsheet that is difficult for consumers to navigate.\textsuperscript{21} The dataset does not include consumer-specific information such as annual deductible levels and additional cost-sharing requirements for Medicare beneficiaries, which directly impact the patient's out-of-pocket expense.

The ACA requires hospitals to establish and make public a list of their CMS-released charge data are not easy to understand.

Chart 3: Inpatient Prospective Payment System (IPPS) Provider Level Charges and Medicare Payments for the Top 100 Diagnosis-Related Groups (DRG)*

<table>
<thead>
<tr>
<th>DRG Definition</th>
<th>Provider ID</th>
<th>Provider Name</th>
<th>Provider Street Address</th>
<th>Provider City</th>
<th>Provider State</th>
<th>Provider Zip Code</th>
<th>Hospital Referral Region (HRR) Description</th>
<th>Total Discharges</th>
<th>Average Covered Charges</th>
<th>Average Total Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>039–Extracranial procedures W/O CC/MCC</td>
<td>010001</td>
<td>Southeast Alabama Medical Center</td>
<td>1108 Ross Clark Circle</td>
<td>Dothan</td>
<td>AL</td>
<td>36301</td>
<td>AL–Dothan</td>
<td>91</td>
<td>$32,963</td>
<td>$5,777</td>
</tr>
<tr>
<td>057–Degenerative nervous system disorders W/O MCC</td>
<td>010001</td>
<td>Southeast Alabama Medical Center</td>
<td>1108 Ross Clark Circle</td>
<td>Dothan</td>
<td>AL</td>
<td>36301</td>
<td>AL–Dothan</td>
<td>38</td>
<td>$20,313</td>
<td>$4,895</td>
</tr>
<tr>
<td>064–Intracranial hemorrhage or cerebral infarction W MCC</td>
<td>010001</td>
<td>Southeast Alabama Medical Center</td>
<td>1108 Ross Clark Circle</td>
<td>Dothan</td>
<td>AL</td>
<td>36301</td>
<td>AL–Dothan</td>
<td>84</td>
<td>$38,820</td>
<td>$10,260</td>
</tr>
<tr>
<td>065–Intracranial hemorrhage or cerebral infarction W CC</td>
<td>010001</td>
<td>Southeast Alabama Medical Center</td>
<td>1108 Ross Clark Circle</td>
<td>Dothan</td>
<td>AL</td>
<td>36301</td>
<td>AL–Dothan</td>
<td>169</td>
<td>$27,345</td>
<td>$6,542</td>
</tr>
<tr>
<td>066–Intracranial hemorrhage or cerebral infarction W/O CC/MCC</td>
<td>010001</td>
<td>Southeast Alabama Medical Center</td>
<td>1108 Ross Clark Circle</td>
<td>Dothan</td>
<td>AL</td>
<td>36301</td>
<td>AL–Dothan</td>
<td>33</td>
<td>$17,606</td>
<td>$4,596</td>
</tr>
</tbody>
</table>

*DRG list represented is not comprehensive


“"It's difficult for people to understand it because it's inherently complicated. Even if you understand each concept individually, it's still difficult to figure out the cost.””

— George Lowenstein, health care economist

from the field
standard charges for items and services. In the fiscal year (FY) 2015 Inpatient Prospective Payment System (IPPS) proposed rule, CMS reminded hospitals of this obligation and indicated that it will provide hospitals with flexibility to determine how they make this information public.22

Since 2005, the government has reported on hospital quality metrics through Hospital Compare.23 Consumers can compare hospital performance across quality measures related to heart conditions, pneumonia, surgery and other procedures. Further, consumers can evaluate hospitals along several performance domains, such as patient satisfaction and efficiency. However, these federal initiatives fail to bring price and quality data together to support consumers in selecting the most-suitable provider for their needs. Further, the price data include only total charges and Medicare payment rates for hospitals, which can serve as a reference point, but have little practical value for the uninsured, the privately insured, or even Medicare beneficiaries.

State Initiatives
States are well positioned to increase price transparency across all local payers and providers by supplying consumers with comparative data on services offered within their local/regional markets. To date, 35 states require hospitals to release information on some charges, and seven rely on voluntary disclosure of charge data.24 Pending legislation, the Health Care Price Transparency Promotion Act (H.R. 1326), would elevate further the states’ role in price transparency. It would mandate that states create laws requiring the release of hospital charge data and patient-specific out-of-pocket estimates. It also would require commercial payers to respond to consumer requests for out-of-pocket estimates.

Some researchers have been critical of state initiatives. In March 2014, the Catalyst for Payment Reform rated only two states as having a “B”-level grade on transparency laws, and no state received an “A.” This grading system does not reflect feedback on individual laws, but rather looks at the state’s overall achievement in increasing price transparency. States that required the release of charges and payment data for inpatient and outpatient services and provided the information in a consumer-friendly manner via easily accessible sources such as websites received higher grades.

