



**RECOMMENDATIONS FOR REPORTING
COST AND PRICE INFORMATION
TO CONSUMERS**

INTRODUCTION

Information about the cost and price of health care services is vital for consumers to make good health care decisions and for providers to understand how they are using resources. Despite the need, Americans lack easy access to meaningful, consumer-friendly information about the costs associated with their care. While much has been made of the rising costs of the health care system overall, reliable information about the prices consumers should expect and their portion of the cost puzzle is often lost in translation. Complex reporting methods and price structures cloud the information that *is* available and make it a daunting task for average health care consumers to make value-based decisions.

Consumer-friendly information related to costs and price has the power to enable individuals to make better-informed decisions about how to spend their health care dollars. Meaningful information will help them choose the best possible care at the best possible price.

To address this concern, the Quality Alliance Steering Committee (QASC) Cost and Price Transparency Workgroup identified principles and recommendations to payers, providers, and third-party entities for making cost and price information available to the public. QASC members approved these principles and recommendations in December 2008.

PRINCIPLES

Cost and price information should enable consumers to estimate the out-of-pocket cost of the health care they purchase and receive; and enable consumers to compare and assess differences among providers, treatments, and health care services.

Cost and price information should be:

- **Actionable**
It should be easy for consumers to use when making decisions about providers, treatments and health care services.
- **Easy to understand**
It should be written in consumer-friendly language using clear and consistent definitions.
- **Easily available**
It should be easy to find, with no cost barriers, and made available in web, print, or other formats most appropriate for the intended audience.
- **Timely**
It should be easily available and accurate at the point of decision-making
- **Credible**
It should be valid, reliable, fair, equitable, and based on a transparent methodology.
- **Personalized and Customized**
It should be relevant given the specific characteristics of the consumer, including insurance coverage/payment status, health status, and demographics.

- **Paired with Quality Information**

It should be presented together with quality information whenever possible, encouraging and facilitating value-based decision making by consumers. Even when quality information is not available, cost and price information should be presented in a context that raises the importance of considering quality in decisions about providers, treatments and health care services. It is important for consumers to know that cost does not necessarily correlate with quality.

When presenting cost and price information to consumers such information should be accompanied by:

- Clear instructions for its use;
- Explanations of the sources of data and their limitations;
- Explanations of variations and exclusions;
- Quality information to the maximum extent possible;
- Notice of the importance of assessing both quality and cost when making health care decisions; and
- Encouragement to confer with their health care **professional** when making health care decisions.

Both *single-point estimates* (averages or means) and *ranges* can provide useful information to consumers.

- While *single-point estimates* can help consumers estimate their out-of-pocket costs (what they will actually pay for care), *ranges* can reflect variations and provide consumers with information about the upper and lower limits of costs they might incur. Information should also be presented to consumers indicating that the severity of any given condition or the mix of conditions can also affect variation.
- The discussion of variations, whenever possible, should be designed to have “educational value,” and the information should be presented in ways that inform consumers about the benefits of appropriate preventive care and effective self-management, in addition to the effects of condition-specific severity and overall health status on variations.
- Use of symbols, such as dollar signs, can help make complex cost information easier to evaluate by consumers when making comparisons. However, use of symbols alone may not provide enough information to enable consumers to estimate out-of-pocket costs.

All methodologies for calculating cost and quality information should be transparent. When cost and quality information are combined, the relative weight of each type of information and the elements within each category should be clearly communicated.

Information provided to consumers should explain the time lag inherent in retrospective information and the degree to which there is uncertainty in prospective information.

Information should be adapted for use by specific populations, taking into account language and cultural issues and specific efforts should be made to ensure that information is available and useful for populations with low health literacy.

Information that follows these principles and recommendations will better equip consumers to:

- Choose providers, treatments and health care services based on consideration of both cost and quality;
- Talk with their health care professionals about treatment options; and
- Plan and budget for their health care expenses.
- In some circumstances, this information may help consumers negotiate fees to obtain the best possible price for their care.

RECOMMENDATIONS

Comparing Out-of-Pocket Costs

Consumers need information that helps them determine their out-of-pocket costs and information that helps them compare those out-of-pocket costs among various providers, treatments and health care services. To the maximum extent possible, consumers also need to know their estimated total cost for particular services and treatments.

