Consumerism and Price Transparency

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HFMA Joint Spring Conference
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Agenda

• The New Consumerism
• Strategies for Success in the New Era
• Resources
The New Consumerism...
. . .Is Creating Price-Sensitive Patients. . .

“Just look for something in my price range.”
Demanding Better Price Information

“Participants repeatedly said they wanted to see a resource, or ask their doctor, to better understand what a particular test or procedure would cost before they agreed to it, and wanted to comparison shop among providers when possible. They said that they also wanted the ability to know what a treatment should cost before they agreed to it, and needed more transparent information on price in order to do this….They were very interested in efforts to share information on price and quality.”

Hospital Pricing Evolved in a Wholesale Environment

- Historically, prices served a wholesale function.
- There was little need to compare hospital prices.
- So the hospital chargemaster did not evolve to be "transparency-friendly."
- And consumers—especially insured consumers—were not very engaged with the price of their health care.
Deductibles Are Increasing Quickly

**PERCENTAGE OF COVERED WORKERS ENROLLED IN A PLAN WITH A GENERAL ANNUAL DEDUCTIBLE OF $2,000 OR MORE FOR SINGLE COVERAGE, BY FIRM SIZE, 2006-2014**

- **All Small Firms (3-199 Workers)**
- **All Large Firms (200 or More Workers)**
- **All Firms**

*Estimate is statistically different from estimate for the previous year shown (p<.05). Note: These estimates include workers enrolled in HDHP/SO and other plan types. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.*

ACA Plan Choices Driven by Costs

Among Exchange Purchasers Nationwide: Costs More Important Than Other Factors In Plan Choice

Among those with exchange plans who considered more than one plan:

Percent who say each was an “extremely” or “very” important factor in choosing their current health plan:

- Monthly premium costs: 36% (Extremely important), 43% (Very important)
- Deductibles and copays: 28% (Extremely important), 45% (Very important)
- Choice of doctors and hospitals available: 23% (Extremely important), 40% (Very important)
- Range of benefits or a specific covered benefit: 22% (Extremely important), 40% (Very important)
- Recommendations from friends or family: 7% (Extremely important), 19% (Very important)

Source: Kaiser Family Foundation Survey of Non-Group Health Insurance Enrollees (conducted April 3 – May 11, 2014)
Exchanges Drove Significant Narrowing of Networks

**EXHIBIT 2**

Network configuration options have increased across incumbents’ offerings

**Incumbents’ 2013 individual market network offerings vs. 2014 exchange offerings**

Number of analyzed networks

<table>
<thead>
<tr>
<th></th>
<th>2013 Individual Market</th>
<th>2014 Individual Exchange</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broad</td>
<td>51</td>
<td>35</td>
</tr>
<tr>
<td>Narrow</td>
<td>14</td>
<td>30</td>
</tr>
<tr>
<td>Ultra-narrow</td>
<td>11</td>
<td>30</td>
</tr>
</tbody>
</table>

1 Incumbents are defined as any existing carrier in 2013 that has filed on the exchange in 2014. 2014 individual exchange data includes silver tier only.

**SOURCE:** McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information; AHA database

Data as of 11/15/2013 McKinsey & Company
With Lower Premiums as a Result

EXHIBIT 4

Broad networks result in a median premium increase of 26 percent

<table>
<thead>
<tr>
<th>Carriers across distinct rating areas</th>
<th>Difference between broad and narrower silver network offerings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PMPM increase(^1) $, percent</td>
</tr>
<tr>
<td>Carrier 1</td>
<td>$74  35%</td>
</tr>
<tr>
<td>Carrier 2</td>
<td>$67  37%</td>
</tr>
<tr>
<td>Carrier 3</td>
<td>$64  26%</td>
</tr>
<tr>
<td>Carrier 4</td>
<td>$64  27%</td>
</tr>
<tr>
<td>Carrier 5</td>
<td>$48  15%</td>
</tr>
<tr>
<td>Carrier 6</td>
<td>$44  17%</td>
</tr>
<tr>
<td>Carrier 7</td>
<td>$21  7%</td>
</tr>
</tbody>
</table>

Median $64 26% 13

1 Compares broad and narrow or ultra-narrow networks offered by the same carrier with the same product type (e.g., HMO, PPO) in a given rating area. If more than two networks offered by a carrier meet these criteria, only the broadest and narrowest networks are included. Analysis based on silver premium for 40-year-old individual non-smoker.