In addition to certain states mandating hospital disclosure of charges, 11 states have passed legislation requiring payers to contribute data to all-payer-claims-databases (APCDs); an additional three states rely on voluntary contributions.26 APCDs include provider-level price data on medical, pharmacy and dental payments from public and private payers.27 More states are considering APCDs because of the potential value of the data and analytics to support population health, as well as health care delivery and payment reforms. APCDs provide information on actual prices paid for specific services and can be used to estimate the cost of entire episodes of care.28 When presented in a consumer-friendly manner, such comprehensive price data can supply accurate estimates for common health services and enable consumers to compare costs across providers before making a treatment decision.29

### APCDs can be packaged in a way that is useful to consumers.

Chart 4: Attributes of All-Payer Claims Databases (APCD)

<table>
<thead>
<tr>
<th>Data Normally Included in APCDs</th>
<th>Data Normally Excluded From APCDs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encrypted patient identification number</td>
<td>Care provided to uninsured patients</td>
</tr>
<tr>
<td>Demographic information (date of birth, gender, etc.)</td>
<td>Denied claims for service</td>
</tr>
<tr>
<td>Type of health care coverage (HMO, PPO, etc.)</td>
<td>Price of health care premiums</td>
</tr>
<tr>
<td>Diagnosis and related procedure</td>
<td>Results from diagnostic tests</td>
</tr>
<tr>
<td>Identification of service provider</td>
<td>Administrative fees</td>
</tr>
<tr>
<td>Type of facility</td>
<td>Back-end settlement amounts</td>
</tr>
<tr>
<td>Service date</td>
<td>Insurer</td>
</tr>
<tr>
<td>Payment date and amount</td>
<td></td>
</tr>
</tbody>
</table>

The Health Care Price Transparency Promotion Act of 2013 (H.R. 1326)

H.R. 1326 would help standardize the requirements for greater price transparency across the country, and enhance payer and hospital participation. Furthermore, it would facilitate research to deepen the field’s understanding of consumer preferences for price-related data and venues for information sharing.

As of May 2014, the bill has been referred to the Subcommittee on Health of the House Committee on Ways and Means.

The proposed law would require:

1. States to enact laws that require hospitals to disclose their charges for certain inpatient and outpatient services
2. Private insurance companies, services and organizations, as well as Medicaid managed care and Medicare Advantage organizations, to provide out-of-pocket cost estimates to consumers upon request
3. The Agency for Healthcare Research and Quality to study and report to Congress on:
   - The types of price-related data that patients find useful when evaluating care choices
   - Consumer preference variability depending on health care coverage
   - Methods for making price information available to consumers in an easy-to-understand format

APCD initiatives vary across states.

Chart 5: State APCD Efforts Across the U.S.

* Status of APCD initiatives fall in the following categories: “existing” includes states with legislatively mandated APCDs; “in implementation” includes states where APCDs have been created through legislation or through conscious effort to create a voluntary APCD; “strong interest” includes states that have expressed strong interest in developing APCDs; “existing voluntary effort” includes states with operational voluntary APCDs; “no current effort” includes states that have not expressed public interest in developing mandatory or voluntary APCDs.

While APCDs contain vast amounts of regional price information by provider and payer, only a few states have attempted to make the price component of this information useful to consumers. Specifically, Massachusetts, Colorado and Maine have developed one or more consumer-oriented tools that bring together price data from APCDs with quality-related information to assist consumers in selecting providers.30

Massachusetts, for example, has collected APCD data since 2008 and developed a website designed to help consumers select a health care provider based on price and quality indicators of hospitals. Patients are able to see whether the hospital received payments in line with, below, or above median state prices. In addition to costs, patients also are able to see how a hospital performed in the areas of patient safety and experience.31

Despite the potential of APCDs to further price transparency efforts, the implementation and maintenance of APCDs can face opposition from payers, who are the main contributors of data. Multi-state payers face a high administrative burden in complying with non-standardized reporting requirements across states.32 Greater standardization of payment data disclosure requirements would reduce

Massachusetts uses APCD data to provide consumers with cost and quality information.

Chart 6: Massachusetts’ “My Health Care Options” Website (2014)

Payer Initiatives
Increasingly, health plans offer cost estimation tools to assist their enrollees in determining expected out-of-pocket expenses. Today, most large national plans provide such cost estimation tools whereas payers with fewer enrollees are less likely to provide and maintain such features, largely due to associated costs. These tools incorporate beneficiary-specific copays, deductibles and coverage exclusions to provide expected out-of-pocket estimates reported in price ranges.34

Aetna’s tool helps plan members determine their out-of-pocket costs prior to treatment.