For insured consumers, **payers** (i.e., health plans, public and private purchasers) are best positioned to provide both kinds of information to their enrollees, and they can do so in a manner that reflects their enrollees' benefit design.

Uninsured/self-pay consumers must depend on publicly available information. To enable uninsured/self-pay consumers to determine the cost of receiving a particular service from a particular provider, **providers** would need to make certain price information for the most common procedures and services publicly available.

Individual providers are not, however, well positioned to make comparative data available (e.g., cost of provider A versus provider B). A **third-party entity** with access to multi-payer data is better positioned to make comparative information available to uninsured/self-pay consumers and the general public.

Throughout this document, there are recommendations for payers, providers and third-party entities to make available information that enables consumers to compare out-of-pocket costs and total costs across providers, services and treatments. There are various ways to do this, but these recommendations do not call for the public release of specific rates negotiated between payers and providers at this time.

These recommendations reflect the goal of providing information that is most useful to consumers. In many cases, they call on payers and providers to move beyond their current disclosure practice and capability. We acknowledge that the current structure of the health care system, including existing legal barriers, creates challenges that must be addressed in order to move towards greater transparency and usefulness of information for consumers, and that lessons learned from these and other efforts (e.g., the development of payments for episode-based bundles of care) should be used to inform and refine these principles over time.

Payers should provide plan-specific information about estimated out-of-pocket costs to their enrollees, and they should present the information in a way that enables their enrollees to compare their estimated costs among different providers and treatments.

- The information should take into account enrollees' specific plan or benefit design, including premiums, deductibles, co-pays, co-insurance, and excluded services.
- The information should enable enrollees to see the estimated total cost of their care, including both the amount paid by the enrollee and the amount paid by the payer.
- This recommendation does not require providers to make public the contractual rates they negotiate with payers.

Providers should make certain price information on the most common procedures and services (i.e., the amount they would charge an uninsured/self-pay consumer) available with an explanation of what the price does and does not include.

- To the extent possible, this information should be accompanied by information on how consumers can obtain financial assistance, including eligibility for various discount programs or otherwise negotiate individual discounts.
- This does not require providers to make public the contractual rates they negotiate with payers.

Third-party entities should make comparative information available. The information should enable consumers, particularly uninsured and self-pay consumers, to make comparisons across multiple providers.

- Third-party entities could include, for example, federal or state governments, community collaboratives, consortia of public and/or private payers, or private firms.
- Third-party entities should be independent and possess a high level of trust, credibility, transparency, and accountability to all affected stakeholders.

Episodes of Care and Annual Treatment Costs

Consumers need information about their estimated out-of-pocket costs for **episodes of care**. While information about discrete services can be useful, the estimated total cost of an episode of care or treatment is generally more meaningful to consumers.

An episode of care may pertain to treatment for both acute and chronic conditions. The information should include costs for all services related to a particular procedure, treatment, or condition, including professional costs, facility costs (in-patient and out-patient), therapeutic costs, diagnostics, and pharmaceutical costs. Episode of care costs can be constructed narrowly (e.g., cost of a C-section would include the fees associated with the hospital, surgeon, anesthesiologist, pathologist, etc.) or more broadly (e.g., all costs related to hip replacement and rehabilitation).

How an episode is defined, and what is included in an episode of care must be accurate, consistent, and meaningful to consumers and should enable comparisons across both providers and treatments, whenever appropriate.

One important type of “episode” relates to consumers who seek care for chronic conditions. Such individuals would greatly benefit from information about the estimated **annual treatment costs** for those conditions. Providing this information is similar to providing information for acute episodes of care, but the costs of services and treatments associated with the chronic condition must be collected over an extended period. The definition of what is included in annual treatment for a particular condition must also be accurate and consistent to facilitate meaningful comparison. National consensus-based standards should be used to define episodes and estimated annual treatment costs whenever possible.

The presentation of information about episodes of care and estimated annual treatment costs should enable consumers to discern differences in the treatment patterns and efficiency of providers. It should make attribution of costs clear and therefore enable consumers to determine whether cost variations are related to physician services, facility costs, or other aspects of treatment.