But Do Consumers Understand What They Are Buying?

• In one study:¹
  – Only 14% of individuals could correctly identify four basic components of traditional insurance design: deductible, copay, coinsurance, and out-of-pocket maximum
  – Only 11% could correctly answer a fill-in-the-blank question about the cost of a hospitalization

• Do consumers understand and have accurate information on who is in (and who is not in) the network?

And How Can We Expect Them to Grasp Complexities Like This?

Two Definitions of Network

These rules have also created another problem, again potentially harmful to plan members, by effectively allowing plans to use two definitions of “network” simultaneously. The ACA stipulates that plan members receiving care outside of the plan’s network are at risk for balance billing. If under reference pricing “designated providers” constitute a network, are providers who are in the larger network, but are not “designated,” permitted to balance-bill?

This could leave patients at risk for substantial out-of-pocket costs that can result from out-of-network balance-billing. Nothing in the ACA suggests that plans are permitted to create a network within a network, shrinking the effective network for specific services and exposing plan members to huge financial risk.

Evidence Suggests Consumers Are Not Getting Good Information Upfront

- Almost half of consumers surveyed report receiving a medical bill larger than expected or for services they believe shouldn’t have been billed to them.
- Nearly three in 10 report being contacted by a debt collection agency about a medical bill.

Satisfied Patients Are More Likely to Pay Promptly and Recommend a Hospital to Others

- High-performing departments had lower net days in accounts receivable—37.5 days—compared to the median (51.3 days).
- Also, 80% of patients at hospitals with high-performing patient financial services departments would “definitely recommend” their hospitals.
- Only 71% of patients at hospitals with “average” patient financial services operations answered the same way.
Satisfaction with Financial Experience Correlates with Hospital Satisfaction

Strategies for Success in the New Consumer Era

1. Get clear on the concepts
2. Give healthcare consumers what they want
3. Collaborate with other stakeholders
4. Be transparent about network status
5. Take advantage of educational and communications resources
1. Get Clear on the Concepts

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.

Cost, Charge, & Price Are Not 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.


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Guiding Principles for Price Transparency

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.

2. Give Healthcare Consumers What They Want

Factors That Facilitate Consumer Engagement with Prices

- Privacy
- Convenience
- Respect
- Ability to assess value of a potential purchase
- Individualized attention
- Understand impact of third-party payments
- Freedom to conduct transaction when not in discomfort

Source: HFMA analysis
Use Hassle Maps to Identify Consumers’ Pain Points

Hassle map (n.): all of the actual steps that characterize the negative experiences of the customer.

- Emotional hot spots/irritations/frustrations
- Time wasted/delay
- Economic hot spots

Source: Adrian Slywotzky, author, *Demand: Creating What People Love Before They Know They Want It*
Classic Example: Netflix

The Movie Rental Hassle Map (c. 1997)

1. Fight with spouse
   - what movie to see—“you decide”
2. Go to store
3. Search and search
   - what’s that trailer I saw?
4. Pick three
5. Go home
6. Fight again—pick one
7. Watch
8. Forget to return
9. Return five days later, pay late fee, get mad

A Healthcare Hassle Map

Elective Surgery for an Insured Patient

1. **Get a referral to a surgeon**
2. **Find out if the surgeon, anesthesiologist, pathologist, and radiologist are in your network**
3. **Find out if the hospital is in your network**
4. **Call to get a preauthorization from your health plan (or realize later that you forgot)**
5. **Figure out where your out-of-pocket costs for pre-op tests will be lowest (or don’t think about this until you get the bill)**
6. **Find out how much the operation will cost you out-of-pocket (or hold your breath until the bill comes)**
7. **Worry about whether you will have to pay anything in advance, and if so, how much**
8. **Have the surgery**
9. **Spend a month dreading getting the final bill in the mail**

