



TRENDWATCH

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.¹ 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.²

“ ”
from the field

“You can be a highly educated consumer now and still not understand what bill is going to hit you.”⁷

— 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.

Chart 1: Definitions of Selected Health Insurance Terms

Element	Definition
Cost-Sharing	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.
Copay	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.
Coinsurance	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.
Deductible	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.
Out-of-Pocket Maximum	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.
High-Deductible Health Plan (HDHP)	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.

Source: Healthcare Financial Management Association. (2014) Understanding Healthcare Prices: A Consumer Guide.

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 services⁴ and requires significant cost-sharing for extended hospital or skilled nursing facility stays.⁵ 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

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.”

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.⁹ 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 agency¹⁰ 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)



from the field

“Health care bills are very confusing and [patients] are getting multiple bills not only from the hospital but from their physicians.”⁸

— 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 quality¹² and doubt that high-quality care can be delivered at low cost.¹³ Patient beliefs are so powerful that researchers report higher price tags improve patient responses to treatments through the placebo effect.¹⁴ 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.¹⁵

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.”¹⁶ 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.¹⁷

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

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

Provider	Quality Data			Price Data
	Uses treatments proven to get results	Has safeguards to protect patients from medical error	Is responsive to patients' needs and preferences	Careful with your health care dollars*
Dr. Jackson	Worse	Better	Better	●
Dr. Lew	Better	Average	Better	● ● ●

* 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.¹⁸ An accompanying consumer guide provides information to consumers on how to seek pricing information.¹⁹

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.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.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)*

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

*DRG list represented is not comprehensive

Source: Center for Medicare & Medicaid Services. Accessed March 2014: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Inpatient.html>

“ ”
from the field

“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.”¹¹

— George Lowenstein, health care economist

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.

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

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

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

Source: All-Payer Claims Database Council. (January 2014). *The Basics of All-Payer Claims Databases*.

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

The Health Care Price Transparency Promotion Act of 2013 (H.R. 1326)²⁵

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.

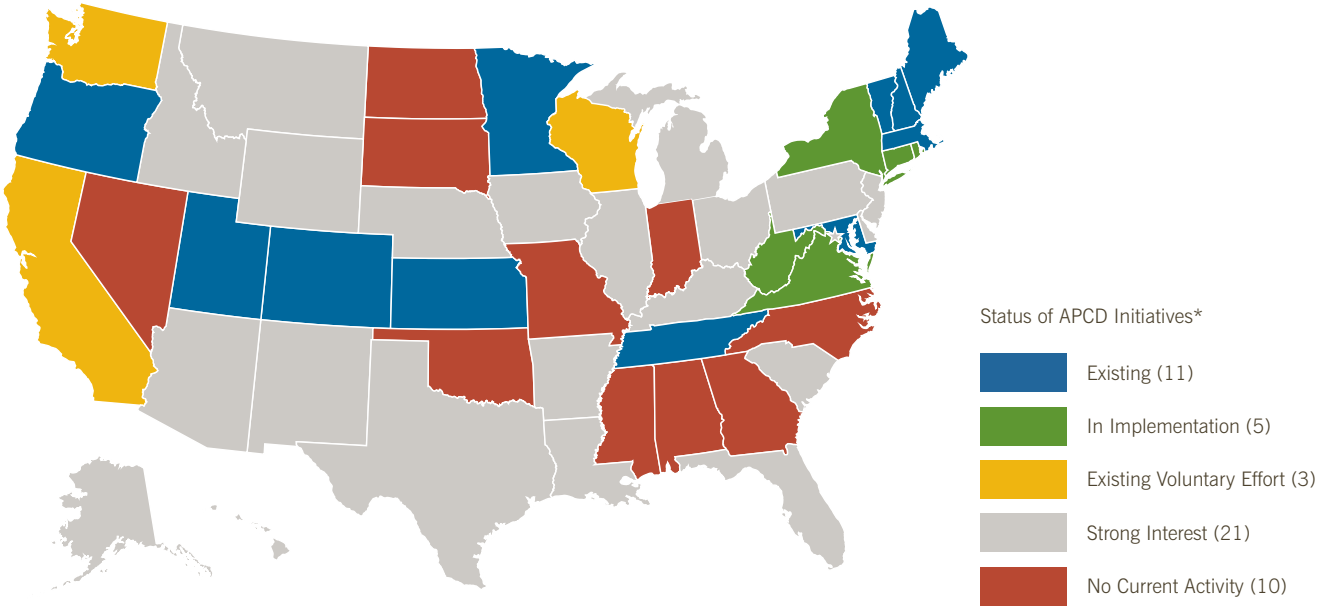
The proposed law would require:

