

# Price Transparency 101: Understanding the Basics

## Introduction

Price transparency is one of the most discussed topics in modern healthcare. Patients are increasingly asking for information about out-of-pocket costs for healthcare services, yet for providers, coming up with an answer that is understandable is not always easy. Since it can be difficult to determine exactly what treatment a person might need until tests and examinations are complete, it can be a challenge to estimate total cost to the patient. Even when it is possible for a patient to get an estimate, the complexity of the healthcare jargon associated with price can make the answer difficult to decipher. This Q & A was designed to help demystify the most common questions pertaining to hospital pricing and covers topics such as commonly used pricing terminology, the reasons behind price differences and the importance of considering quality. Visit [hospitalpricetransparency.com](https://hospitalpricetransparency.com) to view the online version.

## Price & Payment

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What is “price transparency” and why is it important?

A

Price transparency is the ability for you, the healthcare consumer, to access provider-specific information on the price of healthcare services – including out-of-pocket costs – regardless of the setting in which they are delivered.<sup>i</sup>

Q

Why do purchasers and consumers need price transparency?

A

For three main reasons:

1. To help purchasers contain healthcare costs;
2. To inform consumers’ healthcare decisions as they assume greater financial responsibility; and
3. To reduce unknown price variation in the system.<sup>ii</sup>



## What are the different types of healthcare costs?



There are three different types of cost depending on who is paying for the service.

### *Costs to Patients*

This often includes the total amount of premium payments, deductibles and coinsurance paid to healthcare providers and health insurance companies for coverage. The cost to patients also includes healthcare supplies and services received within the coverage period. Healthcare services not covered by insurance can be another type of cost.

### *Costs to Providers*

While providers are paid by insurers for the services they deliver to patients, they incur a considerable amount of operating costs, which often get lost in the equation. These costs can include the amount paid for land, buildings, equipment, supplies, wages and benefits, laundry and housekeeping, and electronic medical records, as well as services used when delivering care to patients. Providers also bear the cost of delivering care to patients who are unable to pay for their own care.

### *Costs to Payers*

Payers in the healthcare system include both private insurance companies and government insurance programs. The cost to healthcare payers is the total amount they distribute in patient claims. Costs to payers also include operating costs such as wages and benefits, supplies, and administrative costs.



## Is there a difference between charges, cost and payment (negotiated contract rate)?



Yes.

### *Charges*

“Charges” refer to the prices providers set for each individual service rendered to patients. Charges serve as the starting point from which payment is negotiated. Most patients do not pay full billed charges for healthcare services.

### *Cost*

A provider’s “cost” refers to the amount spent by the provider delivering services and includes all of the expenses involved in keeping its doors open, from supplies to utilities to labor.

### *Payment / Negotiated Contract Rate*

“Payment” refers to the dollar amount paid by insurers – public or private – to providers for services rendered. The payment represents the results of the negotiation between the individual provider and the individual insurer. Payment also includes the amount received from patients directly for the deductible, coinsurance or co-pays as well as charges for services not covered by the insurance policy.

Q

How are charges set?

A

The charges for healthcare services are derived by calculating the cost of delivering a specific treatment or service to the patient.

Q

Who sets charges?

A

Hospitals have in place a chargemaster, which is a comprehensive list of all items that can be billed to a patient or insurance provider. Chargemasters are extensive, containing thousands of items, depending upon the facility. Under federal law, all insurers, including Medicare and Medicaid, must be billed the amount listed on the chargemaster for the services rendered. However, these charges are rarely paid due to the contracted payment rates negotiated between hospitals and insurers.

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Why do charges for similar services vary among hospitals?

A

There can be variations, sometimes large ones, in the charges hospitals set for the same procedure or service. This is because there are many factors that go into determining the cost of hospital services, and each institution has its own set of factors – or cost structure – to manage. For example, some organizations have higher cost structures due to high-intensity services, such as transplant, trauma, and neonatal intensive care, that are expensive to maintain, or mission-related costs such as teaching, research, or care for low-income populations.<sup>iii</sup> Also a significant factor is that different parts of the country have higher or lower costs of living. This affects wages, which are one of the largest expense categories for hospitals.



