Improving Price Transparency: A Consensus-Based Approach

Chad Mulvany, Director, Healthcare Finance Policy, Strategy and Development
Historical Factors

• Historically, prices have served a wholesale function

• Only recently have prices been viewed as retail

• Without transparency, neither consumers nor hospitals could compare hospital prices

• With thousands of items, the chargemaster is not “transparency-friendly”—and not reflective of “price”
Factors Driving Transparency Today

• Rising deductibles and out-of-pocket payments
  — Continued growth in employer-sponsored high-deductible health plans
  — High exposure to HDHPs in ACA plans
• Employer pressure on private payers & providers
• Third party transparency tools
Factors Driving Transparency Today

Even at Higher Income Levels, Collection Yields on Balances After Insurance Drop Precipitously as Balances Increase

Balance After Insurance - Balance Group Collection Rates by FPL

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FPL &lt; 200%</td>
<td>200-400%</td>
<td>&gt; 400%</td>
</tr>
<tr>
<td>60 Day</td>
<td>29.1%</td>
<td>38.0%</td>
<td>44.7%</td>
</tr>
<tr>
<td>120 Day</td>
<td>37.2%</td>
<td>46.7%</td>
<td>54.1%</td>
</tr>
<tr>
<td>180 Day</td>
<td>39.8%</td>
<td>49.2%</td>
<td>56.6%</td>
</tr>
<tr>
<td>360 Day</td>
<td>41.9%</td>
<td>51.4%</td>
<td>58.5%</td>
</tr>
</tbody>
</table>

75% Decline

Source: David Franklin; Connance; Patient Pay Collectability Data Study Review; March 14, 2014
HFMA Price Transparency Task Force
Participating Organizations

acpe
American College of Physician Executives
The Home for Physician Leaders

CHA
Catholic Health Association
of the United States

THELEAPFROGGROUP

American Hospital Association

AHIP
American's Health Insurance Plans

equityhealthcare

MGMA
Medical Group Management Association

Florida Blue

GEISINGER

PriorityHealth

hfma
Improving Price Transparency

hfma.org/transparency
New Resource for Consumers

- Understand pricing terminology
- Get a price estimate—step by step
- Navigate in-network and out-of-network pricing
- Tap into price information available through providers, payers, and employers

Available as a PDF to other organizations as a public service. Contact Scott Kenemore, skenemore@hfma.org, for permission to post.
What the Task Force Did

• Agree on definitions of terms
• Develop guiding principles for price transparency
• Recommend price transparency frameworks for different care purchaser groups
• Identify transparency-related policy considerations
• Chart the way to achievement of a more transparent healthcare pricing system
Cost, charge, and price should not be used as interchangeable terms.

- **Cost** varies by the party incurring the expense.
- **Charge** is the dollar amount a provider sets for services rendered before negotiating any discounts.
- **Price** is the total amount a provider expects to be paid by payers and patients for healthcare services.
Definitions

...and Parties to the Transaction

Care Purchaser

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

Payer

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

Provider

• An entity, organization, or individual that furnishes a healthcare service.
Value is the quality of a healthcare service in relation to the total price paid for the service by care purchasers.

...which leads us to...
An Actionable Definition of Price Transparency

Readily available information on the price of healthcare services, that, together with other information, helps define the value of those services and enables patients and other care purchasers to identify, compare, and choose providers that offer the desired level of value.
Recommendations Were Guided by These Principles

Price transparency information should:

• Empower patients and other care purchasers to make meaningful price comparisons
• Be easy to use and easy to communicate
• Be paired with other information that defines the value of services for the care purchaser
• Enable patients to understand the total price of their care and what is included in that price

And price transparency will require the commitment and active participation of all stakeholders.
Recommended Guidelines

Health Plans Should Be a Resource for Their Members

• Health plans should serve as the principal source of price information for their members.

