

Report Card

Report Card on State Price Transparency Laws – July 2016

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Dear Colleagues,

We are happy to announce the fourth installment of the Health Care Incentives Improvement Institute (HCI³) – Catalyst for Payment Reform (CPR) Report Card on State Price Transparency Laws. The health care leaders who have been following our report card since it was first released in 2013 will not be surprised by some of the states earning the highest grades in this 2016 edition. Colorado, Maine, New Hampshire, Vermont, and Virginia again stand atop the rankings, with Colorado and Maine moving from Bs in 2015 to As this year. Joining the leading states for the first time is Oregon, whose new transparency law and consumer-facing transparency website earned the state a B this year after receiving an F last year.

The quality of their transparency websites drove up Colorado's and Maine's grades (and contributed to Oregon's new grade), underscoring that how states *present* price information—in addition to how they *collect* it—is essential for making price information accessible and usable for consumers. As such, this year's report card contains a special feature focusing on the best practices for displaying price information as identified by Dr. Judith Hibbard, of the University of Oregon, an expert in how consumers and patients experience, absorb, and act on information about their health care.

In addition, this year's report card offers low-performing states specific recommendations for how they can improve their grade. As in previous years, our scoring methodology rewards states with all-payer claims databases (APCDs) and that publish those data on a well-designed, state-mandated website. That level of commitment remains the model for truly robust price transparency laws. However, our recommended improvements (reflected in Table C) tackle incremental change as well, encouraging states that already collect data to make it more accessible to consumers. Furthermore, not every F is created equal. For instance Louisiana and Washington have new APCD legislation that calls for publishing price information online, but have not yet launched those websites. If such websites are well designed and online by next year, these states can expect to see their grades rise markedly.

Another new aspect of this 2016 report card is the acknowledgement of not just adopted price transparency laws, but also proposed transparency legislation. We recognized a trend in proposed legislation focusing on directing providers or insurers to disclose prices to patients prior to a procedure or service. While this approach is rooted in common sense, it is not a substitute for state laws that require the collection and publication of a wide range of price information. Moreover, although the private sector has made great strides in enhancing price transparency, access to price information often is dependent on the employer or insurer a consumer has and, of course, some have neither. Therefore, there is still an important role for states to play in ensuring that their citizens have access to the information they need to make informed health care choices.

The 2016 Report Card on State Price Transparency Laws is a product of collaboration among valued partners. Analysts at The Source on Healthcare Price and Competition—a program of the University of California, Hastings College of the Law and the University of California, San Francisco—conducted legislative research and summarized each state's enacted and proposed legislation on health care price transparency. Dr. Hibbard provided her valuable insights on how to make price and quality information accessible and actionable to consumers, one of the several ways the report offers a path forward for states willing to improve transparency.

These combined contributions make this document a roadmap for improved transparency at the state level, in addition to a report card with grades. Now, it's up to states to act. When they do, we will recognize their improvements in subsequent report cards.

Sincerely,

Suzanne Delbanco
François de Brantes

Special thanks to Elizabeth Cronen and Elizabeth Bailey, HCF³; Lea Tessitore, Andréa Caballero, and Spencer Sherman, CPR; and Anne Marie Helm, Elizabeth Nicholson, and Becky Wildman-Tobriner of The Source on Healthcare Price and Competition for their contributions to researching, writing, and editing this project.

Introduction

The question “how much does it cost?” is integrated so deeply into the act of buying that consumers often don’t have to ask – prices are printed on menus, stamped on tags, and posted online, among other places. There are services—like car repairs or home improvement—that aren’t easily distilled into standardized, published prices. But rarely do successful professionals get away with answering, “Hard to say; you’ll know when you get the bill” in response to consumer inquiries about costs.

Despite the full integration of price information into almost every other retail experience, it’s typical in American health care for consumers to go into an appointment or procedure knowing nothing about what it will cost until long afterward. State laws mandating health care price transparency for consumers can help fix the mystery surrounding health care prices, unbolting the door between consumers and the information they need to shop for and buy high-quality, affordable health care.

That’s why we launched the Report Card on State Price Transparency Laws in 2013. For purchasers, advocates, legislators and other leaders who believe consumers deserve to know what health care will cost them, it’s essential to know how far states have moved toward adopting strong transparency legislation and to understand what a strong transparency resource looks like.

In this year’s report card we find that too many states still fall far short of requiring and implementing thorough, useable transparency resources. Dozens of states have laws that refer to price transparency, but provide little to help consumers shop for and choose care, and offer little potential to move the health care delivery system toward quality and affordability.

Beyond offering a letter grade for each state, we outline the shortcomings that are holding back transparency in a given state, including the scope of providers whose cost information is available to consumers, the type of cost included, and the accessibility of the information. Addressing these components can send low-scoring states on a path toward robust transparency.

The Need for Transparency

The simple fact that patients often do not have the tools to comparison-shop for health care is remarkable, but how much does it matter? Dozens of studies published in just the past 12 months have addressed this question conclusively, including a recent study in *Health Affairs*,¹ another one in the *American Journal of Managed Care*,² and a narrative in the *Annals of Internal Medicine*.³ More comprehensively, researchers at Yale University launched an ambitious project, called the Health Care Pricing Project, on the heels of a study showing significant variation in the price of common health care procedures and services both between and within states.⁴ Their research showed, for example, that knee replacements were priced more than double at one hospital compared to another *within* the Dallas area.⁵ And in the Atlanta area, the most expensive colonoscopy was more than five times the price of the least expensive one.⁶

Without price transparency, a consumer can't predict whether their bill will be on the high or low end of the spectrum, or anywhere in between. The impact of unexpected high cost bills is clear for uninsured patients who bear the entire financial burden. However, these expenses can be significant and burdensome for insured consumers as well; this is especially true with the rise in high-deductible health plans.

