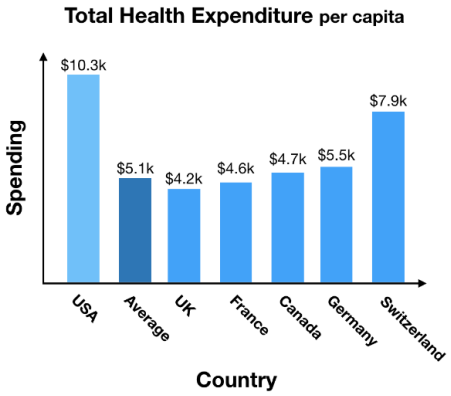
Costs of Care Affordability Accelerator
Cost Primer

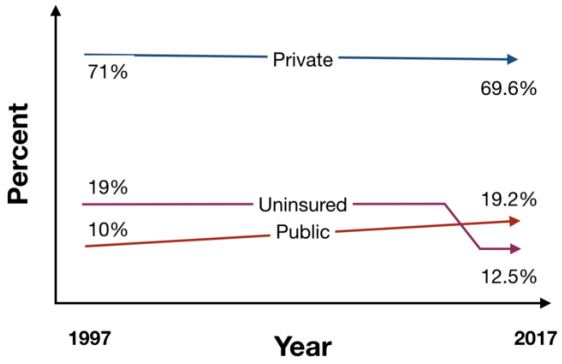
Overview

The purpose of this document is to share a high-level overview of terms and background that might be discussed during the Costs of Care Affordability Accelerator.



Today, the United States is spending more on healthcare than any other nation and providing very little options for patients who are unable to financially afford necessary care. The affordability crisis in our country has been well documented and results from the complex relationships between payers, health systems, practices, and employers.
(Left graphic: Peterson-KFF Health System Tracker, December 2020)

Nearly 70% of Americans receive healthcare coverage from private healthcare payers (ex. United Healthcare, etc.), while 19% receive public/government insurance such as Medicare (65+ & disability) or Medicaid (low income). With the implementation of the Affordable Care Act (ACA) in 2010, more individuals gained coverage through the private markets in a newly established marketplace. These plans were offered as "medal plans" for consumers to shop for in each state and provided subsidies based on income to cover a portion of the premium dollars. *(Right graphic: HHS/CDC/NCHS, 2017)*



Finally, recent legislation has focused on requiring hospitals to post charges for greater transparency and to eliminate balance billing, which was prohibited by Medicare and Medicaid. These laws aim to support greater transparency and reduce surprise bills for patients. However, the onus of implementation falls on health systems and payers to address patient-specific affordability issues as they arise locally.

Below are areas we intend to focus on, but also terms that may arise.

Terms

1. **Indirect Costs**
   - Indirect costs are those costs outside of direct medical management of disease and instead are inclusive of costs otherwise not incurred. Examples include lost wages, lost productivity, childcare, parking, and transportation that otherwise would not be incurred.

2. **Facility Fees**
   - Facility fees are charged by hospitals or hospital-based clinics to cover the overhead costs of maintaining that facility, medical or technical supplies, inpatient medications, equipment and support staff. They do not include professional fees.
3. **Professional Fees**
   - The professional component of a charge covers the cost of the physician's professional services only. This will include the primary physician in addition to any consulting specialists who participate in the care of a patient.
4. **Pharmacy Benefits**
   - Pharmacy benefits cover medication costs for certain medications. For some infusion or injection medications, the pharmacy benefits do not include any associated facility or physician professional fees associated with administering the medications at a clinic or hospital.
5. **In-network/Out-of-Network**
   - In-network providers/services refer to care that is contracted with a payer and has a pre-negotiated rate to render care. Out-of-network providers/services refer to care that is not covered or contracted with a payer, therefore indicating higher rates.
6. **Co-pay**
   - A co-pay refers to an arrangement in which the patient pays a portion of the medical expenses on their own and the insurance company will pay the remaining amount.
7. **Deductible**
   - A deductible is the amount paid before an insurance plan starts to pay. With a $2,000 deductible, for example, you pay the first $2,000 of covered services yourself. After you pay your deductible, you usually pay only a copayment or coinsurance for covered services. In most cases, the co-pay does not count towards the deductible.
8. **Co-insurance**
   - Co-insurance is the percentage of costs of a covered health care service paid (20%, for example) after reaching the deductible amount.
9. **Premium**
   - A premium is the amount paid to the insurance company to maintain healthcare coverage.
10. **Charge**
    - The charge is the price that a hospital, facility, or provider add to a bill, usually not the amount paid by the patient and/or insurance plan.
11. **Allowed Amount or Eligible Expense**
    - The maximum amount a plan will pay for a covered health care service. Usually, this amount is the negotiated rate with the insurance plan.
12. **Reimbursed Amount**
    - The amount that is paid by the insurance plan (never higher than the allowed amount). While the allowed amount indicates what reimbursement may be possible, the reimbursed amount is that less any adjustments such as denials, etc.
13. **Patient Responsibility**
    - Patient responsibility refers to the amount that is paid by the patient after insurance reimbursement is rendered and includes the remaining deductible, co-payment and/or any co-insurance.
14. **Balance Billing**
    - Balance billing is when a provider charges a patient the remainder of what their insurance does not pay. Balance billing is currently prohibited in both Medicare and Medicaid and with the passage of legislation in 2021 is also now prohibited in commercial plans.