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Ask the Experts:
Price Transparency
July 25, 2006

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LARRY LEVITT: Larry Levitt, kaisernetwork.org. Welcome to "Ask the Experts," our regular interactive web show that provides in-depth discussion of current health policy issues and allows you to interact directly with the nation's top policy experts.

The Internet has transformed how we buy many everyday products. We comparison-shop and make plane reservations using Expedia or Travelocity. We purchase books and music on amazon.com and Itunes. Or we can bid and buy just about anything on Ebay. Yet, in healthcare, not only do we not shop around ahead of time to compare prices, most of us can't even make sense of bills from doctors and hospitals after the fact.

Some believe the nature of healthcare defies traditional market forces. We have relationships with particular doctors and the moment at which we need care is hardly the time when we're likely to start shopping around. Others believe that's all about to change. With the growing movement toward high-deductible health plans and health savings accounts, many patients find themselves paying a bigger share of their healthcare expenses out of their own pockets. And, as part of this effort to make the health system more consumer-driven, policymakers and health plans are looking to create more of a medical marketplace.

To explore this drive to make healthcare prices more transparent, we're joined in the Kaiser Family Foundation's

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broadcast studios by an exceptional panel of experts. Chuck Cutler is National Medical Director for Quality and Clinical Integration at Aetna and was previously the Chief Medical Officer for the American Association of Health Plans.

Bob Doherty is Senior Vice President for Government Affairs and Public Policy at the American College of Physicians, which represents 100,000 internists nationwide.

And Jerry Anderson is a professor at Johns-Hopkins University and a widely regarded expert in hospital pricing.

You can reach our panel of experts in two ways: email your questions to ask@kaisernetwork.org or call us here in the studio and ask your question on the air. You can phone toll-free at 1-888-KAISER-8. That's 1-888-524-7378. Thanks to all of you for joining us.

And, Chuck Cutler, let's start with you. Last year Aetna launched a pilot program to disclose healthcare prices in Cincinnati and you've recently announced an expansion of that program that will start shortly. Give us a sense of what's involved in this initiative.

CHARLES M. CUTLER, M.D.: Sure. As you said, Larry, the increase in the consumer sharing expense has made it more important for consumers to understand what their expenses are going to be. At this point, there are over 3 million people on those kinds of health plans, so we felt that it was important to try to provide people with information that would allow them to choose physicians and understand what the costs of

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healthcare were.

Well, we wanted to do this in a way that was reasonably sensitive both to doctors and patients, and to be understandable to patients. So our first step was to provide prices for about 30 different services for each specialty in the Cincinnati area.

LARRY LEVITT: And these are prices for individual physicans?

CHARLES M. CUTLER, M.D.: These are prices that we pay individual physicians, so one of the questions that we've gotten is, is this the usual and customary rate, is this an average for the area? No, it's actually the individual prices specific to that physician. So, if you're an Aetna member, you can go to the web site and look up individual prices for physicians in the Cincinnati area and see, for each type of visit, what a visit will cost you for those services.

LARRY LEVITT: And, as you said, it started in Cincinnati and is being expanded to other communities next month?

CHARLES M. CUTLER, M.D.: That's right. In August, we plan to have the same information available for about 70,000 physicians nationally. And we'll also be adding for the first time some information about efficiency and quality.

One of the things which we heard, which we expected to hear, was that people don't want to make decisions based on price alone; they'd like to have information about quality.

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And, so, we're attempting to provide some level of information about quality and efficiency for physicians as well.

We already have a lot of information about quality for hospital care available on our web site, but people are asking for more information about physicians.

LARRY LEVITT: And you talked about the growth in consumer-driven or high-deductible health plans as being something of the impetus for this, but, [inaudible] I know this has gone further than other health plans in the marketplace. What drove you to, I assume, see this as a competitive advantage?

CHARLES M. CUTLER, M.D.: Well, right now it's a competitive advantage. We actually had anticipated that a number of health plans would follow us. They haven't so far. We just …

LARRY LEVITT: It's either a loan [ph] or it's an advantage?

CHARLES M. CUTLER, M.D.: Well, that's right. I'm sure that there were some health plans that we're concerned about how this might be perceived. We spent a lot of time talking with physicians in Cincinnati before we did this. What we didn't want to do was have a worsening of relationships with doctors or to do something which might make their lives more difficult. And it turns out, actually, in talking to doctors, that they had a number of suggestions about the format and how we showed things that they thought would reduce some of the

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burden that they might get in terms of additional phone calls or questions because patients didn't understand the information. And they wanted it to be very clear what it was that we were describing. We didn't use CPT codes, we used wording that was understandable to laypeople but physicians and their office managers had a number of suggestions about improvements we could make.