The average deductible for an individual “silver” plan—the most commonly purchased⁷ type of plan sold in health insurance marketplaces—is \$3,065.⁸ On average, silver plans cover 70 percent⁹ of eligible costs. According to an HCI³ analysis of one state's hospital prices for vaginal deliveries, a woman with a silver plan could pay \$600 more out of pocket if she delivered her baby at the highest-priced hospital compared to an average priced one. That number jumps to \$1,600 when comparing the highest and lowest priced hospitals. In the figure on the following page, hospitals are arrayed from most affordable to least affordable, with average prices for a routine vaginal delivery ranging from \$4,500 to close to \$10,000, with no measurable differences in the quality of care received. The impact on a plan member enrolled in a silver plan is depicted by two red shaded areas. The darker red represents

1 Newman D, Parente S, Barrette E, and Kennedy K. DATAWATCH: Prices For Common Medical Services Vary Substantially Among The Commercially Insured. *Health Aff.* 2016;35:5923-927. doi:10.1377/hlthaff.2015.1379

2 Higgins A, Veselovskiy G, Schinkel J. National Estimates of Price Variation by Site of Care. *The American Journal of Managed Care.* 2016;3:e116-e121.

3 Grande D. Sticker Shock: The Experience of a Health Care Consumer. *Ann Fam Med.* May/June 2016;14:270-272. doi:10.1370/afm.1921

4 Zack Cooper, et. al. The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured. December 2015.

5 Hospital Prices for Knee Replacement Dallas, TX HRR, 2008-2011. A graph by the Health Care Pricing Project. http://www.healthcarepricingproject.org/sites/default/files/papers/within_market_graphs.zip

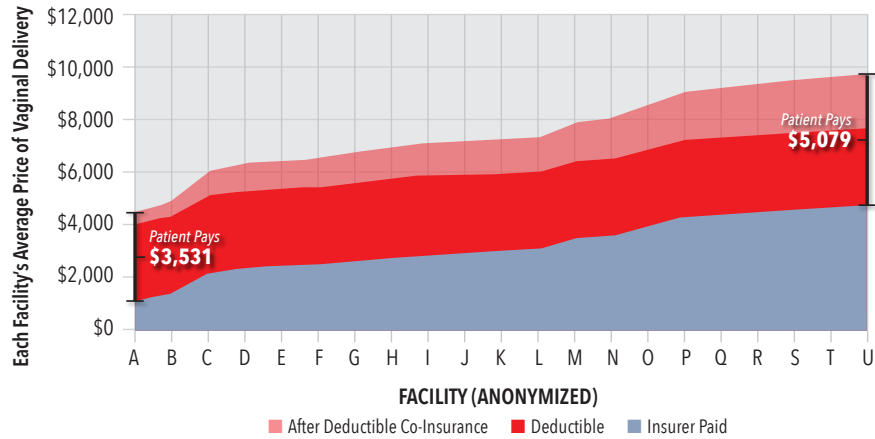
6 Hospital Prices for Colonoscopy Atlanta, GA HRR, 2008-2011. A graph by the Health Care Pricing Project. http://www.healthcarepricingproject.org/sites/default/files/papers/within_market_graphs.zip

7 Total Effectuated Enrollment Data by Metal Level by State. Centers for Medicare and Medicaid Services. December 31, 2015. <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-11.html>

8 Patient Cost-Sharing in Marketplace Plans, 2016. Kaiser Family Foundation. November 13, 2015. <http://kff.org/health-costs/issue-brief/patient-cost-sharing-in-marketplace-plans-2016/>

9 What the Actuarial Values in the Affordable Care Act Mean. Kaiser Family Foundation. April 2011. <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8177.pdf>

the \$3,065 deductible and the lighter red represents the co-insurance payment. For the most affordable hospital, the total out-of-pocket expenses would be \$3,531. For the average priced hospital, the out-of-pocket expenses jump to \$4,393. And for the most expensive hospital, the out-of-pocket expenses grow to close to \$5,100. This shows starkly why price transparency matters; because the lack of information on the price of care hurts the pocket books of Americans every day.



Even an insured patient may have to pay \$5,079, out-of-pocket, at the highest-priced facility compared to \$3,531 out-of-pocket at the lowest-priced facility

Components of High-Quality State Price Transparency Resources

The cost insights from all these analyses underscore how much is at stake as states seek to address price transparency. Real health care price transparency relies on a rich data source and supplies meaningful price information on a wide range of procedures and services, and is presented on an accessible, publicly available web site. Most states *have* approached the subject of price transparency at the legislative level, as only seven states have no statutes addressing it. But in 37 other states, the lack of transparency comes from weaknesses in the design and implementation of their laws, earning them each a D or F in our report card.

