

## HJR 20: Health Care Price Transparency

### ***Topic Terminology: Model Cost Reduction Programs***

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- **Accountable Care Organizations.** “Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program.” (Definition from CMS.gov)
- **Acute Medical Condition.** An acute medical condition develops abruptly due to an accident or sudden onset of a serious disease or physical abnormality (e.g., heart attack). An acute condition often requires immediate medical intervention. In terms of medical pricing, the cost to the patient usually cannot be determined before the person receives treatment.
- **Bundled Payment.** Paying for a set of services instead of each unit is typically called bundled or episode-based payment. Bundled payment is a single payment to providers or health care facilities (or jointly to both) for all services to treat a given condition or provide a given treatment. For example, a payer might pay a set amount for a knee replacement. If the operation and rehabilitation goes well, the provider may be fully reimbursed or even make money on the transaction. But if there are complications, the provider must assume those extra costs and will receive no extra payment. Bundled payment gives an incentive to the health care provider to produce a good quality outcome for the patient. (Health Affairs)
- **Capitation.** “Capitation is a fixed amount of money per patient per unit of time paid in advance to the physician for the delivery of health care services. The actual amount of money paid is determined by the ranges of services that are provided, the number of patients involved, and the period of time during which the services are provided. Capitation rates are developed using local costs and average utilization of services and therefore can vary from one region of the country to another.” (Definition from the American College of Physicians)
- **Chronic Health Condition.** “A chronic illness is a condition that lasts a year or longer, limits activity, and may require ongoing care. More than 125 million Americans have at least one chronic condition, such as diabetes, cancer, glaucoma, and heart disease. Nearly half as many have more than one chronic condition. . . . By the year 2020, the number of people living with chronic conditions is expected to rise to 157 million. Direct medical costs associated with these conditions are expected to double to more than \$1 trillion -- 80 percent of the nation's health care spending -- while a quarter of the American population is expected to be living with multiple chronic conditions.” (PBS.org)

- **Coordinated Care.** Care coordination is a health care delivery model that is organized around collaboration and coordination of the patient and a team of health care professionals carrying out all required patient care activities. This coordination is managed, in part, by using the patient’s electronic medical record and exchanging information among health care providers responsible for different aspects of care.
- **CT Scan.** A CT scan is a radiological imaging test that creates detailed images of the body. It may be used to diagnose an infection, guide a surgeon to the correct area to biopsy, identify masses or tumors within the body, or examine blood vessels. CT scans are performed by a CT scanner. This imaging machine rotates around patients while shooting X-ray beams toward them. A computer that is connected to the machine then creates separate slices, or images, of the body. A doctor can thread the slices together to examine the different structures of the body. Prices for CT scans vary significantly even though the process is relatively the same.
- **Diagnostic Tests.** Diagnostic tests are tests used to gather clinical information to assist in making a clinical decision (i.e., diagnosis). Some examples of diagnostic tests include X-rays, biopsies, pregnancy tests, medical histories, and results from physical examinations. Health care providers determine the cost and price for medical tests.
- **Direct-Pay Health Care.** The direct-pay health care model gives primary care physicians an alternative to fee-for-service insurance billing, typically by charging patients a monthly, quarterly, or annual fee that covers all or most primary care services including clinical, laboratory, and consultative services, and care coordination and comprehensive care management. Because some services are not covered by the retainer, direct-pay practices suggest that patients also have a health insurance policy that covers health care specialists, auxiliary services (e.g., physical therapy), hospitalizations and emergencies. Direct primary care can benefit patients by providing substantial savings for routine health and wellness care and a greater access to physicians. (aafp.org)
- **Electronic Medical Record and Electronic Health Record.** An EMR contains the standard medical and clinical data gathered in one provider’s office. Electronic health records (EHRs) go beyond the data collected in the provider’s office and include a more comprehensive patient history. For example, EHRs are designed to contain and share information from all providers involved in a patient’s care. EHR data can be created, managed, and consulted by authorized providers and staff from across more than one health care organization. Unlike EMRs, EHRs also allow a patient’s health record to move with them – to other health care providers, specialists, hospitals, nursing homes, and even across states. An electronic medical record (EMR) is a digital version of a paper chart that contains all of a patient’s medical history from one practice. An EMR is mostly used by providers for diagnosis and treatment. (healthit.gov)
- **End-of-Life Conditions.** “Healthcare providers consider people to be approaching the end of life when they are likely to die within the next 12 months, although this is not always possible to predict. This includes people whose death is imminent, as well as people who:
  - have an advanced incurable illness such as cancer, dementia or motor-neuron disease
  - are generally frail and have co-existing conditions that mean they are expected to die within 12 months

- have existing conditions if they are at risk of dying from a crisis in their condition
- have a life-threatening acute condition caused by a sudden catastrophic event, such as an accident or stroke