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 of voluntary APCDs. Source: APCD Council. Interactive State Report Map. Accessed April 2014: <http://www.apcdouncil.org/state/map>

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)

The screenshot shows the MyHealthCareOptions website interface. At the top, it says "MyHealthCareOptions" and "A Health Care Resource Provided by the Commonwealth of Massachusetts Health Care Quality and Cost Council". Below this is a navigation menu with options like "For Patients & Families", "About The Ratings", "Frequently Asked Questions", "Resources & Tools", "About Us", and "Feedback". The main content area is titled "Massachusetts General Hospital" and features a search bar. On the left, there is a "Choose a Topic" sidebar with categories like "Patient Safety", "Patient Experience", "Bone and Joint Care", "Cardiovascular Disease", "Digestive System", and "Obstetrics". The main content area displays information for "Cardiovascular Disease: Heart Attack". It includes a description of a heart attack, diagnostic classification (Heart Attack (APR-DRG 190)), and buttons for "Summarized Report" and "View Detailed Report". On the right, there is "Contact Information" for Massachusetts General Hospital. Below the description, there are three quality metrics: "Quality of Recommended Care (Above State Average Quality)" with 4 stars, "Quality of Care - Mortality (Better than U.S. National Rate)" with 4 stars, and "Quality of Care - Readmissions (Not Different than U.S. National Rate)" with 3 stars. At the bottom, there is a "Cost of Care (Above Median State Cost)" indicated by 3 dollar signs (\$\$\$). A "Quality of Care - State Legend" at the bottom explains the star ratings: 4 stars for "Below State Average Quality" and 3 stars for "Not Different from State Average Quality".

Annotations on the right side of the screenshot:

- Blue box: "Patient selects desired health care service and provider..." (pointing to the "Heart Attack" topic selection)
- Blue box: "...and is able to see how providers compare against state average quality and median state cost." (pointing to the quality and cost metrics)

Source: MyHealthCareOptions. Accessed July 2014: <http://hcqcc.hcf.state.ma.us/Default.aspx>

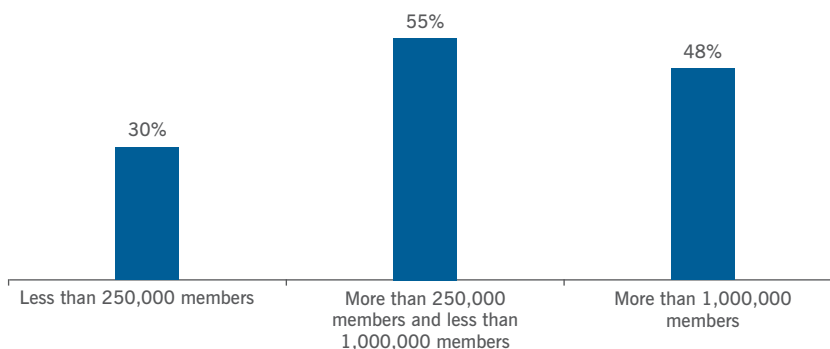
burden, facilitate the exchange of information among states and allow for more detailed analysis of national health care trends.³³

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

Plans with more enrollees are more likely to offer cost estimation tools.


Chart 7: Percentage of Insurers that Offer Out-of-Pocket Cost Calculators to Beneficiaries



Source: HealthSparq. (2013). Health Insurance Plans and Transparency: An Industry Benchmark.

