

New York State Department of Health Price Methodology Workgroup

Final Recommendations

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Note: The Price Methodology Workgroup was organized and facilitated by UHF in collaboration with the New York State Department of Health. UHF prepared this report on behalf of the Workgroup.



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Note: Lynn Rogut, Director, Quality and Team Leader, UHF Quality Institute, prepared this report on behalf of the NYS DOH Price Methodology Workgroup.

Introduction

New York's consumers are feeling the impact of rising costs for health care services and out-of-pocket (OOP) expenses for insurance coverage.^{1,2,3} Affordability is a common concern not only in our state but across the nation: almost half of American adults, whether they are insured, under-insured, or uninsured, report difficulty paying their medical bills.^{4,5} Yet it is hard for consumers, patients, and families to access meaningful, comparative information about health care prices before receiving services.^{6,7} This information gap constrains New Yorkers from being informed consumers, limiting their ability to discover that prices can vary greatly among providers and geographic regions, to consider prices when deciding where to seek care that can be planned in advance, and to select lower-cost providers if preferred.⁸

Although the number of proprietary, governmental, and nonprofit websites that publish provider-level cost and quality information continues to grow, studies have shown that such tools are not highly utilized, relevant information remains scattered across the Internet, and many consumers don't know where to find it when they need it.^{9,10} Some companies, like Castlight and Amino, market their transparency tools directly to employers and health plans, rendering them inaccessible to the average consumer.

¹ A 2019 study by the Health Care Cost Institute and New York State Health Foundation found that health care spending for New Yorkers with employer-sponsored health insurance was both higher and rising more sharply than the national average, and that higher spending also translates to higher OOP and premium costs for consumers. See [Health Care Spending, Prices, and Utilization for Employer-Sponsored Insurance in New York](#), July 2019.

² A 2016 survey found that nearly half of New York State residents (48%) tried to find price information before getting care. Public Agenda, [Still Searching: How People Use Health Care Price Information in the United States, New York State, Florida, Texas and New Hampshire](#), April 2017, p. 17.

³ A recent study by The Commonwealth Fund found that in New York, total potential OOPs, including employee contribution and plan deductibles, ticked up 1.3% from 2018 to 2019, to \$6,558, representing 9.6% of an employee's average income. Collins, S., Radley, D., Baumgartner, C., *State Trends in Employer Premiums and Deductibles, 2010–2019*, November 20, 2020.

⁴ Mehrotra, A., Chernew, M., Sinaiko, A. Promise and Reality of Price Transparency, *N Engl J Med* 2018; 378,14 p. 1348–54.

⁵ According to the Federal Trade Commission, more than 43 million people in the U.S. have medical debts on their credit reports, and medical debts make up more than half of all debts reported by collection companies. Carrns, A. The Debt Is Fake: The Harm Can Be Real. *New York Times*, Dec. 12, 2020.

⁶ Public Agenda, [Still Searching: How People Use Health Care Price Information in the United States, New York State, Florida, Texas and New Hampshire](#), April 2017, p. 42.

⁷ A national public opinion survey conducted in 2020 by the Kaiser Family Foundation (KFF) found that 93% of adults living in the U.S. favored making information about the price of doctors' visits, tests, and procedures more available to patients. See [KFF Health Tracking Poll/ KFF COVID-19 Vaccine Monitor, December 2020](#).

⁸ In its final rule on price transparency requirements for hospitals, effective Jan. 1, 2021, the Centers for Medicare and Medicaid Services noted growing consumer demand and awareness of the need for health care pricing data and a gap in easily accessible pricing information for consumers to use for health care shopping purposes. For more information see, CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates CMS-1717-P, Nov. 27, 2019, <https://www.federalregister.gov/d/2019-24931>.

⁹ Mehrotra, A., Dean K.M., Sinaiko, A.D., Sood, N. Americans Support Price Shopping for Health Care, But Few Actually Seek Out Price Information, *Health Affairs* 2017; 36,8.

¹⁰ Sinaiko, A., Kakani, P., Rosenthal, M.B. Marketwide Price Transparency Suggests Significant Opportunities for Value-Based Purchasing, *Health Affairs* 2019; 38,9, p. 1521.

In response to persistent price variation and continued growth in health care expenditures, federal and state governments have taken recent actions to promote greater price transparency. Since January 1, 2021, the Centers for Medicare & Medicaid Services (CMS) has required all hospitals to publish online their current standard charges for all hospital items and services, including gross charges, discounted cash price, and payer-specific negotiated rates.¹¹ A proposed rule directs health insurers and group health plans to publish negotiated rates with in-network providers and out-of-network pricing. The purpose of both the hospital price transparency requirements and the proposed rule for insurers is to provide transparency that federal agencies believe promotes choice and competition, allows patients to be active consumers, and begins “to narrow price differences for the same services in the same health care markets” through increased competition.^{12,13,14}

Currently, there is no single website where New Yorkers can find comprehensive information about provider-specific pricing and quality, consumer protections, and financial assistance programs, along with educational resources and tools. Nearly two-thirds of New Yorkers surveyed in 2016 said there was not enough information about how much medical services cost, and 80% thought it was important for the state government to provide information that would allow them to compare prices before getting care.¹⁵ Governor Cuomo’s 2020 State of the State agenda prioritized this recognized gap with a proposal to increase transparency in health care costs and quality. The governor directed the New York State Department of Health (NYS DOH), the NYS Department of Financial Services, and the NYS Digital and Media Services Center to create a consumer-friendly website, “NYHealthcareCompare,” where New Yorkers would be able to easily compare the cost, volume, and quality of health care procedures at specific hospitals. The platform would also provide consumers with educational resources designed to support their health care journey; and help them understand their rights and options for obtaining financial assistance, what to do about a surprise medical bill, and more.¹⁶

As preliminary work began on NYHealthcareCompare, NYS DOH sought to ensure that its website would be as meaningful and user-friendly as possible. Early in 2020, the Department’s Office of Quality and

¹¹ The 2021 federal price transparency regulations require hospitals to provide a comprehensive machine-readable file that includes all standard charges for all hospital items and services; and a consumer-friendly display of standard charges for at least 300 “shoppable” services that are grouped with charges for ancillary services that are customarily provided by the hospital. This includes the gross charge, discounted cash price, payer-specific negotiated charge, and de-identified minimum and maximum negotiated charges. (Previous federal regulations from 2019 required hospitals to post “chargemaster prices.”) For more information, see <https://www.cms.gov/files/document/steps-making-public-standard-charges-shoppable-services.pdf>.

¹² Kennedy, K., Johnson, W., Hargraves, J. [*What if Price Transparency Reduced Commercial Price Variation?*](#) Health Care Cost Institute, Jan. 29, 2020.

