That CT scan costs how much?  
Health-care prices are all over the map, even within your plan’s network  
Consumer Reports magazine: July 2012

Rachel Collier paid $9,038 for a CT scan in an ER that ran $318 in an outpatient clinic.

If gas stations worked like health care, you wouldn’t find out until the pump switched off whether you paid $3 or $30 a gallon. If clothes shopping worked like health care, you might pay $80 for a pair of jeans at your local boutique and $400 for the identical pair at the nearest department store—and the clothes wouldn’t have price tags on them.

“Why can’t you or I as a consumer ask what it’s going to cost and be met with something other than a blank stare?” asks Will Fox, a principal with Milliman, a national health actuarial consulting firm. The answer, he says, is that neither providers nor health insurers really want consumers to have that information.

Here’s why: the contracted prices that health plans negotiate with providers in their networks have little or nothing to do with the actual quality of services provided and everything to do with the relative bargaining power of the providers.

Here’s what this system means for consumers:

- Not even staying within your plan’s network will guarantee you low prices. Providers who have a lot of market clout, such as a prestigious university hospital, may command prices several times higher than providers who don’t.
- It may be difficult, if not impossible, to find out the price of health care ahead of time, especially for complex services such as elective surgery. That’s a special problem for people with high-deductible plans, who may be responsible for the first $5,000 or even $10,000 of their health expenses every year.
- If you go out of network, whether on purpose or involuntarily, you may be hit with a five-figure bill that your insurance company isn’t obligated to pay.
- There are ways to protect yourself against being blindsided by a huge bill. But they’re often not easy and don’t always work.

The $4,400 colonoscopy
Consumers often have no clue that prices can vary so much within a network, says Jeffrey Rice, M.D., chief executive officer of Healthcare Blue Book, a Nashville-based company that collects prices paid by large group health plans. “It’s as if some employees went out to fill up the company cars and half came back with receipts for $4-a-gallon gas, the rest for $20 a gallon, and no one asked why,” he says.

In one Midwestern city, Healthcare Blue Book found that prices paid by members in managed-care networks for a colonoscopy ranged from $840 at a freestanding office run by a gastroenterology group to $4,481 at the local academic medical center. (See chart below.)

In Hartford, Conn., an Aetna PPO negotiated a network price of $5,249 for an uncomplicated vaginal delivery at one hospital and $8,941 at another just a few miles away. A member with a typical coinsurance of 20 percent would save $738 in out-of-pocket expenses by choosing the cheaper hospital.

Rachel Collier, 41, a sales executive from San Jose, Calif., got a harsh education in medical pricing in August 2011, when she was stricken with pain in her back, which then moved to her abdomen. Her employer had recently switched its health plan to a Cigna PPO with a $5,000 deductible, and Collier had not yet selected a doctor or hospital to replace the providers at her former plan, a Kaiser HMO.

She went to the emergency room of a hospital in the Cigna network and was given blood tests, a CT scan, and an IV. She went home with a couple of medications, and the pain let up after a few hours.
“A few days later, I got a call from the hospital billing office,” she recalls. “They said, ‘Your total bill is $14,600, including $9,000 for the CT scan, and with your insurance you’ll owe $6,500. But if you want to pay the uninsured rate in cash right now, you can have a discount and it will be a little more than $3,000.’ So I gave them my bank account number and they pulled out the money right away. All I could think was, ‘What the heck just happened?’”

What the heck happened remains unclear; as we went to press, Cigna was still investigating why the hospital didn’t charge Collier the lower network price or submit a claim to the health plan.

What’s not in doubt is that Collier paid much more for that CT scan than she needed to. Cigna allows plan members to look up some cost information online, and it turns out that an in-network freestanding imaging center near her home offers the same type of CT scan that she had in the hospital, but for a mere $318.

Dialing for dollars
If the price for a treatment or test you need is not on your health plan’s website, getting a price quote from a network provider may be difficult if not impossible.

Stephen Griffing, 58, a manufacturer’s representative from Danbury, Conn., ran into the problem when he signed up for an individual Aetna health plan with a $5,000 in-network annual deductible. He needs two common blood tests every six months to monitor the safety of a cholesterol-lowering medication that he takes.

None of the three local network labs he called was able to supply his in-network price for the tests. They weren’t available on Aetna’s member price lookup site and an Aetna customer service representative didn’t have the information, either. “Surely I am not the first person to want to know exactly what something will cost, out of my pocket, before purchase,” Griffing says.

Jerry Diffley, who was then director of billing compliance for Quest Diagnostics, one of the labs involved, says that it had contracts with 75 Aetna plans. “There may be a specific fee schedule for his plan,” he says. “Insurance companies may only pay for the tests for certain conditions, or so many times a year, and without knowing those details, we don’t know what he may pay out of pocket.”

