

Understanding Healthcare Prices: A Consumer Guide



hfma[™]
healthcare financial management association

Contents

- Acknowledgments **2**
- Introduction **3**
- For Consumers with Health Insurance Coverage **5**
- What to Know About Emergency Care **10**
- In-Network and Out-of-Network Care **11**
- For Medicare Beneficiaries **14**
- For Consumers Who Don't Have Health Insurance **15**
- Improving Price Information **16**
- Definitions **17**
- For More Information **20**

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Introduction



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.

Words shown in red are defined on pages 17-19 of this report.

Introduction

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.

| Question | Likely Answers | Tips |
|---|---|---|
| What is the exact name of the procedure? | Laparoscopic cholecystectomy | Ask the doctor to clearly print the name of the procedure. Correct spelling is important and many surgery names sound similar. |
| What ICD-9 or ICD-10 codes will be used? | One or more codes | 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. |
| What is the CPT® code for this procedure? | One or more five-digit codes | CPT codes are the billing codes that are used by providers—usually for physician services—throughout the United States. |
| What tests will I need before the surgery? | Blood tests Diagnostic imaging tests, such as a CT scan or ultrasound | Ask for specifics about which blood tests will be ordered. 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. |
| Will other doctors be involved in my care and bill me for their services? | A pathologist, a radiologist, and an anesthesiologist may be involved in your care. | 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.) |
| What kind of anesthesia will I receive? | General anesthesia | 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.) |
| After my surgery, will I go right home from the hospital? | After you are discharged from the hospital, you should be able to go directly home. | 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.) |
| What medications and follow-up care will I need? | You may need to take [name of medication] for [period of time] after your surgery. | |
| What else should I know about—such as potential complications—that might affect the cost of the procedure? | 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. | 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. |

For Consumers with Health Insurance Coverage

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 web sites 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.

In-Network and Out-of-Network Care

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

| | HMO In-Network | POS In-Network | PPO In-Network |
|--------------------------------|----------------------|----------------------|---------------------|
| Provider's Usual Charge | \$1,000 | \$1,000 | \$1,000 |
| Your Plan's Contracted Rate | \$500 | \$500 | \$500 |
| Your Cost Sharing | \$10 copayment | \$10 copayment | 20% co-insurance |
| Your Plan Pays to the Provider | \$490 (\$500 - \$10) | \$490 (\$500 - \$10) | \$500 x 80% = \$400 |
| You Pay to the Provider | \$10 | \$10 | \$500 x 20% = \$100 |

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

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

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.

In-Network and Out-of-Network Care

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.

For Medicare Beneficiaries

Traditional 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.

Improving Price Information

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

| Guiding Principle | What That Means for You |
|---|--|
| 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. | 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. |
| Any form of price transparency should be easy to use and easy to communicate to stakeholders. | Price information should be easy for you to use and understand. |
| Price transparency information should be paired with other information that defines the value of care for the care purchaser. | Along with price information, you should receive information about quality, safety, patient experience, and other aspects of care that are important to you. |
| 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: <ul style="list-style-type: none"> ▶ 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. |

Source: Healthcare Financial Management Association. "Price Transparency in Health Care: Report from the HFMA Price Transparency Task Force," 2014. Available at hfma.org/transparency.

Definitions

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 insurance

A contract that requires your health insurer to pay some or all of your healthcare costs in exchange for a premium.

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.

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

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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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