

Vermont Department of Banking, Insurance, Securities & Health Care Administration
DIVISION OF HEALTH CARE ADMINISTRATION



FAQ's Relating to Comparative Pricing

1. Why is the State of Vermont reporting charges for hospital and physician services, and what is the purpose?

Under Vermont law, 18 V.S.A. § 9405b, all Vermont community hospitals are required to report charges for "...high volume health care services." The goal is to report "...valid, reliable, useful, and efficient information ..." to be used as a tool in helping the consumer make informed decisions about their healthcare.

2. Who is the audience that these reports are attempting to reach?

Consumers, the public at large, employers, the uninsured, and any other purchasers of health care services.

3. What are the services that are included in the charge lists?

There are three different lists: hospital charges for inpatient stays (DRG codes), hospital charges for outpatient procedures (ICD-9 codes), and hospital and physician charges for common outpatient services (CPT codes).

For inpatient stays and outpatient procedures, the hospital charges for higher volume procedures performed at each hospital are shown. For common outpatient services, the list was selected from a review of other states' websites, employer claims data, and data submitted by Vermont hospitals. Hospital *and* physician charges are shown for this list.

4. What is the difference between "price" and "charge" and how are they defined in the Act 53 reporting?

"Price" and "charge" are often used interchangeably. They describe what the hospital seeks for payment for a health care service or product before the application of any discount, write-off, contract or plan adjustment or allowance, or other reduction to such amount.

5. Why do charges for certain procedures vary across hospitals?

Charges could vary because of the unique circumstances related to each patient's illness. Also, hospitals each have a different mix of patients served, as well as different types and quantities of services that could be provided. All of these are factors that affect the charge for a given service.

6. What if I have insurance? How does that affect the charge and how much I will have to pay?

What you will pay depends upon your insurance plan. If you are insured, you will pay only the co-payment, co-insurance, and/or deductible required by your plan, regardless of the total gross charge. Your insurance company in turn will pay a negotiated amount to the hospital that represents some portion of the charge -- generally less than the full charge. In some cases, a negotiated discount may be able to be applied to your deductible.

7. Is the amount that's listed for a procedure the actual amount that I will be charged and have to pay?

The amounts that are listed for inpatient DRGs and outpatient ICD-9 procedures are the average full charge for a given procedure. However, very few people actually pay full charges (see response to Question 6). The actual amount paid will depend upon many variables, including an individual's insurance plan and the complexity of each individual's procedure.

The amounts that are listed for common CPT outpatient services are the actual price for that service as listed in the hospital Chargemaster as of October 1st. (In selected instances, some prices are established on January 1st.)

8. I keep hearing about the Chargemaster. What is it, and should I be concerned about it?

The Chargemaster is a comprehensive and hospital-specific listing of each item and service that can be billed to a patient, insurance company, or other payer. Every item and service has a specific code and corresponding charge in the chargemaster. Since there are usually multiple health care services provided to a patient, the total invoice typically includes a list of multiple services for a given visit or admission. A patient's bill is the sum total of this array of services. For example, selected medical events for a given patient may have one code or several codes included in the final invoice for patient care.

9. Do I have to pay the full charge if I don't have insurance?

Some hospitals have discount policies for patients who have no insurance, under which the patient receives a discount off of the full charge, similar to the discounts negotiated by insurance companies. All hospitals have free-care policies for low-income patients. You can call a hospital to learn about its policies and application process. Financial counselors are available at the hospitals to help answer specific questions and guide you through the process.

10. Are physician charges included in the prices shown?

Physician charges are included in the list of common CPT outpatient services (Tables 3A-3I). However, the amounts shown for inpatient stays and outpatient procedures (Tables 1A and 2A) do NOT include physician charges. Those charges only include hospital charges.

11. How do I find information on charges for procedures that are not listed in this report?

If you want to find charges on procedures that are not listed, call the hospital directly and talk to their consumer services representative or someone in the billing department. In almost all cases, they can provide an estimated charge but they will not be able to give you an absolute price. Individual circumstances can affect the final charges for care.

12. Should I make a decision based on the charges listed or are there other factors I should consider?

The gross charge is simply one factor in making a decision about healthcare. Other factors that should be considered are the location of your doctor, the services offered by a particular hospital, how many of the procedures the hospital has performed, the quality reporting by a hospital, waiting times for the procedure, etc. You also may want to ask questions of your doctor for a better understanding of possible options for your particular situation.

13. Where does the pricing information come from for these different hospital services?

The source of the inpatient (DRG) and outpatient (ICD-9) pricing information (Tables 1A and 2A) is the Vermont Uniform Hospital Discharge Data Set (VUHDDS). Billing information is compiled into a database and the charges are taken from the database under a set of agreed upon standards.

Hospital and physician pricing for outpatient diagnostic services are based upon Common Procedural Terminology (CPT[®]) code charges that are contained in each hospital's chargemaster. The hospitals provide these prices directly to BISHCA.

14. How can I provide input to improve the information provided and/or where should I direct any questions I might have about this information?

You can call BISHCA directly at 802-828-2900 and ask for the Director of Hospital Regulatory Operations. You can also write to BISHCA at:

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