Payers are best positioned and most likely to have the means to provide this information to their own enrollees, and they can do so in a manner that takes into account enrollees’ benefit design. Certain providers can also make episode-based price information available to the public and can strive to make this information available for frequently used and high impact services and procedures. For those who are not part of integrated healthcare delivery systems, the legal impediments of sharing price information between independent practitioners and providers must be addressed. Third-party entities would have an important role since they are well positioned to integrate data across providers, services, and settings. To the extent that payers can contribute data to third party entities in the business of making comparisons, they should do so.

Payers should, to the greatest extent possible, provide information to their enrollees that is episode-based. They should provide this information in a manner that enables enrollees to estimate their out-of-pocket costs and to make comparisons among different providers, treatments and health care services.

Providers should make episode-based price information available for certain high impact and/or frequently utilized services and procedures.

Third-party entities should provide the general public with episode-based price information presented in a manner that enables consumers to make comparisons across different providers, facilities, and treatments. To the extent possible, they should enable consumers to estimate their out-of-pocket costs.

Episode-based information and estimated annual treatment costs should take into account variations due to complexity, complications, patient characteristics, and other factors. Such variations should be clearly explained to consumers.

Using Information to Determine Costs for Discrete Encounters and Services

Consumers should easily be able to obtain information about the cost and price of discrete encounters and services. Such information generally includes drugs, certain types of office visits, and commodity type services, such as diagnostic, laboratory, and imaging tests. Although this information is important to consumers, it also has significant limitations, as a discrete service or encounter is often only one component of a care episode or the longitudinal care of a chronic condition.

Payers should provide information to their enrollees about the cost of discrete encounters and services in ways that enable enrollees to both estimate out-of-pocket costs and make comparisons among different providers, treatments and health care services.

Providers should make estimated price information for discrete encounters and services available to the public in ways that are easy for consumers to access and understand (e.g., pharmacies should list retail prices of drugs by category and dose).

Third-party entities should, to the greatest extent possible, provide information to the general public concerning discrete encounters and services. They should present this information in a manner that enables consumers to estimate their out-of-pocket costs to the extent possible, and make comparisons across different providers, facilities, and treatments.

Total Annual Cost of Care

When choosing a health plan or funding a health savings account, consumers need information that enables them to estimate their total annual costs of care and to compare their estimated out-of-pocket costs among different plan options. This includes all types of care that an individual receives such as preventive care, acute care, and care related to particular conditions. “Cost calculator tools” are now available to help consumers make such assessments. These tools enable consumers to take into account plan design, health status, and relevant demographic characteristics.

Payers should make cost calculator tools available to their enrollees and potential enrollees to assist them in determining their best options when selecting a plan or funding a health savings account. *Payers* should provide information to enrollees that summarizes their costs.

Providers should respond as best as possible to questions raised by patients on the potential costs of therapies and treatments they might need over a year for their medical conditions.

Third-party entities should to the greatest extent possible, provide information to the general public to enable consumers to estimate their total annual cost of care.

Note: These recommendations do not require reporting of information that would disrupt marketplace negotiations between payers and providers.

ABOUT THE QUALITY ALLIANCE STEERING COMMITTEE

The Quality Alliance Steering Committee (QASC), formed in 2006, is a collaborative effort among existing quality alliances, physicians, nurses, hospitals, pharmacies, health insurers, employers and other purchasers, consumers, accrediting agencies, government, and foundations that are collectively committed to improving the quality of health care across the United States. Together, all of these stakeholders are working to ensure that quality measures are constructed and reported in a clear and consistent way that informs both consumer and employer decision making, as well as the efforts of providers and clinicians to improve.

The vision of the QASC is to advance a high-quality, cost-effective, patient-centered health care system through the coordination of the various groups that are working to provide public information on health care provider performance. Since QASC membership is representative of the broad stakeholders within the health care system, the QASC is well placed to provide impetus to the performance improvement process. The QASC will actively support the collection, implementation and use of standard performance information for:

- Improvement directly by providers,
- Public reporting and more informed employer and consumer decision making, and
- Effective public policies, payment policies, and consumer incentives that reward or foster better provider performance.

The Cost and Price Transparency Workgroup of the QASC has focused on identifying strategies for making information about the cost and price of health care available to the public. This document contains the workgroup's recommendations to payers, providers and third party entities, on the types of cost and price information that should be made available to consumers. These recommendations are aspirational in nature and serve to guide efforts toward greater transparency.

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