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

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



< [Back to Cost Estimate](#)

Start a New Search

Healthwise® Knowledgebase

Aetna IntelliHealth®

Cost of Care

FAQs

Glossary

View Printable Estimate

Cost Details

This estimate is for NGMD00
 Date of estimate: 03/06/10
 Service: **Established Patient Preventive Care Visit Ages 50 - 64**
Female
[View Description of Service](#)

Doe, Jane, MD
Family Practice
1.99 miles
[Directions](#)

Your Total Estimated Payment						
Cost of Service	Aetna Deductible	Plan Plays	Your Cost	Your Deductible Payment	Your Coinsurance Payment	Other
\$150.03	\$0.00	\$125.03	\$25.00	\$0.00	\$0.00	\$0.00
View Payments			Your Total Estimated Payment: \$25.00			

Source: NaviNet. Overview of Aetna's Member Payment Estimator. Accessed March 2014: <https://www.navinet.net/aetnaestimator/overview.htm>

While most payer tools estimate the cost of provider-specific medical encounters, few provide consumers the ability to compare costs across providers.³⁵ One private insurance tool that successfully allows for cross-provider treatment cost comparison is Aetna’s “Member Payment

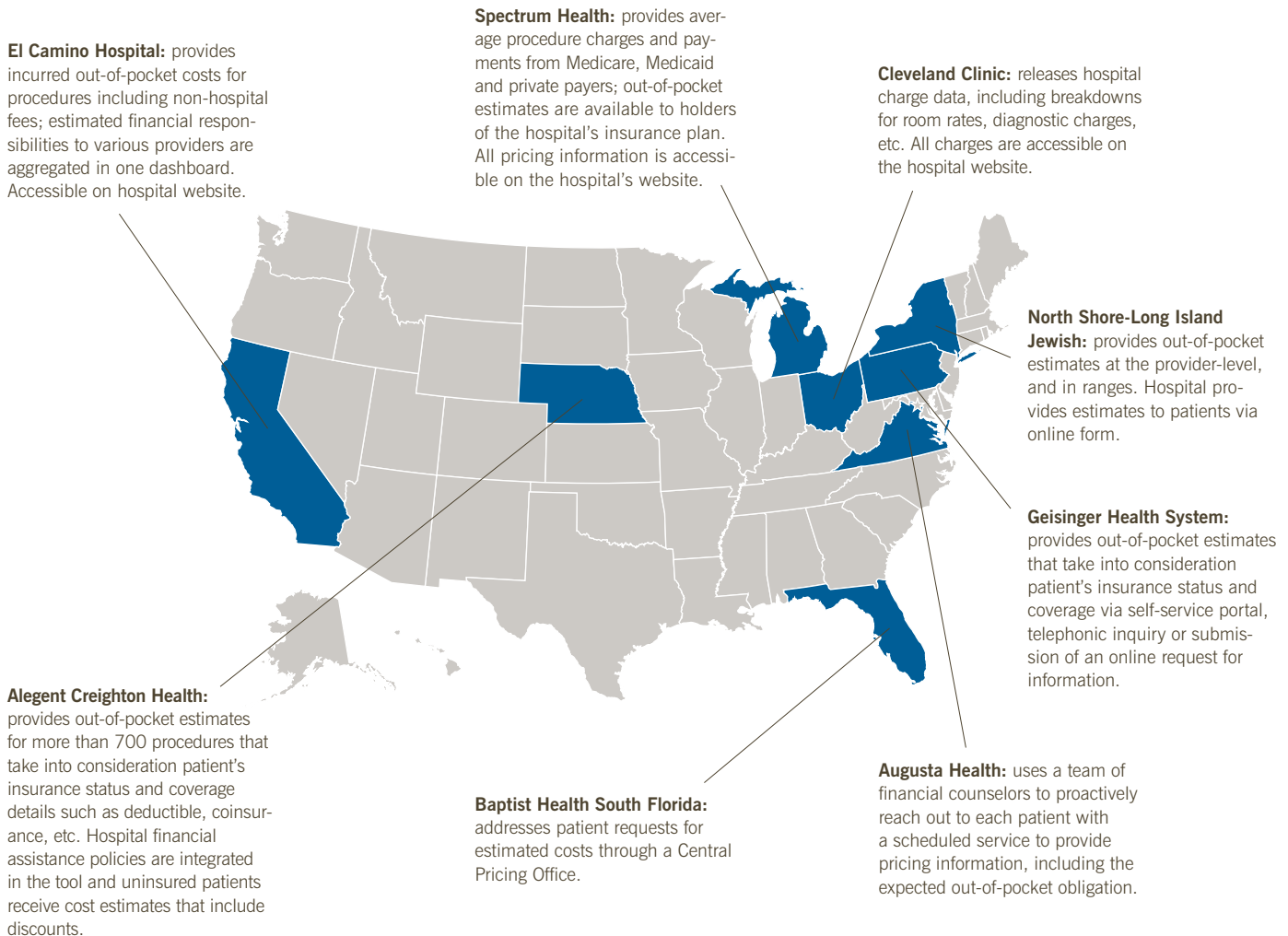
Estimator.” It provides expected out-of-pocket costs by taking into account beneficiary-specific deductible information. All cost estimates are in real time and beneficiaries can compare expected out-of-pocket costs across various providers. Such cost estimation tools