Rich data source: To procure health care price data, states can either compel providers and/or health plans to report prices, or mandate an all-payer claims database (APCD). APCDs collect data from multiple sources including private health insurers, Medicaid, children’s health insurance and state employee health benefit programs, prescription drug plans, dental insurers, self-insured employer plans, and Medicare (if available to a state). APCDs are widely considered to be superior data sources because they include actual paid amounts—not *charged* amounts—which often are significantly lower due to contracted or negotiated rates from providers. When there is no APCD, typically only charged amounts are available in the data turned over from providers to states or consumers, making the price information significantly less useful for comparisons.

A transparency law may also direct health care providers or insurers to divulge price information to consumers prior to a procedure or other service, which is the very minimum amount of information a consumer would expect in any other transaction. This does not meet high standards for transparency because providers and insurers usually differ in how they calculate and present pricing information, making it very difficult to comparison shop.

Meaningful price information: For a consumer, a paid amount is a more consequential price than a charged amount (called “scope of prices” in our scoring). In addition, it is more meaningful to see the entire price for a health care event than to see only a hospital or facility price, or only a physician price for a specific service (called “scope of provider” in our scoring). A transparency resource that collects and displays only one or the other isn’t giving a health care consumer real transparency or full enough data to make an informed decision.

Scope of procedures and services: A robust set of price data will include information on in-patient and out-patient procedures and services, instead of just one category, or only a limited list of procedures and services.

Accessible, mandated website: Having high-quality, comprehensive price information is vital, but it cannot serve health care consumers if that information is not easily obtainable or is not presented in a consumer friendly format. Some transparency laws require only that a state prepare a report using collected price data, or that the data be turned over to consumers only upon request. On the other hand, good legally mandated transparency resources will make the collected data available on a website, and great ones will ensure that the website’s content is current and online tools are easy to use. In addition, the website will be mandated in legislation, making it permanent and not subject to the varying priorities or funding of the agency publishing it.

Scoring Methodology

To evaluate state price transparency laws and their implementation, we distilled the best practices described above into scoring guidelines. The detailed scoring rubric appears in the Appendix that begins on page 17. The key features are summarized below.

TABLE A – SUMMARY OF SCORING CRITERIA

	DATA SOURCE	SCOPE OF PROVIDER	SCOPE OF PRICES	SCOPE OF SERVICES	PRESENTATION OF DATA
LOW SCORING	Providers	Only hospitals/facilities or only clinicians	Charges	Only in-patient, only out-patient, or a limited list of services	Prepared report or by request
HIGHEST SCORING	APCD	Hospitals/facilities and clinicians	Paid amounts	All in-patient and out-patient services	On a public, legislated website, with additional credit for quality of the site

Researchers at The Source on Healthcare Price and Competition, a project of the UCSF/UC Hastings Consortium on Law, Science & Health Policy, conducted a census of health care price transparency laws in all 50 states. For each state that has mandated price transparency, The Source compiled relevant excerpts from the legislation and details on the scope of the laws. HCI³ analyzed the legislation, scored it on the parameters summarized above and assigned a corresponding letter grade, A through F. The transparency laws that were scored are summarized and excerpted in a table available online at <http://bit.ly/transparency-research>.

The Grades

Consistent with best practices, the highest-scoring state transparency resources incorporate many of the characteristics listed in the “highest scoring” row of Table A. In several of the low-scoring states, meaningful price transparency is not out of reach. That’s why our report card lists not just the letter grades, but also practices for states to emulate, and improvements low-performing states can make.

TABLE B - REPORT CARD: HIGHER-PERFORMING STATES

STATE	GRADE	PRACTICES FOR OTHER STATES TO EMULATE	LEGISLATED WEBSITE
CO	A	Collects data in an APCD, including full scope of providers, and paid amounts. Has an excellent website for consumers.	https://www.comedprice.org
ME	A	Collects data in an APCD, including full scope of providers, and paid amounts. Has an excellent website for consumers.	http://www.comparemaine.org
NH	A	Collects data in an APCD, including paid amounts. Has an excellent website for consumers.	http://www.nhhealthcost.org
OR	B	Collects data in an APCD, including paid amounts, and publishes the data on a good website for consumers. Oregon can earn an even higher score if the state collects practitioner prices in addition to facility prices and does so for a greater number of services and procedures.	http://oregonhospitalguide.org
VA	C	Collects data in an APCD, including full scope of providers, and paid amounts. However, a poor website keeps Virginia from earning an even higher score.	http://www.vhi.org
VT	C	Collects data in an APCD, including full scope of providers, and paid amounts. However, a poor website keeps Vermont from earning an even higher score.	http://www.dfr.vermont.gov/insurance/insurance-consumer/2012-pricing-financial-reports

