

PRICE TRANSPARENCY: COMMON DEFINITIONS

Establishing a common language for discussing price transparency is critical for communicating with internal and external stakeholders and for adopting meaningful price transparency principles.

The AAMC strongly urges all hospitals to adopt the list of standard definitions developed by the Healthcare Financial Management Association's (HFMA) Price Transparency Task Force. This multi-stakeholder group convened providers, insurers, and patients to reach consensus on common terminology. The full Task Force Report is available [here](#).

Key HFMA definitions include:

Charge: The dollar amount a provider sets for services rendered before negotiating any discounts. The charge can be different from the amount paid.

Price: The total amount a provider expects to be paid by payers and patients for health care services.

Cost: The definition of cost varies by the party incurring the expense:

- To the patient, cost is the amount payable out of pocket for health care services, which may include deductibles, copayments, co-insurance, amounts payable by the patient for services that are not included in the patient's benefit design, and amounts "balanced billed" by out-of-network providers. Health insurance premiums constitute a separate category of health care costs for patients, independent of health care service utilization.
- To the provider, cost is the expense (direct and indirect) incurred to deliver health care services to patients.

- To the insurer, cost is the amount payable to the provider (or reimbursable to the patient) for services rendered.
- To the employer, cost is the expense related to providing health benefits (premiums or claims paid).

Out-of-Pocket Payment: The portion of total payment for medical services and treatment for which the patient is responsible, including copayments, co-insurance, and deductibles. Out-of-pocket payment also includes amounts for services that are not included in the patient's benefit design and amounts for services balance billed by out-of-network providers.

Care Purchaser: Individuals and entities that contribute to the purchase of health care services.

Provider: An entity, organization, or individual that furnishes a health care service.

Payer: An organization that negotiates or sets rates for provider services, collects revenue through premium payments or tax dollars, processes provider claims for service, and pays provider claims using collected premium or tax revenues.

Price Transparency: In health care, readily available information on the price of health care services that, together with other information, helps define the value of those services and enables patients and other care purchasers to identify, compare, and choose providers that offer the desired level of value.

Value: The quality of a health care service in relation to the total price paid for the service by care purchasers.

The AAMC recognizes that in addition to the definitions adopted by the HFMA Price Transparency Task Force, there are terms specifically of interest to teaching hospitals and academic medicine. The AAMC-defined terms are as follows:

Academic Medical Center (AMC): A clinical enterprise that engages in both education and research in addition to patient care. AMCs often include teaching hospitals, medical schools, and faculty practices. AMCs typically provide clinical education and training to medical students, residents, postgraduate fellows, and other health professionals. They are distinguished by their clinical research programs. Although they account for a small percentage of the nation's hospitals, they provide a disproportionate amount of complex care and health care services for Medicaid beneficiaries and uninsured and underinsured individuals.

Public Good: A service that has a value to society but whose provision cannot properly be financed by private enterprise because its benefits are far-reaching and no one can be excluded from benefitting from the availability of a service. Examples in health care typically include trauma centers, burn units, neonatal units, and producing a physician workforce.

Mission-based Payment: Payment to a provider that incentivizes or compensates for a mission that the provider undertakes despite relatively low financial reward. These payments are commonly viewed as subsidies for public goods such as charity care, teaching programs, and services provided in critical access regions.

Episode: All the health care services provided to a patient to treat a clinically defined condition for a defined period of time (e.g., all the inpatient, outpatient, and rehabilitation services a patient receives during and after knee replacement surgery). A "bundled payment" is a specific type of episode payment defined as one predetermined lump sum payment for an entire episode of care.

Charge Master: A hospital's comprehensive list of items and services provided to patients. The charges listed typically do not correspond to the amount paid by patients and insurers.

Uncompensated Care: Care provided to a patient for which no payment is received. The term typically includes both "charity care" (care provided to patients for which the provider expected no payment) and "bad debt" (services for which the provider anticipated payment but was not paid).

Undercompensated Care: Care provided to a patient for which payment is received (typically from Medicare, Medicaid, or other government programs) but that does not cover the costs to the provider for providing the care.

Reference Pricing: A type of insurance plan that limits payments for procedures/events to a fixed amount, requiring the patient to cover the difference when choosing an out-of-network service. Often, the fixed amount is set to correspond to the lowest-priced option—for example, the price of a generic drug instead of its name-brand counterpart. These coverage limits are intended to be offset by lower premiums.

Tier: A level of health care services that is all paid at the same rate, but the rate is different from other levels of services. Examples of a tier in health benefit design include requiring higher copayments for providers in Tier 3 than for providers in Tier 2, and no copayments for providers in Tier 1. The plans can structure tiers for payments to physicians and hospitals based on quality or cost measures. The number of tiers can vary based on the coverage plan.