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



Source: Healthcare Financial Management Association. (2014). El Camino Hospital’s Consolidated Patient Bills Speed Self-Pay Collections; Healthcare Financial Management Association. Lessons Learned from Price Transparency Pioneers; Baptist Health South Florida. (2013). Baptist Health: A Leader in Hospital Pricing Transparency; Baptist Health South Florida. Insured Patients. Geisinger Health System. MyEstimate. Spectrum Health. Average Prices for Grand Rapids Area. Estimate Your Personal Expense. The Cleveland Clinic. Patient Price Information List. American Hospital Association-provided information on Augusta Health’s program.

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,³⁶ and Alegen 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.³⁷ 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,³⁸ and Spectrum Health provides average procedure charges along with payment rates from government and private insurers.³⁹

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

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

The screenshot shows the 'Estimate Your Personal Expense' form. The form includes a navigation bar with 'Services & Programs', 'Find a Doctor', 'Locations', 'Community', 'Research & Clinical Trials', and 'Quality'. The main content area has a breadcrumb trail: 'Home > Financial Assistance > Estimate Your Personal Expense'. The form title is 'Estimate Your Personal Expense'. Below the title, there is a brief explanation: 'The Personal Expense Estimator provides an estimate for your hospital fees only. Physician fees (such as Radiologist and Anesthesiologist fees) are not included in this estimate and will be billed separately.' The form asks for the following information:

- Who is your insurance carrier? (Aetna)
- What type of care will you be having? (CT)
- What hospital will you be going to? (Center for Advance Medicine)
- Will you be staying overnight? (No)
- What procedure will you be having? (CT)

Buttons for 'Send Info' and 'Start Again' are visible. A disclaimer section follows, stating: 'This estimate is not a guarantee of the amount you may owe the hospital. Estimates are based on the information you provided and reflect the range of cost for 95% of patients with similar criteria. Lenox Hill, Staten Island and Huntington Hospital are currently not included in the estimates. Please contact 1-877-483-2213 for further assistance.' A link for 'NO HEALTH INSURANCE?' is also present.

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

The screenshot shows the 'Estimate Cost Results' page. The breadcrumb trail is 'Home > Financial Assistance > Estimate Your Personal Expense'. The form title is 'Estimate Your Personal Expense'. Below the title, there is a brief explanation: 'The Personal Expense Estimator provides an estimate for your hospital fees only. Physician fees (such as Radiologist and Anesthesiologist fees) are not included in this estimate and will be billed separately.' The results are displayed as follows:

Estimate Cost Results
Based on the information you provided your out of pocket expenses may range from \$33 to \$117.