End-of-life treatment can be extremely expensive because the patient may need care from several medical specialists, 24-hour skilled nursing care, palliative care, and various procedures necessary to relieve symptoms or prolong life, as appropriate. Common end-of-life conditions include: cancer, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), kidney failure, Alzheimer's, Parkinson's, and Amyotrophic Lateral Sclerosis (ALS). Healthcare providers can estimate parts of the cost of end-of-life care, but these costs vary greatly depending on the wishes of the patient and the patient's family as well as the range of medical decisions made concerning medications, surgeries, and life-prolonging treatments." (nhs.uk)

- **Evidence-Based Medicine.** "Evidence based medicine (EBM) is the conscientious, explicit, judicious and reasonable use of modern, best evidence in making decisions about the care of individual patients. EBM integrates clinical experience and patient values with the best available research information. It is a movement which aims to increase the use of high quality clinical research in clinical decision making." (Definition from Masic et. al. 2008)
- **Fee-for-Service.** "A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits." (healthcare.gov)
- **High-Cost Populations.** "As policymakers consider various ways to contain the rising costs of health care, it is useful to examine the patterns of spending on health care throughout the United States. In 2004, the United States spent \$1.9 trillion, or 16 percent of its gross domestic product (GDP), on health care. This averages out to about \$6,280 for each man, woman, and child. However, actual spending is distributed unevenly across individuals, different segments of the population, specific diseases, and payers. For example, analysis of health care spending shows that:
  - Five percent of the population accounts for almost half (49 percent) of total health care expenses.
  - The 15 most expensive health conditions account for 44 percent of total health care expenses.
  - Patients with multiple chronic conditions cost up to seven times as much as patients with only one chronic condition." (ahrq.gov)
- **High-Risk Pool.** "Prior to implementation of the ACA, 35 states offered high-risk pools as a source of non-group health insurance for eligible residents. The first pools were implemented by Minnesota and Connecticut in 1976; North Carolina implemented a high-risk pool in 2009. Pools offered eligibility to people in one or more of the following categories: Medically eligible, HIPAA eligible, HCTC eligible, and Medicare eligible." (kff.org)
- **Insurance Contracts.** In the current health care system, health insurance companies typically negotiate with hospitals for payment rates. The idea is that the insurance companies can get lower prices by having a contract with a hospital that reduces prices while guaranteeing the hospital a large volume of patients who will be directed to the hospital because it is "in network".

- **Medical Guidelines.** “Clinical practice guidelines are systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.’ (Institute of Medicine, 1990)
  - Issued by third-party organizations, and not NCCIH, these guidelines define the role of specific diagnostic and treatment modalities in the diagnosis and management of patients. The statements contain recommendations that are based on evidence from a rigorous systematic review and synthesis of the published medical literature.
  - These guidelines are not fixed protocols that must be followed, but are intended for health care professionals and providers to consider. While they identify and describe generally recommended courses of intervention, they are not presented as a substitute for the advice of a physician or other knowledgeable health care professional or provider.” (nccih.nih.gov)
- **MRI Scan.** “Magnetic resonance imaging, or MRI, is a noninvasive medical imaging test that produces detailed images of almost every internal structure in the human body, including the organs, bones, muscles and blood vessels. MRI scanners create images of the body using a large magnet and radio waves. There is no radiation produced during an MRI exam, unlike X-rays. These images give your physician important information in diagnosing your medical condition and planning a course of treatment.” (Definition from Johns Hopkins)
- **Network Provider.** A provider network is a list of the physicians, other health care providers, and hospitals that an insurance plan has contracted with to provide medical care to its members. These providers are called “network providers” or “in-network providers.” A provider that hasn’t contracted with the plan is called an “out-of-network provider.” (marketplace.cms.gov)
- **Non-Invasive, Outpatient Medical Procedures.** Health providers determine the price of non-invasive medical procedures. The price might have to be adjusted if unexpected complications occur. Non-invasive medical procedures include things like nasogastric tube placement, injections, venipuncture, blood cultures, electrocardiogram tracing, pulmonary function tests, wound closure, casting and splinting, local anesthesia, dermatologic procedures, gynecology procedures, lumbar puncture, and ventilator management.
- **Patient-Centered Medical Home (PCMH).** The Patient-Centered Medical Home (PCMH) is a care delivery model in which patient treatment is coordinated through a primary care physician to ensure the patients receive the necessary care when and where they need it, in a manner they can understand. The value of having a medical home is the patient has a close and continuous relationship with a primary care physician who knows the patient’s history and preferences and can advocate for appropriate care from other health care providers. (acponline.org)
- **Patient Pricing Education.** Patient pricing education involves providing consumers with pricing information and questions to consider, including quality of care (outcomes), coordination of care, rehabilitation options after surgery, insurance deductibles, co-payments, out-of-pocket costs, insurance premiums, location of care and related expenses.

