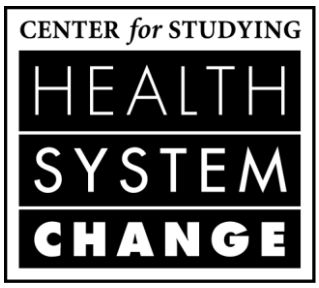

Price and Quality Transparency of Medical Services

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Committee on Energy and Commerce
Subcommittee on Health

Hearing on Making Health Care Work for American Families:
Saving Money, Saving Lives

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Chairman Pallone, Representative Deal and members of the Subcommittee, thank you for the invitation to testify on price and quality transparency of medical services. I am Paul B. Ginsburg, an economist and president of the Center for Studying Health System Change (HSC), a nonpartisan health policy research organization funded in part by the Robert Wood Johnson Foundation and affiliated with Mathematica Policy Research, Inc. HSC's mission is to track and analyze changes in the financing, organization and delivery of health care and the impact of those changes on people. HSC conducts and analyzes periodic surveys of households and physicians and site visits of a representative sample of communities. HSC has conducted research on health care price and quality transparency for many years, with funding from the California HealthCare Foundation, the U.S. Department of Health and Human Services and the Robert Wood Johnson Foundation.

Turning passive patients into active consumers who factor cost and quality into decisions about which doctors or hospitals to choose and which treatment options to pursue remains an elusive goal in the U.S. health care system. Despite well-intentioned efforts in recent years by government, employers, health plans and others to foster health care price and quality transparency, most Americans still choose doctors and hospitals the old-fashioned way—they rely on recommendations from friends and families and physicians.[1]

Despite extensive evidence that the quality of U.S. health care is uneven at best and that Americans pay more for health care than citizens in any other industrialized nation with worse results,[2] health care price and quality transparency in the United States has yet to capture a significant consumer following.

On the cost front, insured Americans face few incentives to consider price when choosing providers because they typically pay the same out of pocket if they use an in-network provider. On the quality front, few consumers believe that quality differs significantly across providers and that these differences can have serious—even life-or-death—consequences. For public and private payers seeking to encourage consumers to use quality information when choosing physicians, hospitals and other providers, a critical first step is to raise consumer awareness of the existence and serious implications of provider quality gaps.[3]

If consumers come to believe that ignorance of provider quality can be hazardous to their health, then there will be a much firmer foundation on which to build transparency initiatives that help patients choose providers wisely and inspire physicians, hospitals and other providers to improve their performances.

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[1] Ha, Tu, and Johanna Lauer, *Word of Mouth and Physician Referrals Still Drive Health Care Provider Choice*, Research Brief No. 9, Center for Studying Health System Change (December 2008).

[2] McKinsey Global Institute, *Accounting for the Cost of US Health Care: A New Look at Why Americans Spend More*, (December 2008); Anderson, Gerald F., and Bianca K. Frogner, "Health Spending in OECD Countries: Obtaining Value Per Dollar," *Health Affairs*, Vol. 27, No. 6 (November/December 2008).

[3] Hibbard, Judith J., and Gregory L. Pawlson, "Why Not Give Consumers a Framework for Understanding Quality?," *Joint Commission Journal on Quality and Safety*, Vol. 30, No. 6 (June 2004).

The move toward greater transparency in health care reflects the confluence of two major trends. One is a development throughout society that institutions need to conduct themselves in a more open and accountable manner. The other is the health care consumerism movement, which envisions consumers assuming more responsibility for and control over their health and health care. To move from the vision of health care consumerism to reality will require credible and accessible information on a wide range of issues, from evidence on what diagnostic and therapeutic strategies are effective to how providers compare on dimensions of cost and quality.

Unlike price transparency, where consumer needs vary greatly depending on whether they are insured or not, and if they are insured, how their benefits are structured, theoretically all consumers can benefit from the same information on the quality of care provided by individual physicians, medical groups, hospitals and other providers. To that end, the potential audience for credible, understandable and actionable health care quality information is significant.