Treatment Facility: Center for Advance Medicine
Insurance Type: Aetna
Procedure: CT

Below the table, there is a disclaimer: 'The Personal Expense Estimator provides an estimate for your hospital fees only. Physician fees are not included in this estimate and will be billed separately.'

Source: North Shore-Long Island Jewish. Accessed April 2014: <http://www.northshorelij.com/hospitals/financial-assistance/estimate-cost>

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.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.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)

Mayo Clinic Health System - Chippewa Valley in Bloomer
 1501 Thompson Street
 Bloomer, WI 54724
 715-568-2000

Blood Infection/Septicemia
 January 2013 - December 2013

The hospital charge does not include physician fees.

Filter on Severity of Illness: 1 2 3 4

	Selected Hospital	All Hospitals in this County	All Hospitals with Similar Patient Volume	All WI Hospitals
Number of Discharges	10	79	137	17,821
Average Length of Stay	3.7 Day(s)	4.5 Day(s)	4.2 Day(s)	5.9 Day(s)
Average Charge	\$12,804	\$21,909	\$25,339	\$36,187
Average Charge Per Day	\$3,460	\$4,903	\$5,965	\$6,185
Median Charge	\$11,706	\$18,696	\$18,571	\$23,743

Source: Wisconsin PricePoint System. Accessed June 2014: http://www.wipricepoint.org/Report_INP.aspx

Castlight Health helps patients assess treatment costs and quality data prior to service.

Chart 12: Castlight Health Price and Quality Transparency Tool

The screenshot displays the Castlight Health website interface. At the top, the user is identified as Melissa Bloom with options for 'Inbox (1)', 'Bookmarked (0)', 'Your Account', 'Overview', 'Log Out', and 'Help'. Navigation tabs include 'home', 'find care', 'past care', and 'your plan'. The main heading is 'Know your costs before you go.' with a subtext: 'Depending on where you go, prices for doctor's visits and services can vary wildly. We'll help you find the doctor and price that's right for you.' Below this, there are three columns: 'Find a Doctor', 'Find a Service', and 'Treat a Condition'. The 'Find a Service' column shows rates for CA for EKG (\$21 - \$83), Phys. therapy (\$20 - \$92), and Lab test (\$4 - \$137). The 'Treat a Condition' column shows Office and ER rates for Earache (\$138, \$708), Pink eye (\$137, \$447), and Sore throat (\$87, \$527). A search bar is present with the text 'Looking for something else?' and 'Search for a doctor, service, or condition'. Below the search bar, it says 'Searching near 4375 Foothill Road Pleasanton CA 94588 (Change)'. On the right, a 'Your plan phase' section shows 'DEDUCTIBLE' selected, with 'ACME PAYS' 100% of routine preventive care and 'YOU PAY' 100% of all other care until the \$4,000 deductible is met. It shows \$1,830 spent to date and \$2,170 remaining deductible. At the bottom, there are 'Your Recommendations' and 'Updates' sections. A recommendation says 'Avoid the emergency room when you can' with a 'Find urgent care' button. An update says 'You have 1 new message in your inbox.' and a link to 'Why do prices vary so much?'.

Source: Castlight Health. Accessed May 2014: <http://www.castlighthealth.com/solutions/>

to patients, who are able to evaluate and consider the cost of treatment prior to or at the point of service.⁴²

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.⁴³ Yet other tools assist consumers in lowering out-of-pocket

expenses by highlighting cost-savings opportunities. Castlight Health,⁴⁴ 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.⁴⁵

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.⁴⁶ 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.⁴⁷ 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.⁴⁸ 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.⁴⁹

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.⁵⁰ 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.⁵¹

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?