Source: Based on the hassle-map construct developed by Slywotzky (2011).
Start Fixing the Hassle Map

Look at the world through the eyes and the emotions of the customer, see what a mess it is, and then ask, "How can I connect the dots from a variety of different places to solve that mess?"
Make Financial Conversations Count

- Discuss specifics about each patient’s financial responsibility
- Proactively provide information on financial assistance & application process
- Offer help applying for Medicaid or coverage through the ACA public exchanges
- Discuss payment plans & options
- Give information on how a prior balance does (or does not) affect current care

Follow established best practices for communicating with patients about financial matters.

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Ensure Easy Access to Price Information

At St. Luke’s, we understand that price transparency is important. If you need help determining how much a procedure will cost, contact St. Luke’s price line at (319) 369-7513. You may also register for free text relay service for people with hearing loss or speech disability.

Ready to help

St. Luke’s has 15 full- and part-time financial counselors available to answer questions. Our Financial Counselors generally need one to two business days to provide an answer.

- E-mail St. Luke’s Financial Counselors

Uninsured and Underinsured

St. Luke’s Hospital provides patient care to a growing number of uninsured and underinsured patients. If you’re carrying a greater burden of your healthcare costs through increasing out-of-pocket deductibles or you lack the financial resources to secure health insurance, St. Luke’s Hospital has developed financial policies to seek fair and equitable payment based on your ability to pay.

St. Luke’s assists patients who cannot reasonably pay for some or all of the care they receive. To find out if you qualify for discounts
Revamp Your Procedures for Resolving Medical Accounts

• Find solutions that are balanced, fair, & reasonable.
• Keep patients informed about payment expectations and time frames.
• Approve business practices used by your hospital—and its business affiliates—at the Board level.

Follow established best practices for resolving medical accounts.

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Examples of Best Practices for Medical Account Resolution

• Make bills clear, concise, correct, & patient-friendly.
• Establish policies & make sure they are followed internally & by business affiliates.
• Be consistent in key aspects of account resolution—from billing disputes to payment application.
• Coordinate with business affiliates to avoid duplicative patient contacts.
• Exercise good judgment about the best ways to communicate.
• Start the account resolution clock when the first statement is sent.
• 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.

Look for Ways to Fix the Consumer’s Hassle
Map Across Care Settings & Over Time

EXAMPLE OF INCREMENTAL IMPROVEMENTS

Inform patients that follow-up care is billed separately
Provide price estimates for follow-up care
Integrate billing for standard follow-up care into billing for a clinical episode
3. Collaborate with Other Stakeholders

- **Health plans** should serve as the principal source of price information for their members.
  - They need provider agreement to do so.
- **Providers** should be the principal source of information for uninsured patients and out-of-network care.
- **Referring physicians and other clinicians** should use price information to benefit patients.

Health Plans Should Develop Robust Transparency Tools

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 on the provider or service sought

Hospitals Should Work Closely with Uninsured & Out-of-Network Patients

For uninsured patients and out-of-network care, hospitals should:

• Offer an estimated price for a standard procedure and make clear how complications may increase the price.

• Clearly communicate pre-service estimates of prices.

• Clearly state what services are included in an estimate.

• Give patients quality and other relevant information, where available. Price alone is not enough.

It’s a New Era…Patients *Want* Their Physicians to Talk about Price

![Poll Chart]

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

...And Physicians Are Recognizing The Importance of Those Conversations

“Because treatments can be “financially toxic,” imposing out-of-pocket costs that may impair patients’ well-being, we contend that physicians need to disclose the financial consequences of treatment alternatives, just as they inform patients about treatments’ side effects.”

“Editorial: Full Disclosure—Out of Pocket Costs as Side Effects.”

Can We Deliver? Our Marketing Colleagues Say Yes

How likely is it that the following will be seen in your hospital’s area by 2020?