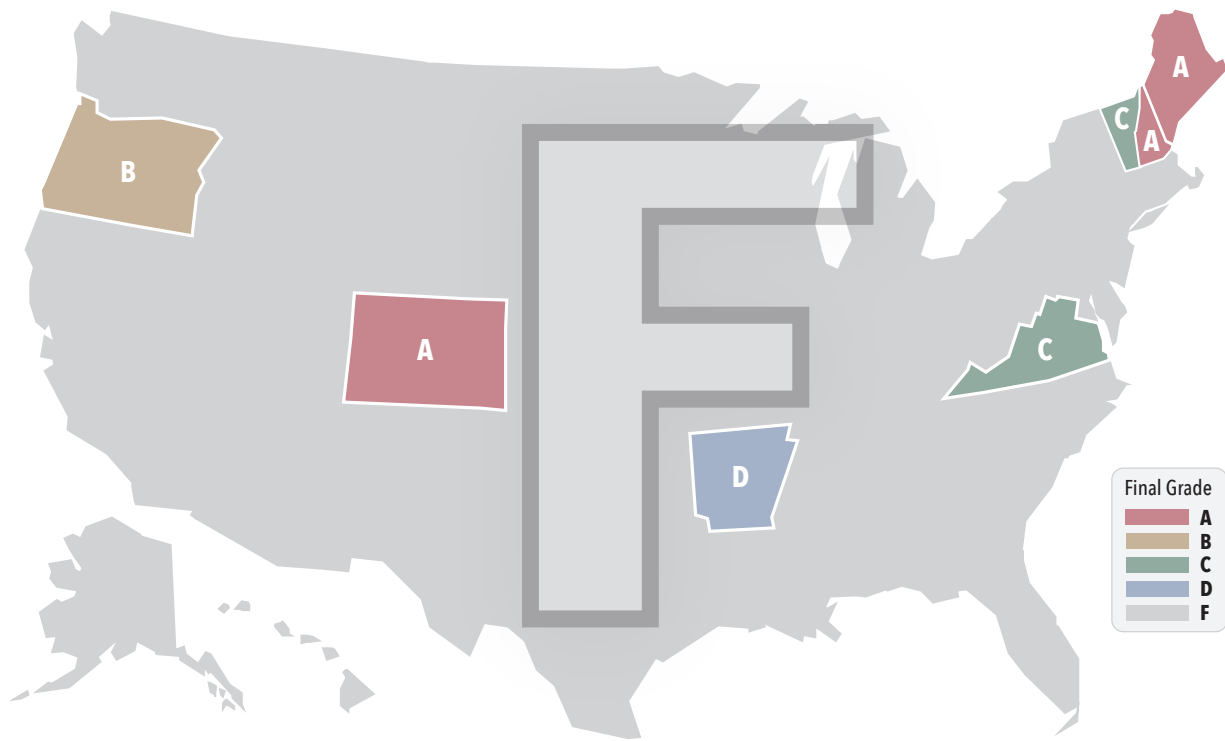


TABLE C – REPORT CARD: LOW-PERFORMING STATES

STATE	GRADE	IMPROVEMENTS NEEDED
AK	F	Commit to price transparency; Alaska has no transparency law.
AL	F	Commit to price transparency; Alabama has no transparency law.
AR	D	Take the data from the state's newly established APCD and post it on a publicly accessible website. Arkansas' law is unclear on how the data must be shared.
AZ	F	Shift from collecting data from providers; establish an APCD and post the data on a publicly accessible website.
CA	F	Legislate submission of price data to a true APCD and post the data on a publicly accessible website. California's current APCD is only voluntary.
CT	F	Take the data from the state's established APCD and post it on a publicly accessible website.
DE	F	Commit to price transparency. At the very least, post to a website the data Delaware is already collecting. Currently, limited information is available, and only in a report.
FL	F	Shift from collecting data from providers; establish an APCD and post the data on a publicly accessible website.
GA	F	Commit to price transparency. At the very least, post to a website the data the state is collecting. Currently, limited information is available, and the law is not clear on how it must be shared.
HI	F	Commit to price transparency; Hawaii has no transparency law.
IA	F	Shift from collecting data from providers; establish an APCD and post the data on a publicly accessible website.
ID	F	Commit to price transparency; Idaho has no transparency law.
IL	F	Shift from collecting data from providers; establish an APCD and post the data on a publicly accessible website.
IN	F	Shift from collecting data from providers; establish an APCD and post the data on a publicly accessible website.
KS	F	Take the data from the state's established APCD and post it on a publicly accessible website. The current law is not clear on how the data must be shared.
KY	F	Shift from collecting data from providers; establish an APCD and post the data on a publicly accessible website.
LA	F	Take the data from the state's newly established APCD and post it on a publicly accessible website. The Louisiana APCD law calls for a website for consumer use "pending the availability of funds," and a consumer website is not now available.