Policy makers on both sides of the aisle believe that more information on provider prices and quality could lower costs and improve the quality of care. But there are striking differences among policy makers about the magnitude of the near-term and longer-term potential of greater transparency in health care. I continue to be concerned that the promise of transparency is being oversold and overhyped by some, creating the illusion that other steps need not be taken to address our country's serious problems with health care affordability and quality. Increased transparency is, in most cases, a good thing, but increased transparency alone cannot remedy the underperforming U.S. health care system.

PRICE TRANSPARENCY

In theory, price transparency is a powerful tool. Consumers could save money by using price information to choose a lower-priced provider. If enough consumers change providers on the basis of price, providers that lose patients will be motivated to reduce their prices, in many cases by increasing efficiency. This market dynamic could benefit many additional consumers—even those that don't consider prices when choosing providers.

But many factors limit the potential of price competition for medical services. Most insured people have benefit designs that do not reward choice of lower-cost providers. Modest-sized deductibles and copayments of any size mean that what the consumer pays does not vary by the provider used. Coinsurance, which is becoming a more significant feature of benefit structures, provides some incentive to consider provider prices, but price differences are typically diluted by the 70-80 percent of the bill paid by insurance. Even very large deductibles are typically exceeded by most hospitalized patients, and out-of-pocket limits blunt the incentives of coinsurance. Indeed, we know that over a year, 10 percent of persons account for 70 percent of spending, meaning a large portion of medical spending is probably accounted for by patients beyond the influence of these price incentives.

Much of the price information available to consumers is not provided in a useful and actionable form. A patient contemplating a knee replacement does not want to know the price of each service that will be provided in the hospital, but rather the total cost of the procedure, including the hospital stay, physician services and any needed rehabilitation after discharge. Fortunately,

efforts to provide hospital price information have evolved from lengthy price lists to ranges of costs per admission for a small number of common procedures. Likewise, the individual price of a physician visit or other service is not very helpful to consumers because the cost of physician care varies both by the number of services provided and the price of services. A physician can have low fees but be an aggressive prescriber of diagnostic tests, especially those that can be provided by her practice.

Many state governments and the federal government have attempted to provide information to consumers on price. This tends to be irrelevant to the large majority of insured consumers, where what they pay depends on their benefit structure and the prices that their insurer has negotiated with providers. Even those without insurance are increasingly offered discounts by hospitals that are unlikely to be picked up in these data. Sometimes, the data are simply not accurate enough to be useful. An effort by the state of Florida to provide retail prices of common prescription drugs at retail pharmacies was hobbled by incomplete data.[4]

Lack of Quality Transparency Hinders Price Transparency

One of the most significant barriers to the effectiveness of price transparency is the limited information available on provider quality. People are understandably reluctant to choose a provider on the basis of price when they do not have sufficient quality information. Although consumers are used to making trade-offs between price and quality when buying many goods and services, few are willing to do this when their health is at stake. Indeed, with experience outside of health care that lower prices are often associated with lower quality, many consumers will be reluctant to choose the lower-cost provider without assurance that the quality will not be lower. So the impact of price transparency is likely to be limited by the state of quality transparency, which, as I discuss below, is improving but still rudimentary and not very consumer-friendly.

Consumer attitudes about the relationship between quality and price underscore a potential unintended consequence of greater price transparency. Some consumers will see price as an indicator of quality and shift toward higher-priced providers—the opposite of the intended effect. This risk is greatest at the present state of price-transparency development because current benefit structures don't discourage using higher priced providers—patients typically pay the same out of pocket whether they use a low- or high-cost provider—and there is little useful information available on provider quality.

Too Much Transparency Can Lead to Higher Prices

Another unintended consequence of price transparency is the potential to impact market dynamics in a way that leads to price increases. It is well known in U.S. and international antitrust circles that in concentrated industries, price transparency can lead to higher prices.[5] When prices are posted, sellers know that price cuts are more likely to be matched by

[4] Tu, Ha T., and Catherine Corey, *State Prescription Drug Price Web Sites: How Useful to Consumers?*, Research Brief No. 1, Center for Studying Health System Change, Washington, D.C. (February 2008).
[5] Ginsburg, Paul B., "Shopping For Price In Medical Care," *Health Affairs*, Web exclusive (Feb. 6, 2007).

competitors, so the opportunity to raise revenues by cutting prices and gaining market share is diminished.