ENDNOTES

1. MedPAC. (2005). *A Study of Hospital Charge Setting Practices*.
2. Avalere Health analysis of American Hospital Association Annual 2012 Survey data, for community hospitals.
3. American Institute for Research. (2012). *Consumer Beliefs and Use of Information About Health Care Cost, Resource Use, and Value*. Robert Wood Johnson Foundation.
4. Medicare Rights Center. (2011). <http://www.medicareinteractive.org/>
5. Congressional Budget Office. (2013). *Change the Cost-Sharing Rules for Medicare and Restricted Medigap Insurance*.
6. IRS.gov. (2014) *New Requirements for 502 (c) (3) Hospitals Under the Affordable Care Act*. [http://www.irs.gov/Charities-%26-Non-Profits/Charitable-Organizations/New-Requirements-for-501\(c\)\(3\)-Hospitals-Under-the-Affordable-Care-Act](http://www.irs.gov/Charities-%26-Non-Profits/Charitable-Organizations/New-Requirements-for-501(c)(3)-Hospitals-Under-the-Affordable-Care-Act); IRS.gov. *Reliance on Proposed Regulations for Tax-exempt Hospitals*. <http://www.irs.gov/pub/irs-drop/n-14-02.pdf>
7. *Journalgazette.net*. (2013). *Out of Pocket: Shopping Around Before Surgery Can Slash Costs*.
8. FierceHealthFinance. (2013). *Meritus Health: Improve Patient Experience One Medical Bill at a Time*.
9. Carnegie Mellon News. (2013). Press Release: *Consumers Don't Understand Health Insurance, Carnegie Mellon Research Shows*.
10. Intuit Health. (2011). *Intuit Health Survey: Americans Worried About Costs; Want Greater Access to Physicians*. Accessed May 2014: http://about.intuit.com/about_intuit/press_room/press_release/articles/2011/IntuitHealthSurveyAmericansWorriedAboutCostsWantGreaterAccessToPhysicians.html
11. *WashingtonPost.com*. (2013). *Do You Understand Health Insurance? Most People Don't*.
12. The National Business Coalition on Health. (2012). *Price Transparency: Now More Than Ever*.
13. California HealthCare Foundation. (2012). *Value Judgment: Helping Health Care Consumers Use Quality and Cost Information*.
14. Waber R et al. (2008) *Commercial features of placebo and therapeutic efficacy*. *JAMA*;299:1016-1017.
15. Hibbard, JH., et al. (2012). *An Experiment Shows That A Well-Designed Report On Costs And Quality Can Help Consumers Choose High-Value Health Care*. *Health Affairs*, 31, no.3 (2012): 560-568.
16. Kurtzman, E., (2013). *Using Performance Information—What Presentation Formats Support Consumer Decision Making?* Presentation delivered at the National Summit on Health Care Price, Cost and Quality Transparency. Robert Wood Johnson Foundation on December 3 2013.
17. Kurtzman, E., (2013). *Using Performance Information—What Presentation Formats Support Consumer Decision Making?* Presentation delivered at the National Summit on Health Care Price, Cost and Quality Transparency. Robert Wood Johnson Foundation on December 3 2013.
18. Healthcare Financial Management Association. (2014). *Price Transparency In Health Care*. https://www.calhospital.org/sites/main/files/file-attachments/hfma_pricetransparencyreport_2014-final.pdf
19. Healthcare Financial Management Association. (2014). *Understanding Healthcare Prices: A Consumer Guide*. <https://www.hfma.org/WorkArea/DownloadAsset.aspx?id=22288>
20. HealthLeaders Media. (2013). *CMS Releases Hospital Pricing Data*. <http://www.healthleadersmedia.com/content/hep-292001/CMS-Releases-Hospital-Pricing-Data>
21. Center for Medicare and Medicaid Services. (2013). *Medicare Provider Charge Data: Inpatient*.
22. Center for Medicare and Medicaid Services. (2014). *Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2015 Rates*.
23. Center for Medicaid and Medicare Services. (2013). *Hospital Compare*. <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalCompare.html>
24. American Hospital Association State Transparency Survey data. (2014).
25. iHealthBeat. (2013). *Bill Aims to Boost Transparency of Health Care Cost Information*; Congress.gov. (March 2013). H.R. 1326 – Health Care Price Transparency Promotion Act of 2013.