¹³ For more information about the Proposed Rule, see <https://www.govinfo.gov/content/pkg/FR-2019-11-27/pdf/2019-25011.pdf>

¹⁴ On October 29, 2020, CMS issued a final rule requiring health plans to make an online price transparency tool that provides cost sharing and other information available to their members. For plan years starting on or after January 1, 2023, the rule requires health plans to offer an online shopping tool allowing consumers to see the negotiated rate between their provider and their plan, as well as a personalized estimate of their out-of-pocket (OOP) cost for 500 of the most shoppable items and services. The following year (effective for plan years starting on or after January 1, 2024), these shopping tools will be required to show the OOP costs for the remaining procedures, drugs, durable medical equipment and any other item or service they may need. See [Health Plan Price Transparency Requirements Final Rule Executive Summary \(hfma.org\)](#).

¹⁵ Public Agenda, [*Still Searching: How People Use Health Care Price Information in the United States, New York State, Florida, Texas and New Hampshire*](#), April 2017, p. 55–6.

¹⁶ <https://www.governor.ny.gov/news/governor-cuomo-unveils-14th-proposal-2020-state-state-increasing-transparency-healthcare-costs>

Patient Safety engaged United Hospital Fund (UHF) to organize, co-lead, support, and facilitate a new workgroup on price methodology. This workgroup would provide input on key decisions related to how pricing information would be reported, building on the recommendations of two recent multi-stakeholder workgroups on key elements central to developing consumer-friendly, quality profiles for hospitals and primary care clinicians located in New York State.

To help solicit a broad range of perspectives and input, participants and subject matter experts for the new Price Methodology Workgroup (PMW) were selected by NYS DOH from consumer advocacy groups, providers, payers, professional and trade organizations, foundations, nonprofits, and consulting organizations. A technical advisor was also engaged to support the workgroup.¹⁷

NYS DOH charged the PMW with providing advice on guiding principles and methodological considerations that could inform efforts to implement a methodology for producing transparent pricing information to help support consumer decisions. With the understanding that the Department's All Payer Database (APD) would serve as the data source for this initiative,¹⁸ and that the greatest degree of variation in prices paid for health care services occurs among people with commercial insurance, the PMW was specifically asked to address several tasks:

- consider approaches and decision points for calculating health care prices and describing variation
- identify resources to help consumers plan for common uses of the health care system
- deliver recommendations to NYS DOH and identify gap areas

The PMW did not consider the following areas, which were beyond the scope of its charge: approaches to creating “cost calculator” information for estimating OOP costs, publishing specific rates negotiated by individual payers and providers, or design elements of the website itself. However, both NYS DOH and the Workgroup recognized that a cost calculator tool would be highly useful to consumers in seeking pricing information, and it was recognized as a need.

Approach and Potential Uses

Five meetings of the PMW were convened virtually from August 2020 through February 2021. The meetings were co-chaired by Anne Schettine, director of the NYS DOH Office of Quality and Patient Safety, and Dr. Anthony Shih, president of UHF, who also served as facilitator. Between meetings, participants were encouraged to seek the input of others within their organizations.

Throughout the process, the PMW shared diverse views and engaged in rich and insightful discussions of key components and methods deemed central to producing and presenting transparent pricing

¹⁷ Appendix A provides a list of the Workgroup's participants and their affiliated organizations.

¹⁸ NYS DOH began implementing its APD in 2016 to house data from public and private insurance payers, including insurance carriers, health plans, third-party administrators, and pharmacy benefit managers, as well as Medicaid and Medicare. With the APD, the Department will have a comprehensive picture of the health care being provided to New Yorkers to support transparency on quality, safety, and costs of care. For more information, see https://nyshc.health.ny.gov/documents/39436/243045/apd_guidance_manual.pdf and [All Payer Database \(ny.gov\)](https://nyshc.health.ny.gov/all-payer-database).

information for a consumer audience on a state website. The primary context for that information was to help consumers understand the potential costs of care for “shoppable” services,¹⁹ and how prices for those services may vary by provider or provider type, or by geographic area. The Workgroup also discussed supporting the negotiation of medical bills (something of particular importance for uninsured consumers and consumers covered by plans with substantial cost-sharing policies like coinsurance and high deductibles), and educating physicians so that they could consider prices together with their patients and help identify lower-cost providers.²⁰

The potential for pricing information to serve the interests of other stakeholders was also discussed – e.g., insurers for health plan product design, purchasers for employee benefit design, providers for competitive positioning, and policymakers for better understanding and responding to patterns in price variation and concerns about health care affordability. However, the Department’s initial focus was on helping to educate New York consumers about price variation for common shoppable health care services, and enabling easy access to provider-specific price estimates and to tools and resources that could empower consumers to shop for care in advance.

Feasibility concerns and other related issues surfaced early in the discussions. Consumer representatives and several other PMW participants, although not all, strongly favored pricing information that would distinguish OOP expenses from amounts paid to providers by insurers and government sources. The Workgroup also emphasized the importance of providing information that could help consumers avoid out-of-network providers when seeking care, or facility charges or professional fees not covered by insurance. However, there was acknowledgment that current limitations in claims data could constrain the ability of NYS DOH to provide pricing information at that level of specificity.

¹⁹ For the purposes of this report, shoppable services are defined as common health care services or procedures that are not emergent and can be planned in advance.

²⁰ A recent study found that referring physicians significantly influence where patients receive care. See Chernew, M., Cooper, Z., et.al. [Physician agency, consumerism, and the consumption of lower-limb MRI scans - ScienceDirect](#).

Organizing Framework

To help elicit the range of input that would be most useful to NYS DOH for developing pricing information for consumers, UHF developed three groupings of key questions for framing the PMW’s discussions.

What pricing information should NYS DOH consider providing?

1. What information available through the APD is the most meaningful and fair for understanding price variation for shoppable services among providers?
2. What payers should be included?
3. What health care settings/providers and services/procedures should be included?

How should NYS DOH provide pricing information?

4. How should services/procedures be defined (i.e., at what level—visit, procedure, condition, bundle)?
5. How should price estimates be calculated and presented? (For example: Should they be adjusted, categorized, or identified by patient characteristics, provider type, geography, etc.? Which characteristics of distributions should be used? What benchmarks should be provided? Should providers be rated or ranked based on price? How should estimates be previewed and refined for accuracy and validity? What caveats and limitations should be explained, and how?)

What other types of information resources should NYS DOH consider providing?

6. What additional resources should be provided to support consumer decisions, help consumers understand price variation and make the best choices, promote informed use of the health care system, and resolve medical bills after services are received?
7. What should NYS DOH consider in planning to make a public use file available?

The remainder of this report outlines the recommendations that emerged from the PMW’s deliberations. These recommendations may not fully align with the views of each individual participant or organization represented; where relevant, we have noted areas of disagreement.

