

Understanding Healthcare Prices

A New York State Consumer Guide



Healthcare Association
of New York State



hfma[™]
healthcare financial management association

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Introduction



If you are like many Americans, you do not know what an emergency department visit, a diagnostic procedure (CT scan or lab test), 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 is 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**; or
- ▶ 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 healthcare, 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 is not always possible 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 increasingly 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 healthcare, they may be less likely to choose care that is of limited benefit to them. Hospital pricing can vary based on a number of factors, such as the percentage of patients who are privately insured; the local labor market; whether the hospital is a trauma center; and the amount of charity care, training, research, and disaster preparedness the hospital provides.

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

Introduction

QUALITY MATTERS, TOO. Of course, the price of healthcare is not the only consideration. Although this guide focuses on prices, learning about the quality of your healthcare is critical as well. Price does not necessarily relate to the quality of care. More expensive does not necessarily 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 **co-insurance**, determine how much of your healthcare costs you pay and how much your health plan pays.

Second, health plans have different **networks** of doctors, 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 will 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 does not have price information for other hospitals or the services of other providers who may be involved in your care.

It is easy to see that healthcare pricing can be complicated. What questions should you ask to get a price estimate? And who has the answers? Read on.

Making Informed Healthcare Choices

In healthcare, more is not always better. For example, sometimes it is 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 is 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, will not harm you, and is truly necessary. That is 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 is 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 York State of Health (also known as insurance exchange) created under 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 guide is designed to help you work with your doctor and your health plan to get price information. While your insurance company is the best source for customized price

information based on your plan, many hospitals have dedicated units, staff, or tools that can help you estimate your cost of care.

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

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 (ICD) 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 (pronounced “Hickpicks”).** Medicare uses these codes in place of CPT codes. If you do not have Medicare, you do not 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. These tools usually use hospital “charges,” which are rarely the amount actually paid to the provider.

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 will 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	Ask for specifics about which blood tests will be ordered.
	Diagnostic imaging tests, such as a CT scan or ultrasound	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

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 are 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.)

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, as some have price information available online. Please see page 21 for information on health plans available in New York State.

If you have not created an account on the plan website, you will need to do so, as 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 enter 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 co-insurance 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. Many hospitals also offer dedicated staff or online tools to help patients estimate costs or discuss financial aid programs.

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 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 do not 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 is 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, take a moment to compare the specifics of the estimate with those on the bill. At that point, you will 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. Do not hesitate to ask about any charges that you do not understand or that do not seem right.
- ▶ **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 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. New York State law provides the same protection and access to emergency services as EMTALA.

YOUR PAYMENT RESPONSIBILITIES: It is important to realize that having the 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). Often a financial counselor can talk with you or your representative (such as a family member) as you are getting ready to leave the ED.

OUT-OF-NETWORK CHARGES IN THE ED: Under the Affordable Care Act and New York State law, health plans cannot require higher copayments or co-insurance for out-of-network ED services provided in a hospital ED or require you get prior approval or authorization before seeking ED services from a provider or hospital outside your plan's network.

BALANCE BILLING: New York State recently passed a consumer protection law aimed at addressing **balance billing** for emergency services. Under certain circumstances, you may be protected from receiving a bill for the difference between the amount billed by the provider for out-of-network ED services and the amount paid by your plan.

PLANS REGULATED BY NEW YORK STATE*

BEFORE APRIL 1, 2015

For those enrolled in a health maintenance organization (HMO): If you visit an ED that is not in your HMO network, the plan is required to make sure you are not responsible for paying any amount in excess of your in-network cost share. The hospital may send you a balance bill because

there is no agreement about payment between the hospital and your plan. You should ask your HMO what process you should follow if you receive a balance bill, so you will be prepared for an emergency.

For those enrolled in a preferred provider organization (PPO) or exclusive provider organization (EPO): If you visit an ED that is not in your network, although the health plan cannot 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 and the amount paid by your health plan.