To avoid disclosing negotiated prices directly, some insurers have developed tools to allow enrollees to estimate their expected out-of-pocket costs for a number of common inpatient and outpatient procedures and diagnoses. These tools typically bundle the physician costs, facility costs, anesthesia, labs and other ancillary services for an episode of care. For example, the Anthem Care Comparison demonstration tool provides this information based on negotiated provider payments for common procedures at in-network hospitals and outpatient facilities by geographic area. The tool also has a guide instructing consumers how to apply the specific copayment and coinsurance provisions in their benefit structure, allowing them to estimate their out-of-pocket costs at different hospitals or outpatient facilities.

The state of New Hampshire goes the farthest by publishing data on per episode hospital costs specific to each of the major insurers in the state, although its initiative is controversial because of the risk that hospital access to insurer-specific payment information could lead to higher prices. HSC is beginning a study of this initiative to examine market responses to the price transparency.

Physician Ranking Programs

Many national insurers have developed physician ranking programs, or some type of narrow, tiered or high-performance provider network. The underlying premise of these initiatives is to measure physician performance based on quality and cost metrics that can be assessed using plans' claims data and making the results publicly available to enrollees. Most often, the results are used only to inform consumers; in some cases, consumers have incentives, such as reduced copayments, to use the higher-performing physicians.

In these programs, quality and efficiency improvements are achieved to the extent that patient volume shifts to higher-performing physicians as a result of changes in physician referrals and consumer choices and lower-performing physicians improving the care they provide. These initiatives have been limited by fragmentation in the insurance marketplace. With each insurer developing its own methods for classifying physicians and having only its own claims data to draw on, the effort has not been credible with physicians.[6]

There are a number of opportunities for government and insurers to make price transparency more effective. For example, if insurance benefit designs emphasized incentives for choosing lower-cost providers, price data would become relevant to many more consumers. And if insurers, including Medicare, pooled claims data on physician performance and used common measures and protocols to designate physicians as higher performing, a much more accurate assessment of physician performance would be possible.

[6] Draper, Debra A., Allison Liebhaber and Paul B. Ginsburg, *High-Performance Health Plan Networks: Early Experiences*, Issue Brief No. 111, Center for Studying Health System Change, Washington, D.C. (May 2007).

Out-of-Network Price Transparency

Many insured consumers are enrolled in preferred provider organizations (PPOs) or other types of health plans that allow them to seek care from providers outside their insurer's network. When consumers use non-network providers, they typically have higher cost sharing and are at risk for balance billing, or paying the balance of provider charges that exceed the usual and customary payment allowed by their insurer for out-of-network care.

Insured consumers going out of network for care have little information about what physicians charge or how much their insurance will pay. The recent settlement in New York over allegations that many insurers artificially suppressed out-of-network payments resulted in funding an academic center to analyze charge data from insurance claims and could lead to better consumer information on typical charges for out-of-network services. Insurers could provide value to their enrollees by providing better information to enrollees about their expected out-of-pocket costs when using out-of-network providers.

Payment Reform and Price Transparency

Interest is growing in moving away from fee-for-service payment, the dominant payment method now used by Medicare and other payers. Provider payment reform could make price transparency more effective. Medicare is well positioned to lead efforts to move toward so-called "bundled payments," where instead of paying piecemeal for care, payment for major acute episodes of care would be combined to cover all services of physicians, hospitals and other providers. Likewise, there is growing interest in moving toward partial capitation, or a fixed per-patient, per-month payment, to compensate physicians and others for time spent more proactively managing the care of patients with chronic conditions. Upcoming Medicare demonstrations of the patient-centered medical home concept will take this payment approach.

Private insurers could either follow Medicare's lead in adopting such methods or work with Medicare on these changes. A reformed payment system would provide much more meaningful units for pricing and permit benefit designs that more effectively engage consumers in comparing provider prices.