• Transparency tools for insured patients should include:
  – The total estimated price of the service
  – A clear indication of whether a particular provider is in the health plan’s network
  – A clear statement of the patient’s estimated out-of-pocket payment responsibility
  – Other relevant information related to the provider or the specific service sought
Providers should be the principal source of price information for these groups. Specifically, providers should:

- Offer an estimated price for a standard procedure without complications and make clear how complications may increase the price.
- Clearly communicate pre-service estimates of prices.
- Clearly communicate what services are included in an estimate.
- Give patients other relevant information, where available.
Provide Simple, Clear Estimates for Self-Pay Patients

**COPA CARE ESTIMATE**

2525 E Roosevelt St
Phoenix, AZ 85008
602-344-1015

Creation Date: 4/3/2014
Completed On: 4/3/2014
Estimate Valid Until: 5/18/2014

Thank you for choosing Maricopa for your healthcare needs. As requested, this letter summarizes the deposit that will be required prior to the requested service being provided. The following anticipated charges are only an estimate for the requested procedure(s) or service(s) outlined below and does not include charges due to complications or any additional procedures.

**Patient Information**

<table>
<thead>
<tr>
<th>Description</th>
<th>Service Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>PF Bx Breast 1st Lesion Stratgctc</td>
<td>Total Estimated Charges: $1,041.00</td>
</tr>
<tr>
<td>Estimated Charges:</td>
<td>Discount: $923.50</td>
</tr>
<tr>
<td>Adjusted Estimated Charges:</td>
<td></td>
</tr>
<tr>
<td>Total Estimated Charges:</td>
<td>$1,041.00</td>
</tr>
<tr>
<td>Self Pay Discount:</td>
<td>-$923.50</td>
</tr>
<tr>
<td>Prompt Pay Discount:</td>
<td>-0.00</td>
</tr>
<tr>
<td>Prior Approval Balance:</td>
<td>-0.00</td>
</tr>
<tr>
<td>Your Estimate:</td>
<td>$717.50</td>
</tr>
</tbody>
</table>

Important Notice about direct payment for your healthcare services. The Arizona Constitution permits you to pay a healthcare provider directly for healthcare services. Before you make any agreement to do so, please read the following important information:

If you are enrolled in a health plan and your healthcare provider is contracted with the health insurance plan, the following apply:

1) You may be required to pay the healthcare provider directly for the services covered by your plan, except for cost share amounts that you are obligated to pay under your plan, such as copayments,
85% of Respondents Can Provide Estimates for Uncomplicated/Routine Services

On a regular basis, my organization can quickly provide uninsured patients with an approximate price estimate for the hospital component of uncomplicated services and routine procedures:

- Yes: 67
- No: 11

Source: Feedback from 78 HFMA Forum members from healthcare provider organizations collected in April 2014.
Employers Should Leverage Transparency Information

• Employers should continue to use and expand transparency tools that help their employees identify higher-value providers

• Self-funded employers should identify data that will help them
  – Shape benefit design
  – Understand their healthcare spending
  – Provide transparency tools to employees
Referring Clinicians Should Use Price Information to Benefit Patients

Physicians and other referring clinicians should

• Help patients make informed decisions about treatment plans
• Recognize the needs of price-sensitive patients
• Help patients identify providers that offer the best value
Payers and Providers Should Take a Patient-Centered Approach

Payers and providers should

• Collaborate!
  – Work together with the patient in mind.