<table>
<thead>
<tr>
<th>Event</th>
<th>Very Likely</th>
<th>Somewhat Likely</th>
<th>Somewhat Unlikely</th>
<th>Very Unlikely</th>
</tr>
</thead>
<tbody>
<tr>
<td>More consumers planning elective procedures will comparison-shop among hospitals on the basis of price and quality.</td>
<td>62%</td>
<td>32%</td>
<td>5%</td>
<td>1%</td>
</tr>
<tr>
<td>Risks and associated costs of clinical complications will be built into the quoted price of care.</td>
<td>31</td>
<td>47</td>
<td>19</td>
<td>4</td>
</tr>
<tr>
<td>Hospitals will be able to furnish prices in advance for most healthcare providers and treatments that are involved in caring for a patient’s health.</td>
<td>45</td>
<td>46</td>
<td>8</td>
<td>1</td>
</tr>
</tbody>
</table>

If Providers and Payers Don’t Deliver Price Information, Third-Party Companies Will

The Q1 2014 Healthcare Transparency Index found that the largest variations in cost came from the facility, for things like room and board during a hospital stay, anesthesia, or labs, not the doctor’s services.

Source: changehealthcare.com
4. Be Transparent About Network Status

Out-of-Network Charges Frustrate Even the Most Diligent Consumers

Paying Till It Hurts

In her series on the costs of health care, Elisabeth Rosenthal of The New York Times examines the price of medical care in the United States, interviewing patients, physicians, economists, and hospital and industry officials. In each installment, readers were invited to share their perspectives on managing costs and treatment.

Consumer 1

Forgive me if someone else posted this already. Its not just the high deductible, but the fact that the deductible does not include out of network care. Case in point, my son has a BCBS policy. He needed an endoscopy. We made sure the doctor, anesthesiologist and surgery center were in network. I thought we had thought of everything. Each was allowed to charge about $400 for the procedure, then bam, he gets a bill from the lab for the biopsy for $1200! Not only were they not in network, that charge does not get applied to the deductible. I hate to say it, but this is not health insurance.

Consumer 2

After countless hours of calling this and that department to try to find out how much my outpatient diagnostic test is going to cost and if all providers are in network I too Consumer 3's good advice and am now connected with a nurse manager to help navigate the mess. Making progress and I just have one more provider to confirm as in network. URGH!
## Take Steps to Mitigate Out-of-Network Issues

<table>
<thead>
<tr>
<th>Situation</th>
<th>Steps to Mitigate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intentional</strong></td>
<td>Health plan should</td>
</tr>
</tbody>
</table>
| Patient seeks care from out-of-network provider |   • Clearly explain impact on out-of-pocket expenses.  
   • Inform patients that it is their responsibility to seek price information from out-of-network providers. |
| **Inadvertent**                | In-network provider should                                                                                                                                |
| Patient schedules a procedure at an in-network provider but also receives services from an out-of-network provider |   • Disclose that individual physician services will be billed separately  
   • Advise patient to confirm network status of physicians  
   • Provide names of medical groups engaged to provide services (radiology, pathology, etc.) so patient can confirm their network status with health plan |
| **Emergency**                 |                                                                                                                                                    |
| No advance opportunity to identify providers’ network status |   • Work with patients on an individualized basis  
   • May need a policy solution                                                                 |

5. Take Advantage of Educational and Communications Resources

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Resources
Price Transparency Task Force Report

- Clarifies basic definitions that are often misused
- Sets forth guiding principles
- Establishes roles for payers, providers, others
- Reflects consensus of key stakeholders

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Price Transparency Task Force Convened by HFMA
Resources
Price Guide to Educate & Engage Consumers

- Describes how to request price estimates, step by step
- Clarifies what estimates may or may not include
- Explains in-network and out-of-network care
- Defines key terms
- Available for posting on your website at no charge
- Hardcopies available for purchase in bulk at a nominal price through AHA’s online store: ahaonlinestore.org

hfma.org/dollars
Best Practices for Resolution of Medical Accounts

A Report from the Medical Debt Collection Task Force

JANUARY 2019
HFMA.ORG

Patient Financial Communications Best Practices

These common-sense best practices bring consistency, clarity, and transparency to patient financial communications, and outline steps to help patients understand the cost of services they receive, their insurance coverage, and their individual responsibility.