TABLE C – REPORT CARD: LOW-PERFORMING STATES, *continued from page 8*

STATE	GRADE	IMPROVEMENTS NEEDED
MA	F	Take the data from the state's established APCD and post it on a publicly accessible website.
MD	F	Take the data from the state's established APCD and post it on a publicly accessible website. That data is now available only in annual reports.
MI	F	Commit to price transparency; Michigan's price transparency law calls only for studying the potential for a price and quality database.
MN	F	Take the data from the state's established APCD and post it on a publicly accessible website.
MO	F	Commit to price transparency. At the very least, post to a website the data Missouri is already collecting. Currently, limited information is available, and only in a report.
MS	F	Commit to price transparency; Mississippi has no transparency law.
MT	F	Commit to price transparency; Montana law calls for considering an APCD, but has not established one.
NC	F	Shift from collecting data only from providers; establish an APCD and post the data on a publicly accessible website.
ND	F	Commit to price transparency. In recent years, North Dakota has eliminated a law requiring the state to produce a report on health care prices.
NE	F	Nebraska recently enacted a law that establishes a committee to evaluate developing an APCD. As a next step, establish the APCD and post the data on a publicly accessible website.
NJ	F	Commit to price transparency. At the very least, post to a website the data New Jersey is already collecting. Currently, limited information is available, and only in a report.
NM	F	Commit to price transparency. At the very least, post to a website the data New Mexico is already collecting. Currently, limited information is available, and only in a report.
NV	F	Shift from collecting and posting data from providers; establish an APCD and post the data on a publicly accessible website.
NY	F	Mandate that data from the state's established APCD be posted on a publicly accessible website. The current APCD law says nothing about how the data must be shared.
OH	F	Shift from collecting and posting data from providers; establish an APCD and post the data on a publicly accessible website.
OK	F	Commit to price transparency; Oklahoma has no transparency law.
PA	F	Commit to price transparency. At the very least, post to a website the data Pennsylvania is already collecting. Currently, limited information is available, and only in a report.
RI	F	Take the data from the state's established APCD and post it on a publicly accessible website. The current APCD law is not clear on how, or how much, data must be shared with consumers.
SC	F	Commit to price transparency. Currently South Carolina collects and publishes revenue and utilization data, not prices for consumers.
SD	F	Shift from collecting and posting data from providers; establish an APCD and post the data on a publicly accessible website.
TN	F	Shift from collecting and posting price data from providers, and make price data from the already-established APCD available on public website. Currently, only quality information from the state's APCD is available to the public online.
TX	F	Commit to price transparency. Currently, Texas law mainly directs facilities and insurance companies individually to provide price information upon request.
UT	F	Take the data from the state's established APCD and post it on a publicly accessible website. It is now available only in a report or by written request.
WA	F	Take the data from the state's newly expanded APCD and post it on a publicly accessible website. Washington has not yet launched a consumer website with price information.
WI	F	Legislate submission of price data to a true APCD and post specific data on a state-mandated, publicly accessible website. Wisconsin's current APCD is only voluntary, and a voluntary website has quality and price information only as general categories, without specifics.
WV	F	Take the data from the state's established APCD and post it on a publicly accessible website. West Virginia's APCD law does not specify how the data will be shared with the public.
WY	F	Commit to price transparency; Wyoming has no transparency law.

Additional Proposals

There also is pending transparency legislation in some states. Informed by our criteria for high-quality transparency laws, we recommend many states take a second look at their proposals.

Most state legislatures addressing transparency in 2016 have prepared bills directing hospitals and clinicians to give consumers price information prior to care, whether by request, or posted on a website. Such mandates are a step toward meeting consumers’ needs, but they are not a substitute for a robust state price transparency resource. Under our scoring system for existing transparency resources, a law only requiring providers to disclose prices upon request or on a website would receive an F grade. The best way to allow consumers to compare prices is—as our scoring criteria reflect—with a searchable website, containing paid amounts for all providers for a wide range of services, from an APCD. Price disclosure laws can be a useful add-on to an existing transparency resource.

However, some of the states considering such legislation have either not yet begun collecting price data, or are not sharing publicly the information they do collect. In addition to the disclosure laws they are pursuing, these states should more fully address the transparency needs of consumers:

- Alabama
- Georgia
- Michigan
- Missouri
- Oklahoma
- Pennsylvania
- Texas
- West Virginia

A few other pieces of proposed legislation show progress, but also have room for improvement:

STATE	WAYS TO IMPROVE
HI	Proposed legislation that will greatly expand Hawaii’s collection of price data should specify how the information will be shared with the public.
NJ	Proposed legislation would establish an APCD. The law will be strongest if it mandates sharing price and quality information on a publicly accessible website.
OK	Proposed legislation would direct the state to collect and publish prices, but only charges, for only 100 procedures, to be made available only by request. The best transparency resources collect and publish online paid amounts.

Price Transparency Resources Consumers Can Use

Price information has no power to improve the affordability of care if consumers can't access it, understand it, or apply it to their own situations. That's why our grading rewards states that bring data together in one place for consumers, as opposed to having them seek it from many different sources. It's also why we measure the *quality* of a state's transparency website, in addition to crediting states for having such websites at all.

Our scoring standards were informed greatly by the consumer-engagement research of Dr. Judith Hibbard, of the University of Oregon. In the past 15 years alone, she has published more than 100 papers on how consumers and patients experience, absorb, and act on information about their health care. Recent published studies by others have cast some doubt on the effectiveness of price transparency when, in fact, thorough and comprehensive research by Dr. Hibbard and her colleagues throughout the last decade shows the influence of such tools on consumer choices. Moreover, those studies concluding that consumers do not use price information have looked at transparency tools that were either badly constructed or incomplete and missing the key ingredients that make price and quality information useful and actionable for consumers. Below are the best practices for displaying price information as identified by Dr. Hibbard.

Best Practices to Maximize Consumer Use

By Judith Hibbard, University of Oregon

Price transparency is a new and important trend in health care. Transparency efforts can help consumers to become aware of the variation in prices and also enable choices that will lessen the financial burden of obtaining care. Price transparency may also influence the pricing behavior of providers, particularly if they believe that consumers are using the information to make choices. The benefits of transparency are only realized, however, if consumers attend to and use the information in making choices. We know from years of experience and decades of research with health care quality transparency efforts, that the way in which information is displayed and presented can make a difference in whether it is understood and used.

A key consideration in price transparency is the difficulty that many people have with numbers. Data from the National Literacy Survey indicate that about half of Americans lack the minimal mathematical skills needed to use numbers embedded in printed materials.ⁱ Less numerate individuals find it harder to derive meaning from numbers.

