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clearing the way for transparency in health care

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In August, during a stop in Minnesota, President Bush "went public" about transparency—urging that better information be made available to the public about the costs and quality of health care. The president then signed an executive order requiring four federal agencies to compile information about the price of care and the quality of care they receive and to make that information available to the public and to each other. The four agencies are the Department of Health and Human Services, the Department of Defense, the Department of Veterans Affairs, and the Federal Employees Health Benefits Program.

These agencies are directed, where possible, to complete four actions:

> Make their information systems "interoperable"—i.e., be able to interact with each other.
> Enact quality measurement programs that have developed with the private sector.
> Make price information on common procedures available to beneficiaries.
> Identify practices that promote high-quality care.

"I think the new trend in medicine is going to be to encourage transparency in pricing, as well as transparency in quality ... How do we encourage consumerism? ... Well, one thing you do is you make sure people understand their options, how much something costs."

—President Bush on Aug. 22, commenting on healthcare transparency before signing his executive order promoting quality and efficiency in federally administered or sponsored healthcare programs

The executive order also specified that these actions should not incur additional costs to the federal government—a point that may not please those private-sector providers that continue to look to the federal government to pay for such efforts.

This event represents an important next step in the administration's campaign to increase transparency in health care. Earlier in 2006, the president participated in a panel discussion at HHS, which had been arranged to promote the availability of information on price and quality. Increased availability of information along with the expanded use of consumer-directed healthcare plans have become a centerpiece of the administration's strategy to use market forces to moderate spending on health care.

Activities to Date

Many organizations are working on making this type of information available. In June, the Centers for Medicare and Medicaid Services started making available pricing information for 41 procedures performed on an inpatient basis in hospitals, and in August, CMS began making available the amounts it pays for 61 procedures performed at ambulatory surgery centers.

Private insurance companies have also become actively involved. In the summer of 2005, Aetna started disclosing to its members the fees it had negotiated with physicians in Cincinnati for 600 common procedures. This August, Aetna started providing price information on 30 of its most widely accessed services to its customers in the areas of metropolitan Washington, D.C., South Florida, and Kansas City, and in several other markets. The company also began to include quality information on physicians in its plan. Quality ratings are available for physicians who specialize in 12 areas. The quality ratings include a measure of efficiency that compares physicians' total claims experience for a particular condition.

In January, Humana took the lead—with other insurers, including United Health Group, following suit—in posting information on a web site for the employees of 200 firms in Illinois and southeast Wisconsin on prices for 30 inpatient and six outpatient procedures. Unlike the information initially provided by Aetna in Cincinnati, this information bundles the data from physicians and hospitals to approximate as closely as possible the cost of a medical episode.

United Health Group uses a somewhat different strategy on its web site to inform its customers. It seeks to provide "directional

guidance" using a star rating system to indicate the names of physicians that pass its quality screens (one star) or quality and efficiency screens (two stars). The assessments cover 21 specialty areas of focus and use severity adjustments and medical episode analysis. By the end of 2006, United plans to have similar types of ratings of all hospitals in its networks based on the hospitals' cost efficiency and quality of care.

The increased focus on healthcare quality ratings has helped fuel the growth of businesses that specialize in assessing healthcare performance, such as the Golden, Colo.-based HealthGrades, which provides healthcare reports on physicians, hospitals, and nursing homes and cost information on 55 medical procedures. HealthGrades provides information on out-of-pocket costs, average negotiated rates by insurance plans, and noninsured rates.

This year also has seen the start of a pilot program called "Quality Health Improvement," designed by the Ambulatory Care Quality Alliance and involving both CMS and the Agency for Health Quality and Research. Under the program, grant money will be given to six states to provide hospital ratings to hospitals, employers, and insurers. The ratings will be based on cost, effectiveness of care, and patient outcomes for various medical conditions.

More generally, 32 states have passed laws that require hospitals to report what they charge for various procedures. One problem is that these data reflect the "list" price, which is usually very different from the rates negotiated by various insurance companies, and which therefore may not provide employees/patients with a sufficiently complete picture for informed decision making.

A Big Challenge

Most providers support the concept of transparency in principle—somewhat less in practice. They worry that the data will be inaccurate or misinterpreted. And although there are skeptics who think providers would just as soon not have this information readily available, there are legitimate issues of concern. One is the appropriate unit of cost. For example, it is not physician fees per se that reflect the total cost of care; rather, it is the costs associated with the entire medical episode that are most relevant, even though patients and insurers may be more interested in the component information, including physician fees. Shifting the focus to episode-of-illness costs may take time as these measurements are just beginning to be used.

It also is important to provide information on quality and outcomes as well as on price, however defined. Quality and outcome measures also need to be adjusted for patients' severity of illness. Measurements in these areas are even less well-developed than cost measurement, but many groups are hard at work to rectify this problem.

Will the Information Be Used?

The problems with cost/quality measurement and reporting will improve over time as long as interest in making such information available continues. The question that remains is whether purchasers—be they health plans or patients—will use the information. Health plans are already indicating a real interest, as a strategy to both moderate spending and improve patient safety. Patients have appeared less interested, but with the growth of consumer-directed health plans and health savings accounts, it is likely that their interest will soon increase substantially. ●

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