Recommendations—Guiding Principles

After an initial review and discussion of the kinds of input that would be most helpful to NYS DOH, the PMW agreed on a set of five broad principles for guiding state efforts to provide pricing information for a consumer audience. **The information on the website should: 1) be accurate, reliable, timely, and transparent; 2) be meaningful and relevant to all New Yorkers; 3) be easy to use and understand; 4) evolve in response to user needs; and 5) acknowledge data limitations and potential unintended consequences for consumers.** Additional descriptions of these principles follow:

1. Accurate, reliable, timely, and transparent
 - Dependable, complete, and up-to-date information that consumers can trust and use to plan for their care
2. Meaningful and relevant
 - Supports comparisons of price variation across providers and provider types using terms and approaches consistent with federal price transparency requirements
 - Has content that aims to meet the information needs of all New Yorkers, including those who have more difficulty navigating the health care system, whose preferred language is not English, or who have literacy or health literacy challenges or specific health care needs (e.g., disabilities, LGBTQ, or HIV/AIDS or other chronic illnesses or conditions)
 - Promotes informed use of the health care system
 - Is paired with other information needed for decision-making, including quality and volume indicators and connections to state, health plan, and other resources for consumers
3. Easy to use and understand (i.e., user-friendly)
 - Recognizes differences in information needs and preferences
 - Explains what price estimates include and exclude, and why they may vary
 - Minimizes cognitive burden and leverages principles of effective web design
 - Uses plain language to describe pricing information and its meaning for consumers; applies best practices to address limitations in English proficiency, literacy, numeracy, or health literacy
4. Evolves
 - Responds to feedback from users and stakeholders
 - Is iterative in nature and expands as the amount of information in the NYS DOH APD advances
5. Acknowledges data limitations and potential unintended consequences for consumers
 - Provides guidance to consumers on limitations of price estimates—e.g., reasons why estimates may differ from actual costs; or why estimates are not the same as billed charges, paid amounts, or patient costs appearing on an explanation of benefits
 - Recognizes differences in information needs and preferences
 - Is cognizant of choice constraints and uses language carefully so that needed care is not delayed or avoided²¹

²¹ According to the Federal Reserve Board, *Report on the Economic Well-Being of U.S. Households in 2019*, May 2020, 25% of adults went without some form of medical care due to an inability to pay. See [The Fed - Report on the Economic Well-Being of U.S. Households in 2019 - May 2020 \(federalreserve.gov\)](https://www.federalreserve.gov/econres/brw/20200501.html).

Recommendations—The Seven Key Questions

The following section, **organized by key question**, outlines the results of the PMW’s discussions about what pricing information NYS DOH should provide, how that information should be provided, and other resources that would be helpful to New Yorkers. Initial and longer-term recommendations are presented, followed by additional input or information gaps that may warrant further consideration by NYS DOH or consultation with a technical expert panel of stakeholders—including consumers.

1. What information available through the APD is the most meaningful and fair for understanding price variation for shoppable services among providers?

The Workgroup discussed the many complexities related to payment for health care services. For instance, insurers offer multiple health plan products; contracts between payers and providers have proliferated, are not standardized, and change frequently; and paid amounts, OOP components (i.e., coinsurance, copayments, and deductibles), and the rate at which consumers spend their deductibles in any given year all vary substantially.



Initial Recommendations

- A. **After reviewing the data elements available in the APD,²² the PMW recommended that NYS DOH use “allowed amount.”** The allowed amount is the maximum amount a plan will pay an in-network provider for a covered health care service; it is also known as eligible expense, payment allowance, and negotiated rate. The allowed amount was viewed as less variable, and PMW participants felt that it best reflects the actual underlying price of health care for any specific service.
- B. Recognizing that health plan benefit design, current contracted rates with payers, and provider discounts determine how much consumers will pay OOP for covered services, along with their remaining deductible, **the PMW recommended that NYS DOH provide links to the price or cost estimators of health plans** operating in New York State to help consumers understand their potential OOP costs.

Longer-Term Recommendation



Timely and accurate payer-specific data that could enable consumers to estimate and compare OOP expenses before receiving care was prioritized by the PMW as a critical need. While health plan cost estimators may currently be the best resource for helping consumers understand potential OOP expenses before receiving care, those tools don’t help with choices about seeking care that is out-of-network or not covered by insurance, and they don’t help New Yorkers without insurance. As additional data become available through the APD or other sources, the Workgroup recommended that NYS DOH consider whether there are **feasible approaches that could help consumers better understand potential**

²² See Appendix B for information about the APD’s data elements.

OOP costs, avoid facility fees and higher costs associated with using out-of-network providers, and identify providers who offer a sliding fee scale.

To maximize the usefulness of price estimates to consumers, a subset of PMW participants, including consumer advocates and other stakeholders, urged the prompt development and publication of both payer- and provider-specific pricing within one to two years.

Other Input

While the PMW recognized that some people who are uninsured or underinsured may be billed full charges and find that type of price information useful, it did not recommend the display of charges in addition to the allowed amount for a shoppable service or procedure. Concerns about displaying charges in addition to allowed amounts included the potential for consumer confusion and cognitive burden; the wider variation in charges, which may be far higher than allowed amounts or discounted rates and may lead consumers to delay or avoid needed care; and the observation that since few patients pay full charges, they are not a useful proxy for pricing information for the uninsured. However, a few participants favored displaying both the allowed amount and charges, given that charges often appear in medical bills, represent the “full sticker price,” may be helpful to people with high-deductible health plans, and may serve as the starting point for negotiations among uninsured patients, payers, and providers or collection agencies.

It was suggested that NYS DOH align its efforts to produce “allowed amount” data with federal price transparency requirements so that consumers could obtain comparable information from different sources (i.e., hospital, health plan, and state websites).

2. What payers should be included?



Initial Recommendations

- A. **The PMW recommended that NYS DOH use commercial claims data** for the first iteration of its price transparency website, recognizing that the APD may not contain complete claims data from ERISA plans,²³ which cover a large proportion of insured New Yorkers,²⁴ and with the understanding that commercial claims data **would initially be aggregated across payers and health plan products**. Use of commercial claims data was preferred because the greatest variation in health care pricing occurs in services covered by commercial plans, in large part because these prices are negotiated on a plan-by-plan basis and not administratively mandated

²³ Employee Retirement Income Security Act (ERISA) health plans are employer-sponsored plans regulated by the U.S. Dept. of Labor; consequently, states may not require such plans to submit claims and other information to a state agency for an all-inclusive health care database (*Gobeille v. Liberty Mutual Insurance Co.* 2016).

²⁴ Estimates for New York indicate that approximately 30–50% of the commercially insured population falls under ERISA benefit plan arrangements. For more information see, <https://www.apcdouncil.org/publication/new-york%E2%80%99s-all-payer-database-new-lens-consumer-transparency>, p. 31.

as with Medicare and Medicaid. Pre-pandemic, approximately half of all New Yorkers were covered by employer-sponsored plans, either as policyholder or dependent.²⁵

- B. The PMW also recommended that NYS DOH consider **reporting Essential Plan (EP) pricing information separately** from other commercial plans (approximately 800,000+ enrollees statewide).²⁶ One consumer advocate felt strongly that the EP could be the best rate for uninsured consumers—or, for those whose eligibility for EP coverage or Medicaid assistance fluctuates based on income, a starting point for negotiating medical bills.

