Healthcare cost and pricing definitions

Allowed amount: Maximum amount on which insurance payment is based for covered healthcare services. This may be called "eligible expense," "payment allowance," or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference.

Coinsurance: Your percentage share of the costs of a covered healthcare service. This (for example, 20 percent) is based on the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20 percent would be $20. The health insurance or plan pays the rest of the allowed amount.

Contracted rates: The amounts that health plans will pay to healthcare providers in their networks for services. These rates are negotiated and established in the plans' contracts with in-network providers.

Copayment: A fixed amount (for example, $15) you pay for a covered healthcare service, usually when you get the service. The amount can vary by the type of covered healthcare service.

Cost sharing: This refers to the ways that health plan costs are shared between employers and employees. Generally, costs are shared in two main ways: through premium contributions and through payments for healthcare services, such a copayments, a fixed amount paid by the employees at the time they obtain services; co-insurance, a percent of the charge for services that is typically billed after services are received; and deductibles, a flat amount that the employees must pay before they are eligible for any benefits.

CPT® code: Current Procedural Terminology (CPT) codes are numbers assigned to medical services and procedures. The codes are part of a uniform system maintained by the American Medical Association and used by medical providers, facilities and insurers. Each code number is unique and refers to a written description of a specific medical service or procedure. CPT codes are often used on medical bills to identify the charge for each service and procedure billed by a provider to you and/or your health plan. Most CPT codes are very specific in nature. For example, the CPT code for a 15-minute office visit is different from the CPT code for a 30-minute office visit. You will see a CPT code on your Explanation of Benefits form (EOB). You can also ask your healthcare provider for the CPT code for a procedure or service you will undergo, or have already received. You may need these codes to receive accurate price estimates. CPT® is a registered trademark of the American Medical Association.

Deductible: The amount you are expected to pay for healthcare services your health plan covers before your health plan begins to pay. For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered healthcare services subject to the deductible. The deductible may not apply to all services, for example, preventive services such as blood pressure screening.

***Gross Charges**: defined as the total charges at the organization's full established rates for the provision of patient care services before deductions from revenue are applied.

High-deductible health plan (HDHP): A plan that features higher deductibles than traditional insurance plans. High-deductible health plans can be combined with special savings accounts such as health savings accounts or health reimbursement arrangements to allow you to pay for qualified out-of-pocket medical expenses on a pre-tax basis.

ICD-9 or ICD-10 codes: The official system of assigning codes to medical diagnoses in the United States. By using these codes, healthcare professionals anywhere in the country can have a shared understanding of a patient's diagnosis.

***In-network**: A provider who is contracted with the health insurance company to provide services to plan members for specific pre-negotiated rates.

***Inpatient:** You're an inpatient starting when you're formally admitted to a hospital with a doctor's order. The day before you're discharged is your last inpatient day.

Network: The hospitals and other healthcare facilities, providers, and suppliers your health plan has contracted with to provide healthcare services.

Noncovered services: Medical services that are not included in your plan. If you receive non-covered services, your health plan will not reimburse for those services and your provider will bill you, and you will be responsible for the full cost. You will need to consult with your health plan, but generally payments you make for these services do not count toward your deductible. Make sure you know what services are covered before you visit your doctor.

***Out-of-network**: A provider who is not contracted with the health insurance plan. Typically, if you visit a provider within the network, the amount you will be responsible for paying will be less than if you go to an out-of-network provider. Though there are some exceptions, in many cases, the insurance company will either pay less or not pay anything for services you receive from out-of-network providers.

Out-of-pocket healthcare cost: Your expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that aren't covered.

Out-of-pocket maximum: The limit on the total amount a health insurance company requires a member to pay in deductible and co-insurance in a year. After reaching an out-of-pocket maximum, a member no longer pays co-insurance because the plan will begin to pay 100 percent of medical expenses. This only applies to covered services. Members are still responsible for services that are not covered by the plan even if they have reached the out-of-pocked maximum for covered expenses. Members also continue to pay their monthly premiums to maintain their health insurance policies.

***Outpatient:** You're an outpatient if you're getting emergency department services, observation services, outpatient surgery, lab tests, X-rays, or any other hospital services, and the doctor hasn't written an order to admit you to a hospital as an inpatient. In these cases, you're an outpatient even if you spend the night at the hospital.

Premium: The amount that must be paid for your health insurance plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

Note: All definitions with the exception of those asterisked were obtained from HFMA *Understanding Healthcare Prices: A Consumer Guide*.