• Embrace transparency
  – Don’t ignore it or fight it.
Allow Patients to Search for Providers in Their Area

Examples: Priority Health, Grand Rapids, MI
Identify Key Service Components and View Range of Prices in the Area

Examples: Priority Health, Grand Rapids, MI

Knee Arthroscopy

Facility Services
Service: Knee Arthroscopy - Arthroscopic treatment of the knee.
Fee Details: Price is for an outpatient procedure. Overnight stay is not included.
Fee: $1,279 - $1,842

Physician Services
Service: Knee Arthroscopy - Arthroscopic treatment of the knee.
Fee Details: Physician fee for procedure and routine postoperative care.
Fee: $922 - $1,124

Anesthesia Services
Service: Knee Arthroscopy - Arthroscopic treatment of the knee.
Fee Details: Price is for an average surgery time of 1 hour. Prices may go up or down based upon the actual surgical time required.
Fee: $1,718
See List of Area Providers Ranked, Based on Relative Price

Provider Listing

This website displays the prices Priority Health negotiates with providers in your Priority Health network. They are grouped as:

- Green: At or below the Fair Price
- Yellow: Slightly above the Fair Price
- Red: Among the most expensive
- Black: Provider doesn't allow contracted prices to be shown. Contact them directly.

Prices shown are lower than prices charged to the general public. They include a discount that Priority Health negotiates with providers who are part of the network for your plan. Before scheduling treatment, call health care providers to double check that they are in your plan’s network and what prices they charge for the services you need.

Facilities

<table>
<thead>
<tr>
<th>Facility</th>
<th>Distance</th>
<th>Physicians</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery Center T</td>
<td>~12 miles</td>
<td>See doctors</td>
<td>green</td>
</tr>
<tr>
<td>Surgery Center A</td>
<td>~7 miles</td>
<td>See doctors</td>
<td>green</td>
</tr>
<tr>
<td>Hospital B</td>
<td>~12 miles</td>
<td>See doctors</td>
<td>yellow</td>
</tr>
<tr>
<td>Surgery Center X</td>
<td>~15 miles</td>
<td>See doctors</td>
<td>red</td>
</tr>
</tbody>
</table>
Transparency Tools

Commercial Transparency Tools Are Widely Available…

Use of Transparency Tools Among Those Who Have Access

Currently, Transparency Tools Don’t Significantly Influence Commercial Revenue

What Percentage of Your Commercial Revenue Comes from A Payer Offering Members A Price Transparency Tool?

- Less than 10%: 27
- 10% - 20%: 10
- 21% - 30%: 3
- 31% - 40%: 2
- More than 40%: 7
- I don't know: 29

Source: Feedback from 78 HFMA Forum members from healthcare provider organizations collected in April 2014.
Providers Believe Transparency Tools Will Become More Prevalent

Number of years before more than 40% of commercial revenue in your market comes from payers that offer their members price transparency tools:

- I don't know: 19
- > 6 years: 8
- 4 to 6 years: 2
- 2 to 4 years: 21
- < 2 years: 28

Source: Feedback from 78 HFMA Forum members from healthcare provider organizations collected in April 2014.
Supporting Societal Benefit and Public Payer Shortfalls
Complicating Matters - The Cost Shift

As the Volume of Medicaid Patients Increase, Private Payer Margins Must Increase for the Provider to Break Even

**Example Health System Break-Even Analysis**

<table>
<thead>
<tr>
<th>Payer Class</th>
<th>Payer Mix</th>
<th>Payer Specific Margin</th>
<th>Contribution to Total Margin</th>
<th>Payer Mix</th>
<th>Payer Specific Margin</th>
<th>Contribution to Total Margin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>14.3%</td>
<td>-15.0%</td>
<td>-2.1%</td>
<td>19.3%</td>
<td>-15.0%</td>
<td>-2.9%</td>
</tr>
<tr>
<td>Medicare</td>
<td>38.5%</td>
<td>-10.0%</td>
<td>-3.9%</td>
<td>38.5%</td>
<td>-10.0%</td>
<td>-3.9%</td>
</tr>
<tr>
<td>Private</td>
<td>40.2%</td>
<td>27.0%</td>
<td>10.9%</td>
<td>53.2%</td>
<td>33.0%</td>
<td>11.6%</td>
</tr>
<tr>
<td>Other Gvt</td>
<td>1.6%</td>
<td>-15.0%</td>
<td>-0.2%</td>
<td>1.6%</td>
<td>-15.0%</td>
<td>-0.2%</td>
</tr>
<tr>
<td>Self Pay</td>
<td>5.5%</td>
<td>-84.0%</td>
<td>-4.6%</td>
<td>5.5%</td>
<td>-84.0%</td>
<td>-4.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>0.0%</strong></td>
<td><strong>0.0%</strong></td>
<td><strong>0.0%</strong></td>
<td><strong>0.0%</strong></td>
<td><strong>0.0%</strong></td>
<td><strong>0.0%</strong></td>
</tr>
</tbody>
</table>