Longer-Term Recommendations

➡ To advance price transparency as more data become available via the APD, the PMW recommended that NYS DOH also consider displaying **pricing information for public insurance programs** (e.g., Medicare fee-for-service data available from CMS). One participant felt strongly that Medicare payment rates should be presented since they are already publicly available. Most participants agreed that since the state's Medicaid program does not require cost sharing, providing pricing information for Medicaid should be a lower priority. But some consumer advocate and provider participants felt strongly that Medicaid pricing information should be included to advance price transparency; they also argued that it would be useful to New Yorkers enrolled in the Medicaid Excess Income Program, who may be monitoring their monthly medical bills and spending down excess income to qualify for Medicaid assistance.²⁷

➡ When it comes to costs, the Workgroup emphasized these **top-of-mind concerns for consumers with insurance**:

- *whether providers participate in their health plan*
- *will the care they need be covered by their insurance*
- *if so, how much will their insurance cover, and what will they be required to pay OOP*

Recognizing that provider-specific price estimates would initially be aggregated across payers, the PMW recommended that NYS DOH take an **iterative approach to aligning price transparency reporting with New Yorkers' need for payer-specific price estimates** (i.e., provider-specific pricing information by **payer type, carrier, and health plan product**).

²⁵ Kaiser Family Foundation, State Health Facts, Health Insurance Coverage of the Total Population, 2019. An additional 26% of New Yorkers were covered by Medicaid/CHIP, 13% by Traditional Medicare and Medicare Advantage combined, 6% by a policy purchased directly from an insurance company, either as policyholder or as dependent, and 5% were uninsured or had coverage under the Indian Health Service only.

²⁶ <https://info.nystateofhealth.ny.gov/news/press-release-ny-state-health-announces-record-high-enrollment-more-49-million-new-yorkers>, Feb. 20, 2020.

²⁷ The Medicaid Excess Income program provides eligibility for Medicaid for certain populations whose monthly income exceeds the Medicaid level. For more information, see [Medicaid Excess Income \("Spendedown" or "Surplus Income"\) Program \(ny.gov\)](#)

3. What health care settings/providers and services/procedures should be included?



Initial Recommendation

- A. The PMW recommended that NYS DOH provide **information that enables consumers to understand price variation for shoppable services across a wide range of settings** or provider types such as inpatient, hospital outpatient, emergency department, ambulatory surgery, medical offices, laboratories, imaging and gastroenterology centers, urgent care, and others. While the Workgroup recognized that due to data and resource limitations, NYS DOH may need to prioritize and take an iterative approach to providing pricing information at this level of specificity, participants agreed that **pricing information for types of providers was key to enabling shopping by service across settings**.
- B. The PMW recognized that NYS DOH would initially align its price transparency efforts with new federal regulations that require hospitals to publish standard charges for a set of 300 shoppable services. The starting point for the state website would be to present pricing information for a subset of 70 shoppable services that are specifically required by CMS, although those might not include all highly utilized services of interest to a consumer. Thus, the Workgroup recommended that NYS DOH add other relevant services over time.

Longer-Term Recommendations



As the quality and completeness of the data in the APD become more stable, the PMW recommended that NYS DOH prioritize **adding pricing information for behavioral health, dentistry, pharmacy, and telehealth** services. Pricing for COVID-19 testing may also become more relevant to insured and uninsured consumers after the current federal public health emergency ends, and consumers become exposed to cost sharing for these services.²⁸

Other Input

On Settings/Providers. The PMW discussed the impact that a health care setting/provider's **ownership status or type of facility license** could have on pricing and that an individual provider's price for a service could vary based on the setting where it was performed (e.g., hospital outpatient surgery versus ambulatory surgery center or diagnostic and treatment center), and whether that facility was associated with a health system (i.e., hospital billing entity) or independent. Several participants emphasized that these differences can affect prices (e.g., whether or not a patient is charged a facility fee), which would be important for consumers to know before choosing where to receive care, as the name of a facility would not necessarily help a consumer avoid an extra fee. However, it was recognized that data constraints may initially prevent NYS DOH from publishing provider-specific facility fees.

²⁸ Federal law requires that all COVID-19 testing approved by the FDA or for which emergency use authorization has been requested (until the EUA has been ruled on) and any associated medical services shall be covered by Medicare, Medicaid, and private insurance without any cost-sharing requirements for the patient. For more information, see <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/07/13/the-laws-governing-covid-19-test-payment-and-how-to-improve-them/>

Participants also observed that:

- New Yorkers cross state lines for care and need pricing for providers located in neighboring states.
- It might be possible to group claims by site of service (i.e., [CMS place of service code](#)), rather than by type of facility license. Such groupings were viewed as more descriptive of where care is provided and more meaningful to consumers than the state’s licensing categories for health care facilities.

The Workgroup considered, but did not specifically recommend, the **unit of analysis that would be feasible for public reporting**—e.g., clinician-specific, practice or group level, clinic or health center, accountable care organization (ACO), or health system. One member pointed out that attribution can be technically complex, e.g., for physicians who are part of groups, work in multiple sites, or are employed by academic health centers. Another indicated that variation in allowed amounts would be unlikely among clinicians in a contracting group. It was also felt that pricing estimates should be as granular and local as possible for consumers. Although attribution complexities were noted (e.g., attributing clinicians to practices or sites), the PMW did not discuss in detail methods related to making pricing information available for community-based settings/practitioners such as minimum thresholds for practice size, grouping practitioners, or population served.

On Service/Procedures: Beyond publishing standard charges for the 70 shoppable services²⁹ specified by CMS, as noted above, one member suggested that NYS DOH include several of the services required by CMS that are especially relevant to primary care clinicians, such as colonoscopy, mammogram, routine blood work,³⁰ sleep study, psychotherapy, physical therapy, and ultrasound of abdomen. Another observed that many of the shoppable services required by CMS are not relevant for non-hospital providers and suggested that expanding the list would be important. A consumer advocate provided information, based on her organization’s experience, about services of interest to consumers in categories such as imaging, women’s health, men’s health, blood tests, dental, and cosmetic/discretionary.³¹ A primary care provider in the Workgroup noted the potential for pricing information to be helpful to consumers as a consideration when comparing treatment options (e.g., physical therapy versus surgery).

4. How should services/procedures be defined (i.e., at what level—visit, procedure, condition, bundle)?

Discussion Summary

The PMW engaged in substantive discussions about the pros, cons, complexities, and limits involved in providing pricing information by **episode or bundle, condition, item, or a hybrid** approach. The Workgroup recognized that although bundles or episodes might be more meaningful for **understanding the “all in” price** (e.g., the total price of a hip replacement including physical therapy after surgery, or childbirth price including the full range of maternity services), consumers are nonetheless used to receiving itemized bills. Participants acknowledged that standardized definitions for bundles and episodes

²⁹ For more information about the CMS regulations and a list of the 70 services with associated codes, see <https://www.cms.gov/files/document/steps-making-public-standard-charges-shoppable-services.pdf>.