- **Pay for Performance (P4P).** “‘Pay-for-performance’ is an umbrella term for initiatives aimed at improving the quality, efficiency, and overall value of health care. These arrangements provide financial incentives to hospitals, physicians, and other health care providers to carry out such improvements and achieve optimal outcomes for patients.” (definition from [healthaffairs.org](http://healthaffairs.org))
- **PET Scan.** “A positron emission tomography (PET) scan is a unique type of imaging test that helps doctors see how the organs and tissues inside your body are actually functioning. A PET scan can measure such vital functions as blood flow, oxygen use, and glucose metabolism, which helps doctors identify abnormal from normal functioning organs and tissues. The scan can also be used to evaluate the effectiveness of a patient's treatment plan, allowing the course of care to be adjusted if necessary. Currently, PET scans are most commonly used to detect cancer, heart problems (such as coronary artery disease and damage to the heart following a heart attack), brain disorders (including brain tumors, memory disorders, seizures) and other central nervous system disorders.” (Cleveland Clinic)
- **Population Health.** Population health is an approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups. To reach these objectives, population health looks at and acts upon the broad range of factors and conditions that have a strong influence on health of a group of people. (definition from the Public Health Agency of Canada)
- **Predictive Modeling.** Predictive modeling is the application of mathematical models to predict an outcome, such as the potential cost or risk associated with managing a specific patient population. Policymakers, insurance companies, and health organizations can use predictive modeling to estimate disease risk and to evaluate the effectiveness of a health care intervention. The models can be used to predict health care costs and utilization (e.g., hospitalization rate, ER/ED, medications) and to identify people with high medical needs who would likely benefit from care management interventions.
- **Reference-Based Pricing.** Reference pricing is a method for controlling health care prices. Insurers or employers calculate a reference price for a routine test or procedure by analyzing past claims for these services. Based on this analysis, the insurer sets a reasonable price for a good-quality routine test or procedure and tells its customers that if they want to go to a higher-cost in-network provider they can, but they will be responsible for the difference between the reference price and the provider’s price. Savings from reference pricing occurs through the combination of 1) patients choosing providers at the reference price, 2) patients paying the difference between the reference price and the allowed charge through cost sharing, and 3) providers reducing their prices to the reference price. ([consumerreports.org](http://consumerreports.org))
- **Strategic Billing.** Strategic billing is a term applied to the practice of hospitals and medical practices using billing strategies that enhance their overall revenue by emphasizing actual treatment or procedures instead of supplies. For example, medical charges are more likely to be paid by insurers and government programs if they reflect operating room time, oxygen therapy, and prescription drugs instead splints, gauze and bandages.
- **Surgical Procedures.** A medical procedure is considered surgical when it involves cutting of a patient's tissues or closure of a previously sustained wound. Surgeries can be exploratory (used for diagnosis), elective (occur at a time convenient for the patient), pre-

planned (C-sections), or emergencies. Surgery may be done as an out-patient or in-patient procedure. In-patient surgery is usually followed by a hospital stay for recovery and sometimes for rehabilitation. These follow-up services add to the cost. Health care providers can estimate prices for non-emergency surgical procedures in advance of the scheduled surgery, so the patient can compare prices between one provider and another. However, any estimate would not include additional costs that may occur because of unexpected complications. (Wikipedia)

- **Telemedicine.** “Telemedicine seeks to improve a patient's health by permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment.” (definition from CMS.gov)
- **Third-Party Administrator (TPA).** A third-party administrator (TPA) is an organization that processes insurance claims or certain aspects of employee benefit plans for a separate entity. This can be viewed as "outsourcing" the administration of the claims processing, since the TPA is performing a task traditionally handled by the company providing the insurance or the company (employer) itself. Often, in the case of insurance claims, a TPA handles the claims processing for an employer that self-insures its employees. Thus, the employer is acting as an insurance company and underwrites the risk. The risk of loss remains with the employer, and not with the TPA. An insurance company may also use a TPA to manage its claims processing, provider networks, utilization review, or membership functions. While some third-party administrators may operate as units of insurance companies, they are often independent.

Third-party administrators also handle many aspects of other employee benefit plans such as the processing of retirement plans and flexible spending accounts. Many employee benefit plans have highly technical aspects and difficult administration that can make using a specialized entity such as a TPA more cost effective than doing the same processing in house. (Wikipedia)

- **Transparency in Health Care Pricing.** Health care price transparency exists when patients can clearly see the price of a treatment and determine how much they will pay out-of-pocket before receiving care. Costs to the patient could include deductibles, co-payments, insurance premiums and any out-of-network penalties. (Robert Wood Johnson Foundation)
- **Value-Based Pricing.** Value-based pricing is paying health care providers based on their success at improving outcomes, keeping down costs, and providing patient satisfaction with their health care experience. For patients, value-based pricing means safe, appropriate, and effective care with enduring results provided at a reasonable cost. For health care providers, it means employing evidence-based medicine and proven treatments and techniques that coincide with the patients’ wishes and preferences.
- **Wellness Services.** Wellness activities are health care services that assist in preventing illness and maintaining or improving general health for the patient. Services may include assessments and screenings, annual physical exams, health coaching and education, disease prevention and immunizations, and care plans for maintaining health at home.