For more information, go to hfma.org/communications.

1. Section 1—Emergency Department

NOTE: All practices must comply with EMTALA and all other Federal, State and local regulations affecting the Emergency Department

1.1. Discussion participants: The patient or guarantor will have these discussions with properly trained registration or discharge representative for routine scenarios; financial counselor or supervisor for non-routine / complex scenarios. Patient should be given the opportunity to request a patient advocate, designee or family member to assist them in these discussions.

1.2. Setting for discussions: No patient financial discussions will occur before patient is screened and stabilized. Once a patient has been stabilized, in accordance with EMTALA, the following times and locations are appropriate for financial discussions.

1.2.1. Emergent Patients: Discussions will occur during the discharge process. The discussion can also occur during the medical encounter as long as patient care is not interfered with and the patient consents to these conversations in order to expedite discharge.

1.2.2. Patients who do not have an emergent medical condition: Following the medical screening, provider representative will have a discussion with the patient during the registration or discharge process. The discussion can also occur during the medical encounter as long as patient care is not interfered with and the patient consents to these discussions in order to expedite discharge.

1.3. Registration, insurance verification, and financial counseling discussions: No patient financial discussions will occur before patient is screened and stabilized, in accordance with EMTALA.

1.3.1. Registration: The provider organization will first gather basic registration information including demographics, insurance coverage, as well as determining the potential need for financial assistance.

1.3.2. Provision of care: Patients will be informed that their ability to pay will not interfere with treatment of any emergency medical condition. Uninsured patients will be informed the goal of collecting information is to identify paying solutions or financial assistance options that may assist them with their obligations for this visit.

1.3.3. Insurance verification: Once screening has occurred and the patient is stabilized, the provider organization will review insurance eligibility information with the patient to ensure information accuracy.

1.3.4. Financial counseling: If appropriate, patient is referred to a financial counselor and/or offered information regarding the provider’s financial counseling services and assistance policies.
Resources
Patient Financial Communications Training

- Agenda for live training on site for your patient access staff
- Slide deck that can be customized
- Sample financial policies
- Coaching guidelines

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Resources
Recognition Signifies Commitment to Community

• Recognition demonstrates commitment to best practices in patient financial communications
• Based on HFMA review of an application and supporting documentation
• All provider organizations may apply
• Recognition valid for two years
• Adopters may use the phrase “Supporter of the Patient Financial Communications Best Practices” in their marketing materials
• Makes a strong statement to your community

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Short Term: Three Steps to Take Now

• Resolve to improve consumers’ financial experience in 2015.
  – Do a “walk-through” of your processes.
  – Engage a patient advisory panel.
• Ask consumers for feedback on the financial services page of your website.
• Check out the resources at hfma.org/dollars
  – Route information about the Patient Financial Communications training program and Adopter program to the right people.
  – Start assessing how your organization’s practices measure up to consensus-based best practices.
Long Term: Build a New Billing & Payment Model

Historical Model

- Gather basic info before & at the time of service.
- Most billing processes are post-service, amounts due based on data gathered after service, calculated retrospectively.
- Patients notified of financial obligations after insurance is billed & paid.

The Near Future

- Gather info before & at time of service. Prospectively calculate expected out-of-pocket costs.
- Providers bill at or right after time of service. Many times, patients know in advance what they owe & agree on terms.
- Insurance bill verifies what the patient already expects.

Pre-Service: Prospective Data Gathering and Processing

At Service

Post-service: Retrospective Data Gathering and Processing
Long Term: Improve Consumers’ Financial Experience for an Entire Care Episode

• Clinical episodes are being redefined to extend across care settings and over time.

• As a long-term goal, financial episodes should mirror clinical episodes.

• This will require a new level of collaboration and coordination among providers.
Logic will get you from A to B. Imagination will take you everywhere.

Albert Einstein