³⁰ Pricing differences were noted among providers with on-site versus independent laboratories.

³¹ For more information, see <https://clearhealthcosts.com/blog/2016/03/whats-database-prices-prices/>.

are lacking, payment for them can vary by health plan, and pricing information can be confusing and may obscure meaningful details that consumers want and need. It was also noted that consumers may not be familiar with bundles. Therefore, bundled pricing for a condition or episode of care may seem like a “black box” that provides less transparency. On the other hand, one participant pointed out that a bundled price for surgery such as knee arthroscopy could be easily presented to consumers as an average that would include the cost of surgery and any related facility fees, imaging, casting, medication, follow-up visits, physical therapy, assistive devices, etc.


A consensus emerged on a compromise approach in which pricing information could be aggregated for shoppable services, or a set of necessary services, but also include a breakdown of common associated ancillaries or other components. Participants offered the following suggestions for consideration but did not make a specific recommendation:

- Use groupings such as a facility charge with a colonoscopy, surgery with an implant, cost of an entire admission, single Current Procedural Terminology (CPT) codes, or two to three groups of CPT codes with a triggering event and designated period, same-day logic.³²
- Provide an alert to consumers about the types of facilities where a consumer may be responsible for additional charges not covered by their insurance (e.g., facility fees or professional fees), and which NYS DOH may not be able to easily identify via the APD’s claims data. There were strong feelings among many participants that consumers should know in advance which providers charge facility fees in order to avoid them, if preferred.

As January 1, 2021, approached (the effective date for the new federal price transparency regulations), **NYS DOH carefully considered how CMS defined “shoppable services,”** and the requirement that hospitals display the charge for a primary shoppable service along with charges for ancillary items and services the hospital customarily provides as part of or in addition to the primary shoppable service.³³ As a starting point for its website, NYS DOH decided to align its approach with that of CMS, as several PMW participants had previously suggested, by applying to existing data the same CPT and DRG codes specified by CMS for the 70 required shoppable services that U.S. hospitals must post on their websites.

The PMW did not provide advice on proprietary analytics or grouper software, which may group services in ways that are difficult to explain to consumers and not as useful.

Longer-Term Recommendations

 The PMW recommended that NYS DOH keep bundles/episodes on its radar as their adoption spreads under value-based payment; and continue to assess consumer preferences regarding the

³² One PMW participant offered an example:

Implant surgery Bundle	Primary Components: Total hip replacement, professional fee	Added Components: Facility charges, anesthesia professional fee, implant cost (if billed separately from facility fee)
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³³ For an example of colonoscopy and associated ancillary services, see <https://www.cms.gov/files/document/steps-making-public-standard-charges-shoppable-services.pdf>

usefulness of pricing information for individual items as opposed to larger groupings (e.g., DRGs, APR-DRGs, pre-/peri-/post-operative care, sets of CPT codes, conditions, episodes, etc.).

5. How should prices be calculated and presented? (For example: should they be adjusted, categorized, or identified by patient characteristics, provider type, geography? Which characteristics of distributions should be used? What benchmarks should be provided? How should estimates be previewed and refined for accuracy and validity? What caveats and limitations should be explained, and how?)

During its meetings, the PMW reviewed and discussed a series of methodological considerations for guiding the calculation and display of pricing information.



Initial Recommendations

- A. The Workgroup agreed that to be useful, the website should facilitate comparisons and **enable a user to identify “at a glance”** which providers have higher prices for a shoppable service, and which ones have lower prices.
- B. Recognizing that there are geographic differences in prices for services and procedures (e.g., a hip replacement may cost less on Long Island than in Manhattan), the PMW recommended that the website facilitate the display of **pricing information by geographic area**.
- C. The PMW agreed that it would be helpful to ask **a future panel of experts** to weigh in on several methodological considerations. These included:
 - a. Claims inclusion/exclusion criteria (e.g., trim points, minimum sample sizes, outliers)
 - b. Unit of service (e.g., surgical procedures, lab tests, visits, minute increments and use of single versus multiple claim lines)
 - c. Combining multiple years of data
 - d. Inflation adjustment of retrospective data (used by transparency websites in New Hampshire and Florida)
 - e. Options for calculating and presenting pricing information
 - i. Selection of descriptive statistics (e.g., mean, median, range, interquartile ranges)
 - ii. Precision indicator (used by New Hampshire)
 - iii. Adjustments for differences in patient characteristics among providers (e.g., demographic, clinical, social risk factors, geography)
 - iv. Stratification by peer group to enable meaningful and fair comparisons of providers
 - v. Severity or complexity indicator (used by New Hampshire)

Consumer advocates expressed concerns about potential influence of industry insiders on a technical expert panel and proposed including consumer representatives to ensure that pricing information would be useful to consumers. Another participant suggested that NYS DOH could use focus groups to test the content resulting from the panel's recommendations and mock-ups for the website.

- D. The PMW also recommended that NYS DOH involve stakeholders in **previewing pricing information for accuracy and validity**.

Other Input

The Workgroup acknowledged that price benchmarks and rating or ranking provider performance against them could be useful to consumers, but views were mixed. Geographic (state, regional, county, national) and peer group benchmarks were discussed, but the PMW understood that they may not all be feasible. Several participants felt that benchmarks were important for placing price estimates in context, and a few favored presenting regional prices and Medicare rates. Others were concerned about the potential for information overload if too many numbers were displayed.

Participants considered whether, in presenting pricing information, providers should be rated or ranked based on price: higher, lower, or similar to the state benchmark; flagged if they exceed a threshold above the state benchmark; or by displaying relative rankings or percentiles. While a few participants favored this type of approach, another expressed concern about using a statewide or peer group benchmark that didn't account for performance differences based on type of hospital (e.g., teaching hospital, safety net hospital, or critical access hospital) or geography. A suggested alternative was for NYS DOH to display comparative prices across settings to promote shopping, rather than linking provider-specific prices to one or more benchmarks.

Although the PMW recommended that a future panel of technical experts consider various price estimate indicators with claims data from the APD, some participants seemed to favor presenting the median and the range. One provider noted that the range might offer more useful information about the ballpark consumers might expect to pay for a service and for assessing health plan networks or high-deductible plans when shopping for insurance. Another felt that average prices would not be actionable for consumers and urged NYS DOH to consider two top of mind concerns – *what other people paid for services, and where I can the get care I need at the lowest cost*.

