



American Hospital  
Association®

## Hospital Price Transparency

### Background

Over the past year, there has been considerable public and policymaker focus on the issue of health care price transparency. While public focus on this issue is not new, trends in the health care marketplace are heightening its importance. Price transparency has been a longstanding issue for uninsured patients, but growing enrollment in plans with higher levels of deductibles and coinsurance is creating a greater demand for meaningful price information for insured patients as well. Employers have been moving in this direction for a number of years. Now, newly insured individuals under the Affordable Care Act (ACA) are expected to primarily choose “bronze” and “silver” plans that include significant levels of cost sharing.

Sharing meaningful information, however, is challenging because hospital care is specifically tailored to the needs of each patient. For example, a gall bladder operation for one patient may be relatively simple, but for another patient, it could be fraught with unforeseen complications, making meaningful “up front” pricing difficult and, perhaps, confusing for patients. Moreover, hospital prices do not include physician and other professionals’ costs or, most importantly, how much of the cost a patient’s insurance company may cover.

### AHA Position

Consumers and their families deserve helpful information about the price of their hospital care, and America’s hospitals and the AHA are committed to providing it. But more can, and should, be done to share health care information with the public, including, but not limited to, hospital pricing information. The AHA and its members stand ready to work with policymakers on innovative ways to build on efforts already occurring at the state level, and share information that helps consumers make better choices about their health care.

**Current Initiatives.** Initiatives to make charge and price data available to the public are emerging on several fronts. Currently, 42 states already report information on charges or payment rates, and make that information available to the public. Last spring, for each hospital accepting Medicare patients, the Centers for Medicare & Medicare Services (CMS) posted on its website average hospital specific charges per patient and average Medicare payments for the most common diagnosis-related groups (DRG) as well as 30 ambulatory procedures. Additionally, the ACA requires hospitals to report annually and make public a list of hospital charges for items and services, although CMS has not released guidelines to implement this provision.

The AHA recently participated in a multi-stakeholder task force to address price transparency convened by the Healthcare Financial Management Association. This task force report includes a set of principles as well as specific action steps required to achieve greater transparency. The report makes clear that achieving a more transparent system is a multi-stakeholder issue and will require consensus among hospitals, physicians and other care providers; the pharmaceutical and medical device industries; commercial and governmental payers; employers;

patients and consumer advocates; and regulatory agencies to develop a workable, meaningful solution. In April, the task force issued price transparency recommendations for health plans, health care providers and others, and a guide to help consumers estimate the cost of care.

**AHA Principles for Price Transparency.** In 2006, the AHA Board of Trustees approved a policy regarding hospital pricing transparency. That policy calls for information to be presented in a way that:

- is easy to access, understand and use;
- creates common definitions and language describing hospital pricing information for consumers;
- explains how and why the price of patient care can vary;
- encourages patients to include price information as just one factor to consider when making decisions about hospitals and health plans; and
- directs patients to more information about financial assistance with their hospital care.

The AHA believes that the path to price transparency has four parts:

Expanding existing state transparency efforts. State governments, working with their state hospital associations, should expand existing efforts to make hospital charge information available to consumers. A 2014 AHA survey found that 35 states require hospitals to report information on hospital charges or payment rates and make that data available to the public; an additional seven states have voluntary efforts. These state efforts range from making public information about individual hospitals' lists of prices (i.e., chargemasters), to pricing information on frequent hospital services, to information on all inpatient services.

Health plan transparency. The ACA requires that health plans provide consumers with a Summary of Benefits and Coverage (SBC). Health plans also must provide a uniform glossary of terms commonly used in health insurance coverage, such as "deductible" and "co-payment," written in plain language.