Chart 8: Aetna’s Member Payment Estimator Tool (Snapshot)

While most payer tools estimate the cost of provider-specific medical encounters, few provide consumers the ability to compare costs across providers. One private insurance tool that successfully allows for cross-provider treatment cost comparison is Aetna’s “Member Payment Estimator.” It provides expected out-of-pocket costs by taking into account beneficiary-specific deductible information. All cost estimates are in real time and beneficiaries can compare expected out-of-pocket costs across various providers. Such cost estimation tools are generally only available to a plan’s beneficiaries and do not allow patients to compare out-of-pocket costs across insurers during plan selection.

The Health Care Cost Institute (HCCI), a non-profit organization, announced in May plans to work with Hospitals across the country are making efforts to increase price transparency.

Chart 9: Sample of Price Transparency Initiatives Across U.S. Hospitals

El Camino Hospital: provides incurred out-of-pocket costs for procedures including non-hospital fees; estimated financial responsibilities to various providers are aggregated in one dashboard. Accessible on hospital website.

Alegent Creighton Health: provides out-of-pocket estimates for more than 700 procedures that take into consideration patient’s insurance status and coverage details such as deductible, coinsurance, etc. Hospital financial assistance policies are integrated in the tool and uninsured patients receive cost estimates that include discounts.

Spectrum Health: provides average procedure charges and payments from Medicare, Medicaid and private payers; out-of-pocket estimates are available to holders of the hospital’s insurance plan. All pricing information is accessible on the hospital’s website.

Cleveland Clinic: releases hospital charge data, including breakdowns for room rates, diagnostic charges, etc. All charges are accessible on the hospital website.

North Shore-Long Island Jewish: provides out-of-pocket estimates at the provider-level, and in ranges. Hospital provides estimates to patients via online form.

Geisinger Health System: provides out-of-pocket estimates that take into consideration patient’s insurance status and coverage via self-service portal, telephonic inquiry or submission of an online request for information.

Augusta Health: uses a team of financial counselors to proactively reach out to each patient with a scheduled service to provide pricing information, including the expected out-of-pocket obligation.

Baptist Health South Florida: addresses patient requests for estimated costs through a Central Pricing Office.

Aetna, Humana and UnitedHealthcare to develop a free online tool offering consumers information on the price and quality of health care services. Pricing information will be based on paid claims data across the multiple plans. The HCCI expects other commercial, Medicare Advantage and Medicaid health plans to provide information for the tool before it is released next year, and to add comparison features and data from fee-for-service Medicare and Medicaid programs in the future.

Provider Initiatives
Despite challenges related to contractual obligations restricting providers from releasing rates negotiated with payers, hospitals have launched a number of price transparency efforts. Some hospitals help patients estimate hospital out-of-pocket costs for common procedures based on their insurance status. Geisinger Health provides price estimates via telephonic or online requests, and Alegent Creighton Health maintains an online cost calculator that provides out-of-pocket estimates applicable to the prevalent types of insurances among the hospital’s patient population. North Shore-Long Island Jewish Hospital provides expected out-of-pocket expenses in a range that reflects costs incurred by 95 percent of similar cases.

Other providers help self-pay or uninsured patients evaluate treatment estimate facility costs by releasing charge data and determining patients’ eligibility for hospital financial assistance. The Cleveland Clinic provides all-inclusive charge information, including room rates via a website, and Spectrum Health provides average procedure charges along with payment rates from government and private insurers.

Moreover, some state hospital associations gather and disseminate average and median outpatient and

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**North Shore-Long Island Jewish provides expected out-of-pocket costs for common procedures.**

**Chart 10: North Shore-Long Island Jewish Transparency Tool (Snapshot)**

**Step 1:** Patients submit desired health care service and insurance detail

**Step 2:** Patients receive estimated out-of-pocket costs

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inpatient price data. The Wisconsin Hospital Association (WHA) was the first state to publish hospital charge and utilization data via its PricePoint website. WHA contracts with 10 other states that have developed their own PricePoint websites.\textsuperscript{40} WHA pairs its pricing data with quality and patient safety data available through its Checkpoint website. Checkpoint is licensed to two other states.

Despite their best efforts, hospitals may not be able to provide complete cost estimates for consumers because they lack access to specific necessary information, such as the portion of the consumer’s deductible that has already been met in any given year. To overcome these information silos, the field needs tools that combine reimbursement and beneficiary utilization data to provide accurate out-of-pocket cost estimates for consumers. The private sector has taken the lead in developing such tools and marketing them to hospitals, health plans and employers.