While there was agreement that previewing pricing information for accuracy and validity would be important, opinions differed about which stakeholders should be involved and how the preview should be conducted. Consumer advocates felt strongly that consumers should be involved. A provider representative suggested a preview process like the one CMS uses for public reporting for hospitals on [Care Compare](#)³⁴ along with an appeals process, although it was acknowledged that steps like this complicate and lengthen the process.

Other ideas for supporting decision-making included helping consumers identify providers that serve patients like them or that might involve higher costs (e.g., out-of-network providers, facility charges, and lack of a sliding fee scale). One participant suggested that the technical expert panel consider the

³⁴ Prior to the public display of data on Care Compare, hospitals are given the opportunity to preview their data during a 30-day preview period. For more information, see https://www.qualityreportingcenter.com/globalassets/iqr_resources/november-2019/pr_jan-2020_ip-hc-preview_help-guide_vfinal508.pdf

feasibility of identifying facility fees in the APD's claims data. Consumer advocates and some others suggested involving consumers in a review to ensure that the methodology summary and explanations of caveats and limitations displayed on the website were easy to understand. One member proposed that consumers have an opportunity to test-drive the website before online publication.

6. What additional resources should be provided to support consumer decisions, help consumers understand price variation and make the best choices, and promote informed use of the health care system?



Initial Recommendations

Given NYS DOH objectives to help consumers understand that prices vary and encourage them to shop before they seek care, the PMW recommended incorporating the following guidance and resources to ensure that the website is meaningful and relevant and easy for consumers to use and understand:

- A. Consider how price estimates will appear within the context of the whole website, since information about health care pricing, quality, and financial assistance programs and options is often unfamiliar territory for consumers.
- B. Use **plain language** and common words, terms, icons, symbols, and other images.
- C. Give **clear explanations and definitions of allowed amount, health care costs, and price variation among providers and geographic areas** (e.g., variation in cost of living and labor costs) and examples of how to understand and use the information presented on the website. Participants emphasized the need to alert consumers that the website's price estimates do not represent the amount a person will or could pay, which depends on their insurance coverage and associated OOP expenses for covered services.
- D. Provide supplemental **reference materials**, videos, conversation guides, or a consumer guide covering the following topics:³⁵
 - i. How to talk with clinicians about the costs of the care they are recommending
 - ii. How to use price estimates in making health care decisions, why price is important to consider; explanations of pricing, allowed amount, and OOP costs including coinsurance, copays, and deductibles; worksheets that could be used to estimate costs in advance and plan for annual deductible spending
 - iii. How to compare provider performance by considering quality, volume, and price estimates together, and identify high-quality, lower-cost options to get the most value
 - iv. How to avoid surprise bills and limit OOP expenses for charges or facility fees that wouldn't be covered by insurance
 - v. How to seek assistance with surprise bills and appeals

³⁵ One participant suggested that NYS DOH adapt materials used on other state transparency websites (see Appendix C for examples of and links to other state websites). Examples of other sources of relevant materials can be found at [Consumer Resources | FAIR Health, Home - Clear Health Costs, 22288.pdf \(hfma.org\)](#).

- vi. How to prepare to negotiate a bill with a provider and negotiate effectively
 - vii. Sources of financial assistance
 - viii. Glossary of terms
- E. Leverage search engines to help **make the website easy to find and optimize it for mobile** devices
 - F. Ease navigation and provider comparisons through **search functions and filters, including map and location searching**

Longer-Term Recommendations



The PMW recommended that, in future iterations:

- A. NYS DOH **pair price estimates with quality ratings and volume data so that consumers can assess value**
- B. Provide information in **Spanish and other languages** commonly spoken by New Yorkers.

7. What should NYS DOH consider in planning to make a public use file available?



Initial Recommendations

- A. In developing a public use file (PUF) on price transparency, the PMW recommended that NYS DOH **consider both audiences and potential uses**: researchers and journalists for price variation, purchasers for benefit design, insurers for health plan product design, providers for competitive positioning, transparency organizations for similar/competing transparency tools
- B. The Workgroup also recommended that NYS DOH **provide open access** to the PUF, rather than upon request, to maximize public access

Other Input

A few participants considered the risk of unintentional exposure of negotiated rates to be minimal. One Workgroup member observed that a PUF can provide opportunities for others to leverage these data, not only for their own purposes, but to inform New York consumers in ways that a single website cannot. Through a PUF, third parties could help NYS DOH extend the impact of its price transparency reporting efforts.

Conclusion and Future Directions

New York State and the federal government have prioritized increased price transparency for health care services and procedures and protections from surprise billing.^{36,37} As payers, employers, regulators, and promoters and protectors of public health, both levels of government play important roles in providing the information consumers, patients, and families need to navigate the health care system and make the best possible decisions, in educating the public about the quality and price of care and how to maximize value for OOP dollars, and in promoting competition in the health care marketplace.³⁸

The PMW welcomed the opportunity to provide early input to the NYS DOH Office of Quality and Patient Safety. The Workgroup's thoughtful deliberations identified user-friendly approaches to public reporting that can promote price transparency, help consumers assess quality and price in advance of receiving services, and support consumer decision-making—and also pointed out gaps where such approaches are now missing. NYS DOH's commitment to engaging stakeholders early in a planning process for providing pricing information to New York consumers and for enhancing existing online resources to help them identify lower-cost providers who can meet their needs are indeed important steps. The timing is especially opportune given recent progress on the contents and analytic capabilities of the APD, which is starting to bridge existing gaps in health care quality and cost data for New York.

NYS DOH and the PMW acknowledge that the first iteration of NYHealthcareCompare won't be able to solve all information needs for all health care consumers and must continue to evolve. Some participants would have preferred that price estimates specific to health plans/products and providers be included, while others viewed the publication of provider-specific allowed amounts across commercial payers as a crucial first step in advancing price transparency in New York State. At times during the deliberations, the PMW struggled with how to provide all the information that could potentially be useful to a consumer, avoiding information overload, and prioritizing what would be most relevant. The recommendations in this report provide a roadmap that can inform that evolution so that New Yorkers have even greater access to timely and trusted information that can support their health care journey, help them make the best possible decisions for themselves and their family members, and better equip them to understand and negotiate medical bills. Future iterations will need to engage patients and respond to user feedback, align with their specific information needs so that OOP expenses can be estimated in advance, and consider promising options for making pricing information and quality ratings available at the point of care, when many decisions are discussed and made. The potential to detect unintended consequences for consumers through post-implementation monitoring will also require careful consideration. But as the Workgroup's commitment and collective insights demonstrate, collaboration among NYS DOH stakeholders and experts is central to equipping New Yorkers with meaningful and relevant information that can support decision-making and help them spend their health care dollars wisely.

³⁶ New York was the first state to enact consumer protections and an arbitration process for surprise bills, in 2015. For more information, see [Surprise Medical Bills | Department of Financial Services \(ny.gov\)](#) and [new-yorks-efforts-to-reform-surprise-medical-billing.pdf \(nyshealthfoundation.org\)](#)

³⁷ [Federal COVID relief legislation](#), signed on Dec. 27, 2020, contains new protections under the No Surprises Act from surprise billing and out-of-network charges, transparency requirements, and support for state APDs, effective in 2022.