Some data presentation approaches that may help consumers understand and use the information in making choices are discussed below; they include: reducing the burden of information processing; interpreting the meaning of the data for the user; and, highlighting best options. Overall these presentation strategies make it easier for consumers to comprehend and use information. People's attention is pulled in many directions; the key is to provide information that is quickly and easily understood, before you lose their attention. The longer it takes, the more effort that is required, the more likely it is that fewer consumers will end up using the information. To make your transparency efforts pay off, make it as easy and simple as possible for consumers to use the information to inform their choices.

Reducing the Burden of Processing Information

Research shows that processing lots of information and bringing it together into a choice are burdensome cognitive tasks. When faced with this type of burden, consumers often make short cuts in decision-making—they choose on only one factor, ignoring other factors. Often this one factor is something they understand and are familiar with. This “short cut” in decision-making often undermines the individual's own self-interest. If we lessen the burden of using information, fewer people will take these short cuts.^{ii,iii} What we know is that “less is more:” providing less information can be more effective. One example of providing fewer data points: simply allowing consumers to narrow their range of options before choosing. Similarly, limiting the parameters of options being compared also helps, as it requires fewer bits of information to be processed. Sometimes this is done by using web-based tools that can narrow options on user-defined preference, such as distance from home, or whether a provider is in a network. Even though we want to give consumers as much information as possible, it is not always an effective approach. Removing comparative information that is less important (nonessential to the decision) also helps make the task easier.^{iv,iii} When less numerate consumers see a “sea” of numbers it feels overwhelming. Showing one column of numbers, or no more than two columns, will be less intimidating to low numerate consumers.

Another way to reduce the information-processing burden is to remove all technical terms and jargon and replace them with plain language translations. Reducing the need to have to look up unfamiliar words is a further way to reduce the burden of using the information. It also increases the chances that the information will be understood and used. We like to believe that users will “click here” to find out what a word means, but the reality is that they will more likely just ignore information they do not understand. Translating technical terms and insider jargon into plain language means that your efforts will be more effective.

Interpret the Data

One of the most helpful strategies for supporting consumer choice is to interpret the data for the user. One of the most effective interpretation approaches is to add an “affective label.”^v An affective label indicates what is good or bad—interpreting the information for the user. In the case of price transparency, this might be indicating what is a good price and what is not. In health care this is not a straightforward proposition. Research shows that some consumers may use price as a proxy for quality. That is, a significant minority of consumers will assume that higher priced providers or services are also the higher quality options. This consumer belief could undermine one of the goals of price transparency. What is the solution?

The best solution is to always pair price information with quality information. Consumers need to see that they don’t have to pay top dollar to get good quality. The way the data is presented can highlight this important point for consumers. For example, by presenting price information within quality tiers or presenting quality information within cost tiers, either way will show consumers that there is variation in both cost and quality and that higher quality and price are not necessarily linked. Simply showing price and quality side by side is also a good solution.

If you have no quality information to show along with price, you run the risk that many consumers will use price as a proxy for quality. When this happens, not only will it push some consumers to choose the high cost options, *but it will also reduce consumers’ willingness to choose the lowest cost options.* Research shows that absent quality information, consumers are reluctant to go to the lowest cost options.^{vi} This may reflect a belief that lower cost providers are “cutting corners” and providing a lower quality service.

Highlight Best Options

If quality information is paired with price information it is possible to ‘call out’ best value options for consumers (see example below). This is a strong ‘nudge’ that will influence choices by allowing consumers to quickly and easily identify best options.^{vi} It is best operationalized by actually showing the price and quality information along with the high value designation, so that consumers can see the reason for the designation.

INTERPRET THE DATA: CALL OUT VALUE KNEE REPLACEMENT

HOSPITAL	IMPROVED FUNCTIONING	PREVENTION OF COMPLICATIONS	AVERAGE COSTS	HIGH VALUE (high quality and low cost)
EVERGREEN HOSPITAL	Average	Below	\$32,685	
LAKEVIEW HOSPITAL	Better	Better	\$23,815	✓
WOODLAND HOSPITAL	Below	Below	\$44,686	
SIERRA VISTA HOSPITAL	Better	Better	\$25,652	✓
PARKDALE HOSPITAL	Average	Average	\$38,789	

All consumers are helped by these strategies, but those who have less skill are helped the most. Improving consumer choice is a key goal of price transparency. Taking steps to make a report more understandable and useable to a wide consumer audience will mean your transparency efforts will pay off with a greater overall impact. ■

i Kirsch I, Jungeblut A, Jenkins L, Kolstad A. Adult literacy in America: A first look at the findings of the National Adult Literacy Survey. 2002.

ii Hibbard JH, Peters EM. Supporting informed consumer health care decisions: data presentation approaches that facilitate the use of information in choice. *Annu Rev Public Health*. 2003;24:413-433.

iii Peters E, Dieckmann N, Dixon A, Hibbard JH, Mertz CK. Less is more in presenting quality information to consumers. *Med Care Res Rev*. 2007;64:169-190.

iv Damman OC, De Jong A, Hibbard JH, Timmermans DRM. Making comparative performance information more comprehensible: an experimental evaluation of the impact of formats on consumer understanding. *BMJ Qual Saf*. November 2015. doi:10.1136/bmjqs-2015-004120.

v Peters E, Dieckmann NF, Västfjäll D, Mertz CK, Slovic P, Hibbard JH. Bringing meaning to numbers: the impact of evaluative categories on decisions. *J Exp Psychol Appl*. 2009;15(3):213-227. doi:10.1037/a0016978.

vi Hibbard JH, Greene J, Sofaer S, Firminger K, Hirsh J. An Experiment Shows That A Well-Designed Report On Costs And Quality Can Help Consumers Choose High-Value Health Care. *Health Aff*. 2012;31:560-568. doi:10.1377/hlthaff.2011.1168.