In addition, the new health insurance marketplaces in each state will provide information to the enrollee about out-of-pocket costs based on the essential health benefits that health insurers are required to include in their plan offerings. But plans can still substitute benefits as long as they are in the same category of benefits and are actuarially equivalent, generally meaning that a benefit can be substituted for another benefit as long as they have the same monetary value. So while these ACA consumer protections will provide basic information about what the health plan covers, they will not provide consumers with detailed

information about what choices the health plan has made in substituting benefits while still meeting the “actuarial equivalent” standard. The resulting differences in what plans cover may continue to make plan comparisons difficult. In addition, the ACA consumer protections do little to standardize the information health plans provide consumers after care is given. The health plan explanation of benefits, or EOB, is largely left to the design of the health plan.

Research on what consumers find useful. More research is needed to better understand what type of pricing information consumers want and would find useful in their health care decision-making. Consumers need different types of pricing information depending on whether and how they are insured. For example, a patient with traditional insurance that typically covers hospital services may want to know what the out-of-pocket costs would be for care at one hospital compared to another. Those with high-deductible health plans or health savings accounts also will need to know what their insurers require as out-of-pocket costs, as patients with high-deductible plans are responsible for the out-of-pocket costs of their initial care, up to their personal deductible.

For uninsured individuals of limited means, information should be provided directly by the hospital; the hospital, in turn, can determine whether a patient qualifies for state insurance programs, free or reduced cost care provided by the hospital, or other financial assistance (see below).

Consumer-friendly pricing language. Providers and insurers need to agree on consumer-friendly pricing “language” – common terms, definitions and explanations to help consumers better understand the information provided.

There are more than 1,300 health plans, plus many more employers who self-insure for employees’ health care, in addition to public payers such as Medicare, Medicaid and the Department of Defense. Each of these payers offers a range of insurance products—types of health plans – and each product can have different combinations and permutations of covered and excluded services, patient cost-sharing, payment schemes and rules. Hospitals must comply with payers’ requirements for preauthorization and admission notification, as well as utilization review and reporting requirements.

Unfortunately, there is no standard set of requirements that hospitals must follow; each insurer can set its own requirements as well as change those requirements at any time without consultation with the hospitals that must comply with them. Further, as payers change patient cost-sharing arrangements – introducing high-deductible health plans, health savings accounts, multi-tiered coinsurance tied to provider rankings—hospitals are devoting more administrative resources to billing activities, making changes to their claims processing systems, and helping patients understand their coverage.

**AHA-supported Legislation.** The AHA supports state-based efforts regarding price transparency, including the Health Care Price Transparency Promotion Act of 2013 (H.R. 1326), which would require states to have or establish laws requiring hospitals to disclose information on charges for certain inpatient and outpatient services, and require health insurers to provide to enrollees upon request a statement of estimated out-of-pocket costs for particular health care items and services. Introduced by Reps. Michael Burgess (R-TX) and Gene Green (D-TX), the legislation also requires the Agency for Healthcare Research and Quality to study the types of health care cost information that consumers find useful, and ways it might best be distributed.

### **AHA Principles for Helping Patients with Payment for Hospital Care.**

America's hospitals are committed to doing everything possible to better serve patients and to treat them equitably, with dignity, compassion and respect from the bedside to the billing office.

In November 2003, the AHA Board of Trustees approved a Statement of Principles and Guidelines on practices hospitals should follow for patient billing and collection. The guidance was updated in May 2012 to reflect advances in the field and changes made by the ACA applicable to tax-exempt hospitals. These guidelines reflect that commitment and demonstrate the shared partnership/responsibility between hospitals and patients to address billing issues in a timely, transparent and forthright manner.

America's hospitals are united in providing care based on the following principles:

Communicating effectively with patients. Hospitals should provide financial counseling to patients about their bills and should make the availability of such counseling widely known. Hospitals should respond promptly to patients' questions about their bills and to requests for financial assistance. Hospitals should use a billing process that is clear, concise, and patient friendly. Hospitals should make available for review by the public specific information in a meaningful format about what they charge for items and services.

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

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

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

For more information, please visit:

*<http://www.aha.org/advocacy-issues/bcc/index.shtml>.*