AFTER APRIL 1, 2015

For those enrolled in an HMO, PPO, or EPO: If you visit an ED that is not in your network, the plan is required to make sure you are not responsible for paying any amount in excess of your in-network cost share. The hospital may send you a balance bill because there is no agreement about payment between the hospital and the health plan, but your health plan is responsible for ensuring you are not responsible for the balance. You should ask your insurer what process you should follow if you receive a balance bill.

PLANS NOT REGULATED BY NEW YORK STATE (ALSO KNOWN AS ERISA-PREEMPTED PLANS)

If you visit an ED that is not in your plan's network, although the health plan cannot 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 plans. Why? Because there is not an established rate that has been agreed upon by the provider and the 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 will be prepared for an emergency.

***If you are unsure if your plan is regulated by the state, you can contact the New York State Department of Financial Services.**

In-Network and Out-of-Network Care

Know Before You Go

You have 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? 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 of your network, it is a different story. Providers outside your network have not agreed to any set rate with your insurer. Some plans do not cover out-of-network care at all, while others may require higher copayments, deductibles, and co-insurance for out-of-network care. If you normally have to pay 20% of the cost of the service in-network, you may have to pay 30% out-of-network. Often, you will have to pay that plus any difference between your insurer’s allowed amount and what the provider charges.

In an HMO, you generally have to pay the full cost of any out-of-network care, except for emergency services and for non-emergency services referred or authorized by the HMO.

In a PPO, POS, or EPO, if out-of-network care is covered, you will usually have to pay:

- ▶ A higher deductible than in-network 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 cost substantially more. When you need care, it is important to find out if all of your providers are in your plan’s network.

New York State’s “Out-of-Network” Law

The New York State “Out-of-Network” or “Surprise Bill” Law goes into effect on March 31, 2015 following years of debate over the adequacy of out-of-network reimbursement and the dismay caused by balance bills received by patients. The major provisions of the law provide additional consumer protections when a patient goes out of network for necessary medical services.

Specifically, the law:

- ▶ holds patients harmless for any dollar amount owed beyond the in-network cost share for emergency services and surprise bills;
- ▶ creates new disclosure requirements for hospitals, physicians, and health plans when patients seek out-of-network services;
- ▶ creates an independent dispute resolution process for patients, plans, and physicians who disagree about out-of-network reimbursement for emergency and surprise bills; and
- ▶ bolsters network adequacy requirements and the state’s authority to enforce adequacy standards.

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. If 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—for example, \$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 plus the difference between the allowed amount and provider's charge	30% of the allowed amount plus 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 plus \$1,000 - \$800 = \$200	30% of \$800 = \$240 plus \$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. 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?

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.**

Do not 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. Plans are required to 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.

As mentioned previously, health plans cannot require higher copayments or co-insurance for out-of-network ED services provided in a hospital ED or require you get prior approval or authorization before seeking ED services from a provider or hospital outside your plan's network.

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 will not pay the same amount to the provider if it is not a true emergency. That means you will be left with a higher bill. Plus, you will get more personalized care from your own doctor. If you are not sure what constitutes an emergency, or what emergency costs are covered, ask your insurer.

Your Action Plan: Do Not 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 are having a complex procedure, like 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.

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 includes Part A for hospital insurance and Part B for medical insurance—with supplemental coverage available through Medigap. Instead of traditional Medicare, some people choose coverage under Part C, Medicare Advantage, which is coverage offered by private plans (typically HMOs and PPOs) and must include the same level of coverage included in traditional Medicare. (Prescription medication coverage is 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. According to New York State regulations, hospitals will notify you if you are under observation status, which impacts your coverage for a nursing home stay—you must be admitted to the hospital for three consecutive days in order to be eligible.

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 navigate. 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 or (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 is 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 or (800) 633-4227.