³⁸ As some policy analysts have observed, the promise of health care markets depends in large part on patients learning about the costs of proposed health care interventions before receiving them, but prices are hidden from view. "The very existence of publicly available price information can change how a marketplace functions." Ubel, P. *Sick to Debt, How Smarter Markets Lead to Better Care*. Yale University Press, 2019, p. 23, 39, 96.

Appendix A: Price Methodology Workgroup Participants

Co-Chairs: **Anthony Shih**, President, United Hospital Fund, and **Anne Schettine**, Director, NYS DOH Office of Quality and Patient Safety

Technical Advisor: **Niall Brennan**, President and Chief Executive Officer, Health Care Cost Institute

Participants:

Susan Beane, Vice President and Medical Director, Healthfirst

Chuck Bell, Programs Director, Advocacy, Consumer Reports

Elisabeth Benjamin, Vice President, Health Initiatives, Community Service Society of New York

Carol Cronin, Executive Director, Informed Patient Institute

Rose Duhan, President, Community Health Care Association of New York State

Kimberly Feigin, President, New York State Radiological Society, Memorial Sloan Kettering Cancer Center, Department of Radiology

Marilyn Fraser, Chief Executive Officer, Arthur Ashe Institute, Assistant Professor of Medicine, SUNY Downstate Medical Center, Co-Director of the Brooklyn Health Disparities Center

John Freedman, President, Freedman Healthcare

Anthony Fiori, Senior Managing Director, Manatt Health

Robin Gelburd, President, FAIR Health (Thomas Swift, COO)

Vito Grasso, Executive Vice President, New York State Academy of Family Physicians

Lovisa Gustafsson, Vice President, Controlling Health Care Costs, The Commonwealth Fund

Kathleen Harris, Advisor, Northeast Business Group on Health

Timothy Kelly, Chief Strategy Officer, AdvantageCare

Kevin Krawiecki, Vice President of Fiscal Policy, Healthcare Association of New York State

Robert La Penna, Network Director for Payment Innovation Programs, Empire Blue Cross Blue Shield

Eric Linzer, President and Chief Executive Officer, New York Health Plan Association

Robert LoNigro, Executive Vice President of Health Care Operations, Heritage Provider Organization

Thomas Mahoney, Chief Medical Officer, Common Ground Health

Richard Miller, Executive Vice President and Chief Business Strategy Officer, Northwell Health

Georg Muller, Director Network Strategy—The NYS Empire Plan, UnitedHealthcare National Accounts

Robert Panzer, Chief Quality Officer and Associate Vice President, Patient Care Quality and Safety, Professor of Medicine, and of Community Medicine, University of Rochester Medical Center

Claire Parde, Executive Director, The Healthcare Consortium

Sara Rothstein, Director, 32BJ Health Fund

Ankita Sagar, Chair, Early Career Physicians Task Force, New York Chapter American College of Physicians;
Director of Ambulatory Quality for Medicine Service Line, Northwell Health

MaKaya Saulsberry, Consumer Empowerment Program Officer, New York State Health Foundation

Joseph Sellers, Vice President, Medical Society of the State of New York

Lea Tessitore, Senior Project and Research Manager, Catalyst for Payment Reform

Lois Uttley, Program Director, Women's Health Program, Community Catalyst

John Van Valkenburg, President, New York State Association of Ambulatory Surgery Centers

Elie Ward, Director of Policy, Advocacy & External Relations, New York State American Academy of Pediatrics

Elisabeth Wynn, Executive Vice President, Finance, Greater New York Hospital Association

NYS DOH: Emily Bean, MaryBeth Conroy, Mark Dauphinais, Natalie Helbig

UHF: Anne-Marie Audet, Joan Guzik, Pooja Kothari, Kevin Mallon, Lynn Rogut, Chad Shearer

NOTE: The recommendations and areas of agreement set forth in this report may not fully align with each individual participant's views or with the views of the organizations represented on this list.

Appendix B: Payment Information Collected by NYS DOH

Data Source	Claim or Encounter	Amount Allowed	Charge	Amount Paid	Coinsurance / Copayment	Deductible	Sub-Capitated Proxy Payment
SPARCS	Claim		✓				
Medicare FFS	Claim		✓	✓	✓	✓	
Medicaid FFS	Claim	✓	✓	✓	✓	✓	
Medicaid & Child Health Plus	Encounter		✓	✓	✓	✓	✓
Commercial (Off-Exchange)	Encounter		✓	✓	✓	✓	✓
Qualified Health Plan	Encounter		✓	✓	✓	✓	✓
Essential Plan	Encounter		✓	✓	✓	✓	✓

NOTES:

Amount Paid, Coinsurance/Copayment, and Deductible may all include other insurance Coordination of Benefits (COB).

Facility submitted and audited Ratio of Cost to Charges (RCC) is applied to SPARCS charges to estimate facility costs.

Allowed amount would be calculated based on amounts paid for services and procedures by payers and patients (including coinsurance, copayments, and deductibles).

Appendix C: State Website Scan Summary

Prior to the launching of the PMW, UHF staff scanned price transparency websites/reports and associated methodologies for 14 states. Websites were selected based on two criteria: use of an all-payer claims database (APCD) as the data source; or a cooperative, claims-based initiative involving payers that had been established to promote price transparency and assemble data. Selected characteristics for seven of the websites are provided below.

1. Connecticut: [The Healthscore CT Cost Estimator](#)

Overview: The Healthscore CT Cost Estimator draws upon data from the state’s APCD to provide consumers with useful information about the typical costs of common inpatient and outpatient services and procedures at various facilities throughout the state.

Price Estimate: The price estimate displayed on CT Cost Estimator is labelled “Typical Cost,” which is defined as the estimated amount paid during the period 2016–18 by the insurer and the amount paid by the patient (copayment, coinsurance, and deductible) combined for the service. This amount is shown as a median for the facility where the service took place, and components for facility and professional costs are provided separately.

Payer Type(s): Commercial only. Excludes Medicaid, Medicare, Medicare Advantage

Provider Type(s): Inpatient, outpatient (surgical procedures, imaging, gastroenterology)

Benchmark: State median

User-Friendly Features: The website displays an arrow to show whether a provider’s typical cost is higher or lower than the state median. The allowed amount (labeled “charge amount”) is provided as a reference for those who are uninsured to help them negotiate with health care providers. Separate drop-down menus for inpatient and outpatient services and procedures use common terms. Map and location searching are supported.

Source: <https://healthscorect.com/cost-estimator>

2. Florida: [FloridaHealthPriceFinder](#)

Overview: Pricing information on FloridaHealthPriceFinder comes from Florida’s largest commercial health insurers, which submit claims data to the Agency for Health Care Administration’s vendor, Health Care Cost Institute.