Going Further with Transparency: Leveraging an APCD to Expose Price and Quality of Care for Hysterectomy Procedures

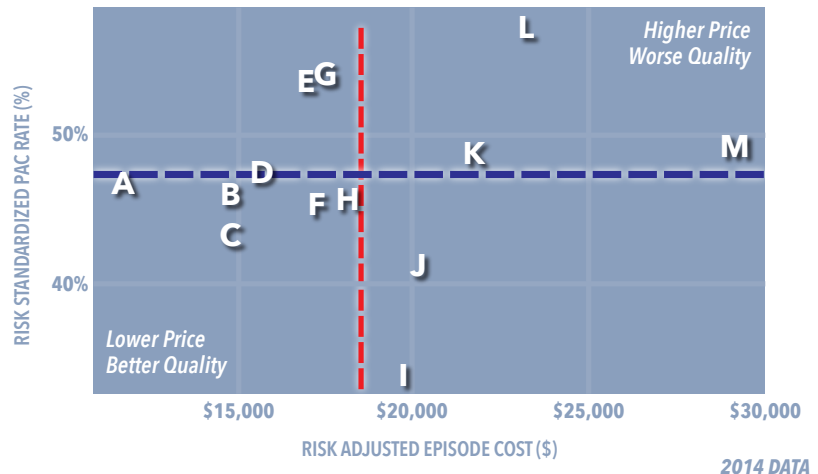
It's clear from the report card grades and descriptions that APCDs are crucial to state success with price transparency. A state that publishes straightforward price and quality information from its APCD is meeting its responsibilities under our grading criteria. However, a state that opens its data for exploration creates opportunities for even richer insights.

One such state is New Hampshire. Unlike most states with APCDs, which provide their databases to researchers for analyses, New Hampshire also authorizes the publication of the results of those analyses as long as they are shared with the state prior to publication.

HCI³ analyzed New Hampshire's 2014 data on hysterectomies to demonstrate the kinds of findings that are possible with access to an APCD. Advanced analytic techniques were used to:

- Identify services and procedures listed in the database that may have been tied to potentially avoidable complications, a possible signal of low quality
- Account for the severity of a patient's condition when considering these potentially avoidable complications
- Account for the severity of a patient's condition when measuring the costs of treatment

In the resulting chart, each facility is plotted on two axes, one that shows the average, severity-adjusted price for a hysterectomy, and the other shows the severity-adjusted rate of complications.



A	CHESHIRE MEDICAL CENTER	H	SOUTHERN NH MEDICAL CENTER
B	ELLIOT HOSPITAL	I	ST. JOSEPH HOSPITAL OF NASHUA
C	EXETER HOSPITAL INC	J	CONCORD HOSPITAL
D	CATHOLIC MEDICAL CENTER	K	LITTLETON REGIONAL HOSPITAL
E	PORTSMOUTH REGIONAL HOSPITAL	L	DARTMOUTH-HITCHCOCK MEDICAL CENTER
F	WENTWORTH-DOUGLASS HOSPITAL	M	LAKES REGION GENERAL HOSPITAL

If the state of New Hampshire were to package these data following Dr. Hibbard's recommendations, there's little doubt that most consumers would avoid facilities L and M, which would likely have the result of driving down excessive prices. In addition, further scrutiny on the observed rates of complications for this and other episodes of care by state medical specialty groups and regulators may drive better quality, which is especially needed in hysterectomy surgery.^{vii}

The sophisticated analysis performed by HCI³ helps ensure that these comparisons among facilities are fair. Risk standardizing^{viii} the potentially avoidable complication rates and severity adjusting the prices mean that receiving sicker, more-expensive-to-treat patients won't obscure the quality and affordability achievements of the facilities where they are treated.

Not every state will have the resources necessary to risk standardize and severity adjust data; they may be able only to publish the data. That's why opening the data to outside analysts, as New Hampshire does, is a potentially powerful step in furthering the impact of price and quality transparency.

vii de Brantes F, Rastogi A, Wilson A. When is the Most Popular Procedure the One with the Worst Outcomes? Health Care Incentives Improvement Institute. 2016. <http://www.hci3.org/wp-content/uploads/2016/07/hysterectomy-issue-brief.pdf>

viii de Brantes F, Wilson A, Rastogi A. Piercing The Darkness: A Generalizable Approach To Reliably Measuring Quality Of Care. Health Care Incentives Improvement Institute. 2015. http://www.hci3.org/wp-content/uploads/2015/11/Transparency_Sccrd_WhitePaper_HCI15026-11.13.15-R1.pdf

Conclusion

Our 2016 Report Card on State Price Transparency Laws shows that price transparency—an obvious expectation integrated into every other consumer experience—is on the minds of state legislators and other health care leaders throughout the U.S. It also highlights why this information is so critical to every health care consumer in every state; prices for routine and very common procedures can vary by more than 50 percent, even in the same geographical area, placing a potentially significant financial burden on individual consumers, a burden that can be avoided with robust health care price transparency.