- ▶ **Use New York's Medicare counseling service.** Check out the information provided by New York'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. For more information on the state's SHIP, please call (800) 701-0501 or visit www.aging.ny.gov/HealthBenefits.
- ▶ **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 that 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 (co-insurance, 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 do not need and are not eligible for a Medigap policy.)

For Consumers Who Do Not Have Health Insurance

If you do not have health insurance coverage, learn about your insurance options and find out if you are eligible for financial assistance. If it is not an emergency, request a price estimate before care.

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**. In New York, consumers may enroll through the New York State of Health. 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 New York's Child Health Plus. Both programs cover millions of families with limited income. For more information, see the sidebar or visit www.nystateofhealth.ny.gov. Also, your hospital can help you find out if you qualify for any of these programs and guide you through the application process.

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. New York's hospitals have always provided financial assistance for patients with limited means. New York's Financial Assistance Law ensures hospitals provide free or discounted care for uninsured families with incomes below 300% of the federal poverty level, or \$71,550 for a family of four.

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, and what is

Where to Buy Health Insurance

The New York State of Health, also called the Health Insurance Exchange, is a new way to find quality health insurance coverage. It can help if you do not have coverage now or if you have it but want to look at other options.

When you use the Exchange, you will 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 will learn if you qualify for assistance with out-of-pocket costs. And you will see all the health plans available in your area so you can compare them side-by-side and pick the plan that is right for you. The Exchange 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 typically begins in October and ends in February each year. 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. For more information, visit nystateofhealth.ny.gov or call (855) 355-5777.

not—which may include 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 healthcare after you leave the hospital, and possible unforeseen complications.

Improving Price Information

Hospital leaders want consumers to be able to access meaningful information so they can make informed choices. Healthcare pricing is complicated—we want to help you navigate this process and understand your options. HANYS and HANYS’ members have been working to create tools, including this guide, to make it easier.

HANYS’ members are working to ensure patients can find advanced estimates for care; information on the hospital’s financial aid policy, with fast eligibility determination; and access to well-trained staff to help you navigate pricing—especially if you are uninsured.

Patients should receive clear information and support on financial assistance options—fear of

a hospital bill should never get in the way of getting necessary healthcare. Hospital counselors help thousands of New Yorkers sign up for Medicaid or the New York State of Health annually.

HANYS is also working with regulators to improve the information displayed on state websites. We believe pricing information should be relevant, useful, accessible, easy to navigate, and explain how and why the price of patient care can vary—such as the facility’s teaching status, labor market, government underpayment, etc.

Finally, remember price information should just be one of many factors considered when making decisions about care and health plans.

Source: Based on the work of the HANYS Transparency Task Force.

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 the 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 cannot afford to purchase private health insurance coverage.

Co-insurance Your percentage share of the costs of a covered healthcare service. This (for example, 20%) is based on the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health plan’s allowed amount for an office visit is \$100 and you have met your deductible, your co-insurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.

Contracted rate The amount 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 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; or 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. 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.

Deductible The amount you are expected to pay for healthcare services your health plan covers before the plan begins to pay. For example, if your deductible is \$1,000, your plan will not pay anything until you have met your \$1,000

Definitions

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.

Exclusive provider organization (EPO) A health plan where you can only use the doctors and hospitals within your network, with the exception of emergency care, and there are no out-of-network benefits.

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 do not have to pay taxes on this money. There is a limit on the amount you can put into an FSA each year. In 2015, contributions were limited to \$2,550 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 account (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 are not subject to federal income tax at the time of deposit. Funds must be used to pay for qualified medical expenses. Unlike an FSA, funds roll over year to year if you do not 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.

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.

