Price Transparency

Kentucky Hospital Association

Consumers deserve meaningful information about the price of their hospital care. Kentucky's hospitals and the Kentucky Hospital Association (KHA) have taken steps to make this information available.

Kentucky's hospitals provide financial counselors to assist consumers, on request, obtain information about their costs for hospital services. Hospitals are providing estimates of a patient's anticipated out of pocket costs, based on their health plan, deductible, and cost sharing requirements. Some hospitals have cost estimators on their websites to assist patients.

KHA has comparative hospital charge information on its public website (www.kyhealthcareconsumer.com). Consumers can obtain the following information:

- **Inpatient Services:** KHA provides the average hospital charge for each MS-DRG, along with the hospital's patient volume for the selected DRG
- **Outpatient Surgery:** KHA provides the hospital's average charge per case for outpatient procedures, along with charges at the 20th and 80th percentile so that consumers can be informed of the range of charges, based on complexities that vary with each patient
- **Other Outpatient Procedures:** KHA provides the hospital's average charge for selected imaging, therapy, and other frequently used outpatient services.

This information is more meaningful to consumers than the posting of hospital chargemasters which began this year, since consumers lack information to know which charges they are likely to incur with a given procedure or hospital stay. KHA's data provides consumers with a starting point to research price and volume. KHA plans to include links to each hospital's financial counseling office along with development of a a function for consumers to request price quotes from local hospitals.

Patients are concerned about what they will *personally* owe - not the health plan's negotiated rate with the provider or the provider's charge - and their out of pocket costs are governed by the health plan's deductible, coinsurance, and narrow network requirements. For example, a hospital's charge or negotiated rate may be higher but if that facility is in the plan's narrow network, the patient would likely have lower out of pocket costs.

KHA Recommendations for Price Transparency

KHA supports the following policies:

- **Requiring insurers, not providers, to provide timely assistance to their enrollees in determining which providers are in-network and the consumer's out of pocket costs** for a given service, based on their particular health plan. This could be accomplished by requiring health plans to provide an "advance explanation of benefits (EOB)" by phone or electronically, through the insurer's website.
- **Extending price disclosure requirements to ambulatory service providers, not just hospitals.** Patients with high deductible plans, typically set at $2,500, will exceed that limit from a hospital admission. Therefore, individuals with HSA coverage may be most interested in comparing prices for care to be delivered that leads up to meeting their deductible – physician office visits and other ambulatory care for which they are likely to be responsible for paying the full cost.
- **Providing meaningful quality data along with price transparency so that consumers can distinguish value.**

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KHA opposes the following policies:

- **Hospitals should not be mandated to publish payer-specific negotiated charges for all items and services as is contained in the CMS proposed CY 2020 OPPS rule.** This will be extremely damaging to hospitals because we believe it could lead insurers to reduce payment to the lowest rates. This data will not provide value for consumers, who are interested in their out of pocket costs, not rates paid by insurers. It will, however, impose tremendous new burdens and costs on hospitals to comply and lead to confusion and data that is not useful. For example, health plans use different reimbursement methods – DRG, per diem, percent of charges – with many using bundled rates which prevents the posting of negotiated rates at the item level. This will be challenging to manage and maintain, while costing significant resources that could be put to better use providing financial counseling and cost estimates for consumers.

- **Arbitrary time limits should not be imposed on providing cost estimates to patients.** The Lower Health Care Cost Act (S.1895) would require providers to give patients good faith estimates of their expected out of pocket costs for specific health services **within 48 hours of a request or face $10,000/day fines. Hospitals are already helping patients obtain this information, but a mandatory 48 hour turnaround time with hefty fines is inappropriate, especially for small and rural facilities with limited staff.**

- **Arbitrary time limits should not be imposed on patient billing.** The Lower Health Care Cost Act (S. 1895) would require patients to receive a list of services upon discharge and receive their bill within 30 days or else the bill would not have to be paid. The No Surprises Act (H.R. 2328) prohibits providers and facilities from billing patients more than one year after the date of service. Billing delays can occur due to multiple factors including inaccurate insurance information given by the patient and IT system issues. Also, if a patient refuses to pay an amount owed, hospitals should not be precluded from billing the patient if more than one year has passed. **Eliminating responsibility for payment of a late bill or owed amounts not paid after one year would only further harm hospitals by removing revenue needed to pay staff and maintain access to services.**

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