26. APCD Council. *Interactive State Report Map*. <http://apcdouncil.org/state/map>
27. APCD Council. (2014). *The Basics of All-Payer-Claims-Databases*. The Robert Wood Johnson Foundation. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf409988
28. Freedman HealthCare. (2014). *Realizing the Potential of All-Payer Claims Databases*. The Robert Wood Johnson Foundation. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf409989
29. The Commonwealth Fund. (2010). *All-Payer Claims Databases: State Initiatives to Improve Health Care Transparency*.
30. APCD Council. (2014). *The Basics of All-Payer-Claims-Databases*. The Robert Wood Johnson Foundation. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf409988
31. My Health Care Options. <http://hcqcc.hcf.state.ma.us/Content/FrequentlyAskedQuestions.aspx#answer4>
32. The National Conference of State Legislatures Briefs for State Legislators. (2010). *Collecting Health Data: All-Payer Claims Databases*. http://www.ncsl.org/portals/1/documents/health/ALL-PAYER_CLAIMS_DB-2010.pdf
33. Miller, P., (2012). *Testimony Presented to the Public Health Committee Supporting House Bill No. 5038*. APCD Council.
34. The Wall Street Journal. (2009). *How to Research Health Care Prices*.
35. HealthSparg. (2013). *Health Insurance Plans and Transparency: An Industry Benchmark*.
36. Geisinger MyEstimate. http://www.geisinger.org/patients/business_services/estimator/
37. Alegent Creighton Health. <https://www.alegentcreighton.com/body.cfm?id=4735>
38. The Cleveland Clinic Patient Price Information List. https://my.clevelandclinic.org/Documents/Patients/HB197_MAIN_2010.pdf
39. Spectrum Health Average Prices for Grand Rapids Area. <http://www.spectrumhealth.org/AveragePrices>
40. Deloitte Center for Health Solutions. (2007). *Health Care Price Transparency: A Strategic Perspective for State Government Leaders*.
41. Catalyst for Payment Reform. (2013). *The State of the Art of Price Transparency Tools and Solutions*.
42. Emdeon Patient Responsibility Estimator. <http://www.emdeon.com/responsibilityestimator/>
43. Delbanco, S., (2013). *Price Transparency Tools: The Good News, The Challenges, and The Way Forward*. Health Affairs Blog. <http://healthaffairs.org/blog/2013/11/20/price-transparency-tools-the-good-news-the-challenges-and-the-way-forward/>
44. Full disclosure: Avalere is an investor in Castlight Health.
45. Castlight Health. <http://www.castlighthealth.com/solutions/>
46. The Commonwealth Fund. (2007). *Health Care Opinion Leaders' Views on the Transparency of Health Care Quality and Price Information in the United States*.
47. Baicker, K. and Chandra, A. (2009). *Improving Health Care Quality and Values: Local Challenges and Local Opportunities*. Harvard Kennedy School.
48. Ubel, P., et al. (2013). *Full Disclosure — Out-of-Pocket Costs as Side Effects*. The New England Journal of Medicine, 369, 1484-1486.
49. Healthcare Financial Management Association. (2009). *Strategies for a High-Performing Revenue Cycle*.
50. PWC Health Research Institute. (2012). *The Future of Academic Medical Centers: Strategies to Avoid a Margin Meltdown*.
51. Catalyst for Payment Reform. *Price Transparency An Essential Building Block for High-Value, Sustainable Health Care System*; <http://www.leapfroggroup.org/media/file/PriceTransparencyActionBrief.pdf>

TrendWatch, produced by the American Hospital Association, highlights important trends in the hospital and health care field. Avalere Health supplies research and analytic support.

TrendWatch—July 2014
Copyright © 2014 by the American Hospital Association.
All Rights Reserved



American Hospital Association
800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001-4956
202.638.1100
www.aha.org



Avalere Health LLC
1350 Connecticut Avenue, NW
Suite 900
Washington, DC 20036
202.207.1300
www.avalere.com