Definitions

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](https://www.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, 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 are not reimbursed by insurance. Out-of-pocket costs include deductibles, co-insurance, and copayments for covered services plus all costs for services that are not 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% 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

New York State Department of Health.

www.health.ny.gov

New York State of Health. New York's health insurance exchange marketplace.

www.nystateofhealth.ny.gov

Department of Financial Services. The New York State agency that provides a consumer guide to health insurance and health plan information.

www.dfs.ny.gov

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

New York State Health Insurance Assistance Program (SHIP). This website provides information on New York's SHIP and Health Insurance Information, Counseling, and Assistance program that helps Medicare beneficiaries with health insurance questions.

www.aging.ny.gov/HealthBenefits/Index.cfm

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.

New York State Health Profiles. Department of Health's website including data on patient outcomes and quality indicators for healthcare facilities.

profiles.health.ny.gov/hospital

Hospital Compare. This federal government website has information about the quality of care at over 4,000 Medicare-certified hospitals across the country.

medicare.gov/hospitalcompare

INQUIREhealthcare. An online resource developed by the Healthcare Incentives Improvement Institute to provide healthcare quality, cost, and safety information to consumers.

www.inquirehealthcare.org

MyMedicare.gov. Medicare's free, secure online service for accessing personalized information about your Medicare benefits and services.

New York State Insurance Providers

Aetna Health Inc. www.aetna.com
Affinity Health Plan www.affinityplan.org
AlphaCare of New York, Inc.
www.alphacare.com
AMERIGROUP New York, LLC
www.amerigroup.com
Amida Care, Inc. www.amidacareny.org
Easy Choice Health Plan
www.easychoicehealthplan.com
Capital District Physicians Health Plan
www.cdphp.com
Care Improvement Plus
www.careimprovementplus.com
Catholic Special Needs Plan, LLC
www.archcare.org
Center Care, Inc. www.centercare.com
CIGNA Health and Life Insurance Company
www.cigna.com
Community Blue www.bcbswny.com
Cuatro, LLC www.cuatrobenefits.com
Elderplan, Inc. www.elderplan.org
EmblemHealth www.emblemhealth.com
Empire HealthChoice www.empireblue.com
Essence Healthcare of New York, Inc.
www.essencehealthcare.com
Excellus Health Plan www.excellusbcbs.com
Freelancers Insurance Company, Inc.
www.freelancersinsuranceco.com
Health Net Insurance of New York, Inc.
www.healthnet.com
Health Plus Prepaid Health Services Plan, Inc.
healthplus.amerigroup.com
Health Republic Insurance of New York
www.healthrepublicny.org
HealthFirst www.healthfirst.org
Health Now New York, Inc.
www.healthnowny.com
HealthSpring Life & Health Insurance
Company, Inc. www.healthspring.com

HHH Choices Health Plan, LLC
www.healthfirst.org
Hudson Health Plan
www.hudsonhealthplan.org
Humana www.humana.com
Independent Health
www.independenthealth.com
Liberty Health Advantage, Inc. www.lhany.com
MedAmerica Insurance Company of New York
www.medamericaltc.com
MetroPlus Health Plan, Inc. www.metroplus.org
MVP Health Plan, Inc. mvphealthcare.com
Neighborhood Health Providers
www.getnhp.com
New York State Catholic Health Plans, Inc.
www.fideliscare.org
North Shore-LIJ CareConnect Insurance
Company, Inc. www.nsljicareconnect.com
Northwestern Long Term Care Insurance
Company www.northwesternmutual.com
Oscar Insurance Corporation www.hioscar.com
Oxford Health Insurance, Inc.
www.oxfordhealth.com
Quality Health Plans of New York, Inc.
www.qualityhealthplansny.com
SCHC Total Care, Inc. www.totalcareny.com
Senior Whole Health of New York, Inc.
www.seniorwholehealth.com
Sierra Health and Life Insurance Company, Inc.
www.sierrahealthandlife.com
Touchstone Health HMO, Inc.
www.touchstoneh.com
Tufts Insurance Company
www.tufts-health.com
UnitedHealthcare www.uhc.com
Univera Community Health, Inc.
www.univeracommunityhealth.org
Wellcare of New York, Inc. www.wellcare.com

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