Thus, design and implementation of the legislation matter. In fact, the potential for transparency to empower consumers, shift costs down, and raise quality rests entirely on the strength and comprehensiveness of each state law's implementation. This is a perspective that is often lost in some of the research on the effectiveness of price transparency, even though no one should be surprised that weak resources yield poor results. Importantly, a very strong and thorough body of research demonstrates that consumers *will* seek lower-priced, high-quality providers when given the right information in the right format.

Many states may see low grades for themselves. However, in this report card, they also have a roadmap for improvement. It's up to states to apply that roadmap to benefit from the desired and proven positive effects of price and quality transparency. ■

Appendix

Each state's price transparency legislation was analyzed according to the Legislation Scoring Rubric, at right, with 100 total points possible for excellent legislation.

Legislated websites were scored out of 50 points. Out of the total 150 points (legislation and website combined), each state's number of points was converted to a percent.

- 90-100% = A
- 80-89% = B
- 70-79% = C
- 60-69% = D
- 59% and below = F

LEGISLATION SCORING RUBRIC				LEVEL SUBTOTAL	DATA SOURCE SUBTOTAL	TOTAL	
DATA SOURCE = PROVIDER	Ability for patient to request pricing information prior to rendering of services			1	10	50	100
	Scope of Price (two levels, can only have 1 score out of 2)	Paid Amounts	4	4			
		Charges	1				
	Scope of Services (three levels, can only have 1 score out of 3)	All in-patient services and out-patient services	3	3			
		All in-patient services or out-patient services	2				
		Most common in-patient services or out-patient services	1				
	Scope of Health Care Providers (three levels, can only have 1 score out of 3)	All hospitals and providers	3	3			
		All hospitals or providers	2				
		Susbet of hospitals/providers	1				
	Provision for publishing a public report on pricing information			1			
	Scope of Price (two levels, can only have 1 score out of 2)	Paid Amounts	4	4			
		Charges	1				
	Scope of Services (three levels, can only have 1 score out of 3)	All in-patient services and out-patient services	3	3			
		All in-patient services or out-patient services	2				
		Most common in-patient services or out-patient services	1				
	Scope of Health Care Providers (three levels, can only have 1 score out of 3)	All hospitals and providers	3	3			
All hospitals or providers		2					
Susbet of hospitals/providers		1					
Provision for posting pricing information on a public website			3	30	50		
Scope of Price (two levels, can only have 1 score out of 2)	Paid Amounts	4	12				
	Charges	1					
Scope of Services (three levels, can only have 1 score out of 3)	All in-patient services and out-patient services	3	9				
	All in-patient services or out-patient services	2					
	Most common in-patient services or out-patient services	1					
Scope of Health Care Providers (three levels, can only have 1 score out of 3)	All hospitals and providers	3	9				
	All hospitals or providers	2					
	Susbet of hospitals/providers	1					
DATA SOURCE = APCD	Ability for patient to request pricing information prior to rendering of services			1	10	50	
	Scope of Price (two levels, can only have 1 score out of 2)	Paid Amounts	4	4			
		Charges	1				
	Scope of Services (three levels, can only have 1 score out of 3)	All in-patient services and out-patient services	3	3			
		All in-patient services or out-patient services	2				
		Most common in-patient services or out-patient services	1				
	Scope of Health Care Providers (three levels, can only have 1 score out of 3)	All hospitals and providers	3	3			
		All hospitals or providers	2				
		Susbet of hospitals/providers	1				

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LEGISLATION SCORING RUBRIC, <i>continued from page 17</i>				LEVEL SUBTOTAL	DATA SOURCE SUBTOTAL	TOTAL	
DATA SOURCE = APCD	Provision for publishing a public report on pricing information			1	10	50	100
	Scope of Price (two levels, can only have 1 score out of 2)	Paid Amounts	4	4			
		Charges	1				
	Scope of Services (three levels, can only have 1 score out of 3)	All in-patient services and out-patient services	3	3			
		All in-patient services or out-patient services	2				
		Most common in-patient services or out-patient services	1				
	Scope of Health Care Providers (three levels, can only have 1 score out of 3)	All hospitals and providers	3	3			
		All hospitals or providers	2				
		Susbet of hospitals/providers	1				
	Provision for posting pricing information on a public website			3			
	Scope of Price (two levels, can only have 1 score out of 2)	Paid Amounts	4	12			
		Charges	1				
	Scope of Services (three levels, can only have 1 score out of 3)	All in-patient services and out-patient services	3	9			
		All in-patient services or out-patient services	2				
		Most common in-patient services or out-patient services	1				
	Scope of Health Care Providers (three levels, can only have 1 score out of 3)	All hospitals and providers	3	9			
All hospitals or providers		2					
Susbet of hospitals/providers		1					

LEGISLATED WEBSITE SCORING RUBRIC			
Scope of Content	Contains broad scope of price, providers, and services	12.5	50
Ease of Use	User interface, intuitive design	12.5	
Utility	Facilitation of provider selection	12.5	
Timeliness/Accuracy	Reliability and currency of data	12.5	