1. A 5% Increase in Medicaid Patients...
2. Requires 6.0% Increase in Private Margins to Breakeven.

As a Result, Hospitals Depend on Private Payer Rates to Sustain Operations. This Cost Shift Is A “Hidden Tax” on Purchasers of Private Insurance.
## Outstanding Issues

### Complicating Matters - The Cost Shift

Without This Hidden Tax, Many Hospitals Would be Unable to Sustain Operations

**Example Health System Break-Even Analysis**

<table>
<thead>
<tr>
<th>Payer Class</th>
<th>Avg Medicaid Case Mix</th>
<th>High Medicaid Case Mix</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Payer Mix</td>
<td>Payer Specific Margin</td>
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<td>Medicaid</td>
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</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. A 5% Increase in Medicaid Patients... Without an Increase in Private Margins...
2. ...Results in Unsustainable Losses.
Other Outstanding Issues

• Determining effect of transparency on prices (if any)
  – For consumers, more transparency is better.
  – But in the B2B marketplace, the jury is still out.
• Surfacing issues with out-of-network balance billing
  – Inadvertent out-of-network use
  – Emergency care
• Reassessing hospital chargemasters
  – It’s time for change!
Outstanding Issues

Percent of Charge Contracts Are Still Prevalent

What Percentage of Your Net Patient Revenue Is Tied to Percent of Charge Contracts?

Source: Feedback from 51HFMA Forum members from healthcare provider organizations collected in November 2013.
Checklist for Preparing for Price Transparency

• Secure board and executive team support
• Identify a reasonable starting point
• Consider how care purchasers will access the information you provide
• Identify other information sources that will help patients assess the value of the services you provide
• Be prepared to explain healthcare pricing
Transparency Is Part of a Three-Pronged Approach

- Price Transparency
- Patient Financial Communications
- Medical Account Resolution
Guiding Critical Conversations

• Every day, healthcare professionals conduct sensitive financial discussions with patients.

• Now there are accepted, consistent best practices to guide them in these communications.

hfma.org/communications
## Best Practices Address Key Issues

<table>
<thead>
<tr>
<th>Provision of Care</th>
<th>Registration and Insurance Verification</th>
<th>Financial Counseling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Share</td>
<td>Prior Balances (if applicable)</td>
<td>Balance Resolution</td>
</tr>
</tbody>
</table>
Setting Parameters

Best practices for medical account resolution take the uncertainty out of the billing and collection experience for patients.

hfma.org/medicaldebt
Account Resolution Best Practices

• Prepare for successful account resolution by educating patients and following best practices for communication before or as close to time of service as possible.

• Make bills and all communications clear, concise, correct, and patient-friendly.

• Establish policies for account resolution and ensure that they are followed internally and by business affiliates.

• Be consistent in key aspects of account resolution—from billing disputes to payment application.

• Coordinate account resolution activities with business affiliates to avoid duplicative patient contacts.

Source: http://staging.hfma.org/medicaldebt/
Account Resolution Best Practices

- Exercise good judgment about the best ways to communicate with patients about bills.
- Start the account resolution clock when the first statement is sent to the patient.
- Report back to credit bureaus when an account is resolved (in the event that an account is reported to a credit bureau).
- Track all consumer complaints.
- Use best practices, principles, and guidelines to inform their organizational approach to medical account resolution.

Source: http://staging.hfma.org/medicaldebt/
Questions?

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