## Where can I find payment information?



While private insurance companies do not typically release comprehensive payment information because it would undermine their ability to compete for business, there are several ways for consumers to educate themselves.

### *The Centers for Medicare and Medicaid Services*

Medicare releases annual payment information for inpatient and outpatient procedures. For more information, visit [cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Inpatient.html](https://cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Inpatient.html).

### *All-Payer Claims Database*

Some states adopt an APCD, which is a large-scale database that collects medical claims, pharmacy claims, dental claims, and eligibility and provider files from private and public payers. For more information, visit [www.apcdcouncil.org](http://www.apcdcouncil.org).

### *FAIR Health Medical Cost Look Up*

This consumer-oriented tool provides information on out-of-pocket costs to consumers. For more information, visit [fairhealthconsumer.org/medicalcostlookup.php](http://fairhealthconsumer.org/medicalcostlookup.php).



## Is the payment I am responsible for all I should consider in selecting a provider?



No. Payment is only one aspect of choosing a healthcare provider. The ease of seeing a physician, or access to a healthcare provider, is also a consideration. Similarly, the *quality* of healthcare being delivered is an important factor when it comes to choosing a provider.



## Where can I find information on quality measures?



Today there are more places than ever to find hospital quality data. One of the most common and comprehensive sources for quality data is Medicare's Hospital Compare website. For more information, visit [medicare.gov/hospitalcompare/search.html](https://medicare.gov/hospitalcompare/search.html). Here you can find information on the timeliness of care, number of readmissions and complications, and also surveys of past patients' experiences.

In addition, the Dartmouth Atlas of Health Care has a website dedicated to benchmarking providers against one another to compare quality measures. For more information, visit [dartmouthatlas.org](http://dartmouthatlas.org).

## Coverage

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Does the type of coverage I have (e.g., Private, Medicaid, and Medicare) impact my costs?

A

Yes. It is very common for health insurance entities – both public and private – to charge various amounts for deductibles, co-pays, and co-insurance depending on the insurance plan. All of these variables can have a direct impact on the amount of money you spend on healthcare services. In addition, high-deductible plans – which typically require a large payment from the patient before the insurance company begins paying – are becoming more common in the United States as employers are finding it increasingly difficult to cover the entire cost of healthcare for their employees.

Q

Why do some people on Medicare pay a different amount for the same procedure than others?

A

Each provider has different operating costs. For example, a hospital that serves a large number of uninsured patients and is also a certified teaching hospital, which means it trains residents, will have much higher operating costs than a hospital that does not have a training program or has a limited amount of patients who are unable to pay their bills. Those higher operating costs are ultimately reflected in the price of care for Medicare-covered procedures. Another explanation for cost variation among Medicare enrollees is based on the type of Medicare health insurance. For instance, Medicare Advantage Plans, offered by private companies such as health maintenance organizations (HMOs) or preferred provider organizations (PPOs), often have different prices when compared to traditional Medicare plans since they are negotiated by private companies.



### What are the financial responsibilities of insured patients?<sup>iv</sup>



#### *Deductible*

The amount you owe for healthcare services before your health insurance plan begins to pay. For example, if your deductible is \$100, your health insurance won't pay anything until you've met your \$100 deductible for healthcare services. Your deductible may not apply to all services. For example, some plans offer a yearly mammogram or physical exam free of charge.<sup>v</sup>

#### *Co-pay*

The fixed amount of out-of-pocket costs you pay when visiting the doctor's office for a particular healthcare service. One example is a visit to your primary care doctor. If your co-pay is \$20, that means you pay \$20 per visit regardless of the reason for seeing your doctor, and your insurance company pays the rest.

#### *Co-insurance*

The amount of covered benefits that the patient is responsible for paying after reaching his or her deductible amount. For example, if your coinsurance is 20 percent of medical costs, and the insurer's contracted rate for the service is \$100, you pay \$20 and the insurance company is responsible for \$80.