Out-of-network price traps
Julie Lindgren was hit for more than $20,000 after getting out-of-network cancer surgery.

Few consumers understand the severe limitations on the out-of-network benefit that PPOs and similar plans tout as an advantage over HMOs, which typically don’t pay for any out-of-network care except in rare emergency situations. (See our advice on HMOs vs. PPOs.)

“The PPO says it will pay 60 or 70 percent of the allowable amount for out-of-network providers,” says Jennifer Jaff, executive director of Advocacy for Patients with Chronic Illness, a nonprofit consumer group in Farmington, Conn. “People think that means 60 or 70 percent of whatever the out-of-network provider charges. That’s not what happens. It’s a fixed percentage of whatever the insurer decides is the right amount.”

And that amount, what’s often called the UCR (“usual, customary, and reasonable”) price, is often much less than the bills that come from the non-network providers. That can leave patients on the hook for the balance—the amount not reimbursed by their plan.

Julie Lindgren, 47, a nuclear-medicine technologist from Seattle, chose an out-of-network doctor and hospital in 2005 when she was facing a risky surgery to treat kidney cancer.

The surgery was a success, but the bills that came afterward were a shock. Lindgren recalls that the total came to some $28,000, of which insurance paid about $5,000. Ultimately, the hospital wrote off a portion of its bill, but the surgeon and the anesthesiologist demanded their full fee of $9,000, which she paid in part by borrowing from family.
What is a reasonable price?
Traditionally, insurers have based UCR prices on what providers charge. Some rely on proprietary internal numbers, and some use national data collected and analyzed by Fair Health, a nonprofit organization based in New York City.

But that’s changing, as more insurers have begun setting their out-of-network price as a percentage of what Medicare pays for the service. A March 2012 investigation by the New York State Department of Financial Services found that most plans that use this method pay between 110 percent and 150 percent of what Medicare pays. “It sounds like a lot but it’s extraordinarily low,” says Robin Gelburd, Fair Health’s president.

Because of Medicare’s size—it pays a bigger portion of the nation’s health-care bill than any other single entity—and ability to set prices without negotiating with doctors, its fee schedule “does not come close to reimbursing what providers actually charge” non-Medicare patients, says Connecticut State Healthcare Advocate Victoria Veltri.

We used an online calculator at fairhealthconsumer.org to determine that the “fair,” or typical, price for a laparoscopic gallbladder removal in Consumer Reports’ Yonkers, N.Y., ZIP code is $6,700. A plan that reimbursed 60 percent of the fair price would leave patients owing a balance of $2,680. But Medicare pays only $855 for the procedure in our neck of the woods. So a plan that based its 60 percent reimbursement on 140 percent of Medicare would leave patients with a balance bill more than twice as high: $5,981.

Of course, the financial damage can be even worse when, as frequently happens, the out-of-network hospital or doctor charges more than the fair price—sometimes a lot more.

We spoke with a man in a Northeastern state whose wife chose an out-of-network neurosurgeon for a complex procedure to correct a severe case of scoliosis. The insurer said the UCR was $111,875, but the surgeon charged $591,875, leaving the patient with a bill of $480,000. She asked not to be identified because she is working with a state consumer advocate to negotiate a settlement.

Bills out of the blue
An obvious way to avoid getting hit with stratospheric out-of-network bills is not to use out-of-network providers. But that’s not always possible: Sometimes, especially in the hospital, you can be seen by an out-of-network provider without even knowing it. Annmarie Bragdon, 41, from Farmington Hills, Mich., used a network hospital and doctor when her infant needed surgery for a congenital kidney problem. “But we got a bill of about $10,000 for the anesthesiologist, who was out of network,” she says.

‘The provider knows you're on the hook, no matter what. And the insurance company knows they're going to pay what they're going to pay.’ - Jennifer Jaff, patient advocate

The company Bragdon worked for intervened and arranged for her to pay the same rates as for an in-network anesthesiologist. But not everyone is so lucky, as documented in the report by the New York State Department of Financial Services.

It cited some jaw-dropping bills that patients received from out-of-network doctors who treated them in emergencies: $31,700 for surgery for a brain hemorrhage, $83,000 for reattaching a finger severed in a table-saw accident. “These hospital-based specialists have insurers completely over a barrel,” Will Fox of Milliman says. “They say, ‘If you don’t pay us our full billed charges, we won’t play.’”

Why don’t hospitals force doctors to participate in networks? “An individual hospital could have 50 different plans,” says Caroline Steinberg, a vice president of the American Hospital Association. The hospital might not know “which plan a physician has negotiated a contract with.”

Or as patient advocate Jennifer Jaff puts it: “Nobody in this drama has an interest in helping you. The provider knows you’re on the hook, no matter what. And the insurance company knows they’re going to pay what they’re going to pay.”