Price Estimate: Estimates are based on the actual amounts paid by health insurers to health care providers (including the portion paid by the insurer as well as any patient deductible, coinsurance, or copayment) derived from 70+ million claims for the two-year period of 2016–17. Averages are displayed (not an arithmetic mean, but a combination of means and medians) for 295 care bundles.

Payer Type(s): Commercial

Provider Type(s): Inpatient, ambulatory facilities

Benchmarks: County, state, and national medians and ranges

User-Friendly Features: Searching for services is easy and can be done by clicking on a body part. Care bundles are described in plain English, specify included services, and link to associated bundles. Service- and procedure-specific resources are provided on what to expect, questions to ask, and how to prepare.

Source: <https://pricing.floridahealthfinder.gov/#!/insights/FAQ>

3. Maine: [CompareMaine](#)

Overview: CompareMaine shows the average cost of common health care services, tests, and procedures at 300+ health care facilities in Maine. Cost estimates come from the state’s APCD based on 7.4+ million claims from 31 payers.

Price Estimate: The website shows the “average cost,” which is defined as the median amount paid by an insurance company and the insured individual to a facility or provider for a health care service (items, several bundles, and 15 episodes) for the period 2019–20.

Payer Type(s): Commercial only (for five individual insurance carriers); excludes public payers

Provider Type(s): Inpatient, outpatient, emergency department, surgery centers, diagnostic imaging centers, health centers, labs, clinics

Benchmark: Statewide average

User-Friendly Features: Consumers can search for facility-level pricing information by five different insurance carriers or all carriers combined. Facility and professional costs are shown separately. Map and location searching are supported. When available, quality, utilization, and cost information are displayed side by side.

Source: <https://www.comparemaine.org/?page=methodology>

4. Maryland: [Maryland Wear the Cost](#)

Overview: Wear the Cost is operated by the Maryland Health Care Commission. The website displays costs by hospital to shed light on total cost of care, based on utilization and payment data that the state collects from commercial insurers for Maryland’s privately insured population. The website also sponsors an awareness campaign, SIGN THE APPEAL, to encourage the public to appeal to doctors, hospitals, and insurance companies to work together to make all costs public and provide the highest quality care at the lowest possible costs.

Price Estimate: Maryland uses an episode grouper to provide the median episode cost at the hospital level for 10 episodes of care for the period 2016–17. The website also displays cost components (payments billed to and paid by insurers) for inpatient, outpatient, professional services, retail pharmacy, and potentially avoidable complications.

Payer Type(s): Commercial

Provider Type(s): Individual hospitals for 10 care bundles, including associated inpatient, outpatient, professional services, and retail pharmacy costs

Benchmark: Statewide average and range

User-Friendly Features: The website has an engaging design, provides a summary of expected costs and costs related to avoidable complications, breaks costs down into five components, and displays an indicator of quality and cost side by side (e.g., readmissions/potentially avoidable complications). However, the number of care bundles is quite limited. Resources are provided on a range of topics.

Sources: <https://www.wearthecost.org/jointheconversation/cost-breakdowns/> and [Join the Conversation - WearTheCost.org](#)

5. Massachusetts: [MassCompareCare](#)

Overview: CompareCare helps consumers compare costs of medical procedures and services in different health care facilities and different cities.

Price Estimate: The median amount in 2015 that a payer paid to a provider as well as the member cost-sharing amounts (i.e., copayment, coinsurance, and deductible) for 295 health care services. Cost estimates were calculated as the median service encounter cost for each service rendered by a provider.

Payer Type(s): Commercial only, for eight payers

Provider Type(s): Outpatient and obstetric care. Providers include those located in Massachusetts, New Hampshire, Connecticut, Rhode Island, or Vermont that rendered a select set of outpatient services in 2015. Professional fees for global obstetric care are also available.

Benchmark: None

User-Friendly Features: Consumers can filter pricing information by facility for eight different health plans or all plans combined. The website contains a comprehensive library with resources on health insurance, quality, and costs. It also provides conversation guides, advice on how to troubleshoot issues, and a glossary.

Source: <https://masscomparecare.gov/cost-data-methodology>

6. New Hampshire: [New Hampshire Health Cost](#)

Overview: NH HealthCost was developed by the New Hampshire Insurance Department to improve the price transparency of medical and dental services in New Hampshire and inform consumers about the approximate cost of care before it is received. Cost data are provided for the period 2019–20 from the state’s major health insurance companies. Consumers can filter for one of three insurance carriers, other insurance, or no insurance and type of plan (individual or group). When the patient is not insured, the HealthCost estimated cost for medical and dental procedures is based on charges minus any discount the provider may offer to uninsured patients if the health care provider submitted this information to the database.

Price Estimate: The patient cost estimates are based on the median amounts paid (by both the insurance carrier and the patient) using claims data from the New Hampshire Comprehensive Health Information System database. The website also provides a precision indicator of cost estimate variation (low, medium, and high) to indicate how likely an individual patient’s cost would vary from the median, and a complexity indicator (low, medium, high) that indicates whether the provider treats patients with more complex health problems who may be more expensive to treat.

Payer Type: Commercial only

Provider Types: Inpatient, outpatient, ambulatory surgery, other facilities, medical practices, and individual clinicians

Benchmark: State median

User-Friendly Features: The website provides pricing information for medical and dental services. Consumers can sort by type of insurance or no insurance and by plan type. When a consumer compares selected hospitals, the webpage provides cost and performance results on quality and safety indicators for comparison purposes.

Source: <https://nhhealthcost.nh.gov/methodology-health-costs-consumers>

7. Washington: [HealthCareCompare](#)

Overview: HealthCareCompare supports searches for high-quality doctor groups and hospitals, and helps consumers compare prices for common medical procedures and treatment at nearby hospitals, ambulatory surgery, and other outpatient health centers. Pricing information is based on claims records for people with commercial health insurance who got care during the reporting year. Claims are supplied

by insurers that provide health insurance coverage in the state and cover about 2 million people, many of whom buy insurance through their job.

Price Estimate: Median prices and ranges (25th and 75th percentiles) for paid amounts to hospital and outpatient centers in 2018 are calculated for 100 common procedures and services. The price includes fees paid to the facility, the doctor, and any other health professionals.

Payer Type: Commercial only

Provider Types: Hospital inpatient, outpatient, ambulatory surgery centers for approximately 100 common procedures and services

Benchmarks: State median and range

User-Friendly Features: A smart search feature is provided (exact terms or codes not required), and consumers can sort by geography, by cost, or alphabetically. A box next to the price estimate describes what is included. For searches on inpatient services/procedures, the CMS overall star rating is displayed directly above the price estimate. A large button is provided for access to more detailed quality indicators. The website also has a cost calculator tool.

Source: [Methodology | Washington HealthCareCompare \(wahealthcarecompare.com\)](#)