### What's the difference between a covered and non-covered service?



The differences between covered and non-covered services are essentially what they sound like – some are paid for by your insurance, while others are not. Whether or not a service is covered is dependent upon your insurance policy. For example, Medicare will pay for an annual physical exam as part of a *covered* service. However, Medicare does not pay for normal dental procedures. Non-covered services are services patients are responsible for paying on their own.



### If I am uninsured, do I pay the hospital's charges?<sup>vi</sup>



That depends. If you are earning a yearly salary that would support health coverage, then you could be expected to pay the full charge. If your annual earnings are low you may qualify for a sliding-fee or discounted-fee schedule to help pay your healthcare bills. Most hospitals have financial assistance and charity care policies that can be found on their websites. You can also contact the hospital directly and ask them for information on their financial assistance and charity care policies.



### What is “charity care”?



“Charity care” is the term hospitals use to describe services for which they neither received, nor expected to receive, payment because of the patient’s inability to pay. Patients whose services fall into this category do not qualify for government health insurance programs, such as Medicaid, and cannot afford to buy private health insurance coverage or to pay out-of-pocket for healthcare services. This can include people who have insurance but cannot afford the portion of their expenses they are responsible for, or who have extraordinary healthcare expenses.



### What options do I have if I’m uninsured?



Thankfully, under the Affordable Care Act most people have access to some type of coverage. Should you find yourself uninsured and wondering how you’ll pay for care, there are a few questions you should ask yourself before making any decisions.

#### *Do I qualify for Medicaid or insurance premium assistance under the ACA?*

If you are below 138% of the Federal Poverty Level (FPL) you may qualify for Medicaid coverage. If you do not qualify for Medicaid it is important to consider purchasing coverage. A serious illness and hospitalization can be very costly. If you are making between 138% and 400% of the FPL, you may qualify for subsidies to help reduce the cost of health care premiums. If you are uninsured and have already received care, you should contact the hospital regarding its financial assistance plan.

#### *Do I have the ability to pay for healthcare out of pocket?*

If you have the ability to pay out-of-pocket for your healthcare expenses, providers will sometimes offer what is called a “prompt payment discount” meaning if you pay your balance quickly and in full, providers will offer a discounted rate for the services you received. Many hospitals also offer financial assistance plans based on level of income.

#### *What if I don’t qualify for Medicaid and can’t pay for healthcare on my own?*

If you are below 100% of the FPL, you may qualify for free care through a program known in Ohio as the Hospital Care Assurance Program, or HCAP. If you are above that income threshold, you should contact the hospital regarding its financial assistance plan.

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<sup>i</sup> Catalyst for Payment Reform, *Price Transparency: An Essential Building Block for a High-Value, Sustainable Health Care System*. [http://www.catalyzepaymentreform.org/images/documents/CPR\\_Action\\_Brief\\_Price\\_Transparency.pdf](http://www.catalyzepaymentreform.org/images/documents/CPR_Action_Brief_Price_Transparency.pdf).

<sup>ii</sup> IBID.

<sup>iii</sup> American Hospital Association. *Pricing Transparency Efforts Accelerate: What Hospitals and Other Stakeholders Are Doing to Support Consumers*, July 2014. <http://www.aha.org/research/reports/tw/14july-tw-transparency.pdf>.

<sup>iv</sup> Davis, E. "Copay Vs. Coinsurance – What's the Difference and Which is Riskier?" *About Health*, April 15. <http://healthinsurance.about.com/od/faqs/f/Whats-The-Difference-Between-Copay-And-Coinsurance.htm>.

<sup>v</sup> Healthcare.gov. "Deductible." Accessed May 27, 2015. <https://www.healthcare.gov/glossary/deductible/>.

<sup>vi</sup> U.S. Department of Health and Human Services. "NHSC Sliding Fee Discount Program Information Page." March, 2015. <http://nhsc.hrsa.gov/downloads/discountfeeschedule.pdf>.