QUALITY TRANSPARENCY

Providing data on quality is much more challenging than providing data on prices, but the potential rewards are large. The challenge comes from the complexity of measuring quality. Meaningful outcome measures are often lacking, shifting the quality focus to measures of process, or how often patients receive recommended treatments associated with better results; provider credentials; and patient satisfaction. The wide range of process measures is difficult to condense into summary measures that are meaningful for consumers. Much more information is available on hospital care than on services provided by physicians. A particularly important challenge is that patients have not shown a great deal of interest in quality data. As stated earlier, research suggests a lack of awareness by consumers about the extent to which quality varies from one provider to another is a major barrier to greater consumer use of comparative quality information.

Inspiring Providers to Improve Performance

Until consumers are motivated to use quality information to choose providers, the main value of public quality reporting will likely be to motivate providers to improve their performance. For example, the Centers for Medicare and Medicaid Services provide reporting hospitals with more detailed comparisons of their quality indicators to national norms than are available to the public. This is designed to support hospitals' efforts to improve quality. Experience with publication of provider quality data that providers are very responsive in the sense that they take steps to improve whatever dimensions of quality they are being measured on. For example, HSC site visit research has found that hospitals devote substantial resources to improving aspects of quality that are reported to the Medicare program or to the Joint Commission.[7]

The potential for providers to make use of quality data will expand in the future. For example, if reliable data were available on the quality of care of specialist physicians, primary care physicians would have a stronger basis for making referral recommendations. Health plans have begun to use quality data to support incentives for enrollees to choose among physicians in their network, but they could go much further with more useful quality data.

Roles for Government and Private Sector

Government has an important role to play in advancing quality transparency. Public reporting requirements or incentives generate the necessary raw material for transparency. Government tends to have more credibility in this area than other entities, especially when providers and consumers have "a seat at the table" when programs are designed. Government can also play the role of convener. For example, to prepare for payment reform, the federal government could convene provider leaders and private insurers to work together on such projects as developing episode groupers that would be used by all payers. Providers would be more accepting of these reforms if they played a role in developing the measures and believed that all payers would use them.

The private sector can also play a role in quality transparency by analyzing publicly available data and communicating it. Opportunities exist for both not-for-profit organizations, such as Consumers Union, which is trusted by many consumers, and for commercial data vendors, such as Web MD. Indeed, private insurers often contract with these commercial data vendors to communicate publicly available quality data to their enrollees.[8] Outsourcing the activity to entities with more experience in communicating to consumers is one motivation, as is the brand name that these entities have with consumers.

Although outside of the scope of this hearing, I want to raise the connection between quality transparency and effectiveness research. With quality transparency measurement so focused on

[7] Pham, Hoangmai H., Jennifer Coughlan and Ann S. O'Malley, "The Impact Of Quality-Reporting Programs On Hospital Operations," *Health Affairs*, Vol. 25, No. 5, (September/October 2006).

[8] Tynan, Ann, Allison Liebhaber and Paul B. Ginsburg, *A Health Plan Work in Progress: Hospital-Physician Price and Quality Transparency*, Research brief No. 7, Center for Studying Health System Change, Washington D.C. (August 2008).

processes, it is limited by the current state of evidence on which diagnostic or therapeutic strategies improve patient outcomes. There are risks that quality measurement will push medical practices in directions that ultimately turn out to be at odds with evidence not yet discovered. So progress in developing the evidence base for medicine will increase the value of engaging consumers and providers to respond to quality and price transparency.

CONCLUSION

In conclusion, increased price and quality transparency has the potential to increase the value obtained from our now underperforming health care system. But both are at very early stages—where the benefits are probably very small. These tools will get better and may have more impact over time, especially if government takes wise steps to support them. Progress in other key policy areas, such as provider payment reform and effectiveness research, will be very important to realizing the potential of greater transparency. But there is also the risk of overselling the near-term or long-term potential of greater transparency so that we delude ourselves that other steps are not needed.