Commercial Vendor Initiatives
The need for health care price and quality information has attracted the attention of commercial vendors. Private companies have developed tools that bring together disparate data sources (including but not limited to all-payer claims databases, plan data, employer datasets, patient-reported data, etc.) and deliver information in a format patients can understand and use. Tools also are tailored to deliver information depending on patient preferences for obtaining transparency data. Some utilize a “high touch” model, which involves telephone calls and frequent interaction via electronic media such as email; others rely on web-based platforms to share cost and quality information.\textsuperscript{41}

Increasingly, commercial vendors offer transparency tools that help hospitals estimate each patient’s financial obligation. Technologies such as the Emdeon Patient Responsibility Estimator help hospitals to provide real-time out-of-pocket cost estimates.

**PricePoint provides median and average price data.**

Chart 11: Wisconsin PricePoint System (Snapshot)

to patients, who are able to evaluate and consider the cost of treatment prior to or at the point of service. The type of information provided differs across vendor tools. Some offer physician and hospital out-of-pocket estimates in one repository. Other tools allow patients to obtain an estimate for longer-term care episodes, such as pregnancy, that include all checkups as well as delivery costs. Many of these tools report quality data in addition to price, allowing consumers to evaluate their available treatment options. Yet other tools assist consumers in lowering out-of-pocket expenses by highlighting cost-savings opportunities. Castlight Health, for example, provides not only estimated out-of-pocket costs and quality data, but also pinpoints opportunities for lowering employees’ health care spending by using lower-cost care settings.

Despite the numerous price transparency efforts by the government, providers, payers and commercial vendors, no single stakeholder group has access to all the data necessary to provide consumers with an accurate estimate of their out-of-pocket costs. Price transparency efforts need to evolve as care and payment modalities change. For example, as health care reimbursement moves away from traditional fee-for-service payments, wherein each provider involved in a procedure is paid separately, to bundled payments for all the services provided during an episode of care, patients will need a clear understanding of what is and is not included in the price provided. Achieving complete and relevant price transparency will require collaboration between various stakeholder groups, each of which has access to unique pricing data and resources to provide consumers with appropriate information to support decision-making.

Transparency will bring many benefits, but can result in unintended consequences.

Increased price and quality transparency results in numerous benefits. Making price and quality information easily accessible will encourage providers to benchmark and improve their performance against peers. Research shows that hospitals that observed quality improvements at neighboring providers enhanced their own performance on those quality indicators by 0.2 percentage points, regardless of their performance during the previous year. Easily understood price and quality data also could focus the consumer on value.

Information on expected out-of-pocket costs prior to treatment can prepare patients for their financial obligations and potentially reduce the burden of bad debt on hospitals. Michigan-based Oaklawn Hospital offers patients who choose to pre-register a week in advance of treatment an estimate of their out-of-pocket costs, including copays and required deductible. The hospital found such price transparency in advance of treatment improved point-of-service collections. While patient-specific price estimates currently are available only for high-cost services such as outpatient surgery and endoscopies, Oaklawn Hospital is planning to expand available estimates to include chemotherapy and obstetric procedures.

While the benefits of greater transparency are considerable, several unintended consequences may result. Price transparency could lead to price-driven competition that endangers the public benefits of mission-driven care. Hospitals provide social goods that benefit the general population, such as conducting medical research, training tomorrow’s physicians and other health care professionals, and providing care for disadvantaged populations, the costs of which are included in hospital prices. One study found that 78 percent of consumers are not willing to pay higher prices to be treated at academic medical centers that typically have such mission-related expenses. Absence of adequate patient volumes and revenues to support teaching and research could put these social goods at risk. Organizations that have higher cost structures due to high-intensity services such as transplant, trauma and neonatal intensive care, which may be inadequately reimbursed from payers, may also be at risk.

Price transparency also could lead policymakers and other stakeholders to demand price controls, severely eroding the margins that providers require on insured patients to support payment shortfalls from Medicare, Medicaid and uncompensated care. Finally, unmanaged transparency efforts could lead to increases in health care prices. Some hospitals that are poorly reimbursed compared to their local peers might renegotiate reimbursement rates with insurance companies, driving up prices.

Conclusion

The push for greater transparency likely is here to stay. Hospitals and other providers recognize the need to work with federal and state governments, insurers, employers and commercial vendors to increase the availability and usefulness of price information for consumers. While the potential unintended consequences of enhanced transparency need to be monitored, greater visibility into price and quality data is necessary as consumers become increasingly engaged in their health care decisions.

**POLICY QUESTIONS**

- What safeguards can be put in place to avoid unintended consequences of price transparency?
- What research needs to be done to develop tools that better engage consumers?
- How can funding for social goods be protected as consumers become more cost conscious?
- What else can policymakers do to promote the sharing of meaningful pricing data?