Don’t let this happen to you
A patient in a Northeastern state hired an out-of-network back surgeon to correct severe scoliosis, expecting her PPO to pay 80 percent of his bill. But the insurer, like most, paid only 80 percent of what it considered an appropriate fee for the service, leaving her legally liable to pay the balance—a heart-stopping $480,000. The patient is working with her state’s consumer advocate in hopes of negotiating a settlement.
How to avoid unwelcome surprises
Jeffrey Rice, M.D., shopped around to save 90 percent on foot surgery for his son.

- **Understand your health insurance.** OK, it’s not a fun read, but it pays to familiarize yourself with the rules and cost-sharing features of your health plan. How much is the deductible? What out-of-pocket costs apply toward it? Is there an extra copay for the emergency room? Do you need advance approval for tests, elective procedures, or specialist visits? Does the plan allow you to go out of network at all? Many HMOs don’t, except for emergencies when you are outside the plan’s service area or for hard-to-find treatments for rare conditions.

- **Stay in network if you can.** Network providers have agreed to accept the negotiated health-plan price as payment in full. Even if you haven’t met your annual deductible, you’ll still pay the in-network price, and if you have met it, you’ll only be on the hook for your copay or coinsurance.

- **Compare network prices.** Many health plans now post some price information online. Take advantage if you can. If you can’t, call your health-plan customer-service number. If that fails, call providers directly, but be aware that some of them truly might not know your network’s price. Jeffrey Rice, M.D., chief executive officer of Healthcare Blue Book, used this tactic a few years ago to save big when his son needed outpatient foot surgery. The hospital quoted a price of $15,000 to $25,000. But having the procedure in an outpatient center, with the same surgeon, cost just $1,515.

- **Don’t pay until all bills are in.** You may receive a hospital bill with scary-looking high “charges” on it. Don’t panic, and don’t write a check. They’re list prices, typically much higher than the network price you’ll actually owe. Save all provider bills and compare them with the explanation of benefit (EOB) forms that you’ll eventually get from your health plan. You will generally owe only the “patient responsibility” amount indicated on those forms for in-network care.

- **Fight back against stealth out-of-network bills.** If you get blindsided by a bill from a non-network doctor after surgery or an emergency-room visit in a network hospital, you might be able to get it reduced if you make enough noise. First, ask the doctor to discount the fee. If that fails, complain to the hospital, your insurer, your employer (especially if you work for a large company), and your state insurance department or state health insurance consumer advocate. See our advice on managing your health-care bills.

- **For elective out-of-network care, find out about your plan’s reimbursement policy.** That information should be in your health-plan documents, but if not, call the plan and ask. Some set their own “allowed amount,” some use the Fair Health pricing database, and some pay a set percentage of Medicare’s fee schedule. Typically a plan will pay a portion, such as 60 percent, of that agreed-upon price. You’ll be obligated to pay the rest plus the balance of whatever your out-of-network provider decides to charge. So if a non-network doctor charges $2,000 for a treatment and the insurance company says the allowed price is $1,000, it will reimburse you $600 and you’ll owe the doctor $1,400.

- **Negotiate prices with the out-of-network provider in advance.** Start by looking up the “fair” prices in your geographical area for your test, procedure, or operation on FairHealthConsumer.org, HealthcareBlueBook.com, or both. Fair Health also has a sliding tool that shows what your reimbursement will be if your plan pays a percentage of Medicare’s fee schedule for out-of-network services. Use those results as a basis for negotiating a price agreement with the out-of-network provider, and get it in writing. Healthcare Blue Book has a printable standard contract you can use for that purpose. Failure to agree on a price in advance could leave you liable for a very, very large balance bill.

- **For complex out-of-network procedures, prepare for lots of homework.** If your procedure or surgery isn’t included on either HealthcareBlueBook.com or FairHealthConsumer.org, ask the out-of-network provider for the CPT codes (standard medical billing codes) for each service to be performed. Also get the provider’s tax identification number and the ZIP code of the location where the service will be performed. “Call the insurance company with this information, and they are absolutely obligated to tell you what they will pay,” says Jennifer Jaff, executive director of the nonprofit group Advocacy for Patients with Chronic Illness. “This is not information they’re going to have at their fingertips. Chances are it’s going to take days.” Once you have that information, negotiate with your provider as above.
What price an MRI: $504 or $2,520?
These are actual prices paid by large employers nationwide, as collected by the Healthcare Blue Book. The low prices represent the 10th percentile, and the high prices the 90th percentile. The “fair” price is based on Healthcare Blue Book’s own evaluation.

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<th>Fair</th>
<th>High</th>
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★ One bill for all services – no additional facility and radiology fees – charges often added on by hospital imaging centers
★ A local radiology team with extensive subspecialty training, expertise and know-how
★ Extensive parking around our centers, with easy access to walk right into our registration area
★ Say “NO THANKS” to the more expensive hospital imaging centers

Say YES and Spend LESS