So, we tried to do this in a way that would maintain good relations with the physician community as well, but we think people make different decisions after they understand the costs. At Aetna all of us now have one form of CDHP or our own health plan and I can give you lots of anecdotes of things that occurred to Aetna staff once we understood what the costs of various services were, and making different choices.

LARRY LEVITT: So you actually think people switch doctors as a result of [inaudible]?

CHARLES M. CUTLER, M.D.: Well, we haven't seen people switch doctors. For the Aetna employees the kinds of things that occurred were more use of generic drugs and other things that one might expect with a CDHP. What we have seen is a use of the web site, so we're getting between 600 and 1,000 hits on the web site, checking prices. I don't think that, for patients who have a relationship with a physician, it's necessarily going to serve to motivate people to change physicians, unless there are very dramatic differences in cost. On the other hand, when one is choosing a physician, or

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choosing to establish a relationship, it might well have an effect there.

LARRY LEVITT: Bob Doherty, you represent physicians. What's your view of the idea of health plans disclosing physician prices, first of all?

ROBERT DOHERTY: Well, I think the idea of transparency we support. I mean, I think if you look it from your own personal perspective, all of us would like to know as much as we can about the physicians we see that we trust for our health care and hospitals we go to and so forth.

I think, though, that there is too much focus on price as a predicator of cost of care. That is, knowing what a physician charges, say, for a mid-level office visit – and most of my members are primary care doctors – the regular doctor who takes care of your daily problems – doesn't tell you when you go into the office whether you're going to need a mid-level visit or the highest-level visit, doesn't tell you whether you need to be referred to a specialist or a consultation, doesn't tell you whether you're going to need laboratory testing. So, price is very different than cost of care – not that price isn't important, but price by itself I don't think gives you much in the way of accurate information to choose a healthcare professional.

Similarly, unless you know what the insurance company has negotiated with the physician what the price structure is for that insurance company, you really don't know what your

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out-of-pocket costs will be because it's really a comparison between what the insurer will allow and what the physician is allowed to charge. And that is subject to contracts and if your physician has a contract would say a dozen different health plans, each one would be very, very different in terms of its pricing structure, its allowables, how it determines what the market price is, and, interestingly, I just got an explanation of benefits, not from Aetna, from a family member, just yesterday and out of a $485.00 charge, $292.00 is not allowed. The reasons were, it said, see note, and one was that it exceeded the maximum price for that service. But there is no way for this particular health plan to know, respectively, what the price is so, even if the provider is willing to disclose their fees, there is no way that I can tell, in advance, what they allow, never mind the methodology. How close is their market rates really reflecting what the market charges for those services?

LARRY LEVITT: And, Chuck, let me just clarify, in Aetna's case, you are actually disclosing the amount, the contracted rate, between the health plan and the doctor?

CHARLES M. CUTLER, M.D.: Yes, that's right. There may be differences between plans in terms of what plans will pay. So, if someone has an HMO plan, for example, and they go to see a physician, no matter what that doctor pays, they may only pay a co-payment, so their out-of-pocket costs may still be only $10 or $20. On the other hand, if they have a PPO plan, the

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PPO plans will have different cost sharing arrangements. Again, to Bob's point, you know, that may vary, but whether the base fees to which that co-insurance is applied is what's on the web site. So, what we're showing is only network physicians, so if you go out of network, I think some of Bob's issues …

ROBERT DOHERTY: This is [inaudible] network provider, in this case …

CHARLES M. CUTLER, M.D.: ... that, if you're in network – and you obviously want to encourage people to stay in that network, then what they will pay is whatever proportion of cost sharing they have on that specific fee.

LARRY LEVITT: And, Bob, I think part of where you were going was – I mean, I think there are many different ways to approach the issue of price transparency; obviously a health plan disclosing the prices is one way, requiring or asking doctors or hospitals to disclose their fees is another way, and some of what you talked about I think points to the complications of expecting doctors to disclose …

ROBERT DOHERTY: Well, it's not so much the doctors. I'm looking from the consumer point of view. What I would like to know, if I go out of network for specialty care – in this case the example I was giving was an out-of-network healthcare professional – and if I'm going to shop around, I need to know not only what that healthcare professional is charging, to the extent that that is predictable, and that's not always

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predictable because you don't know what care you're going to need – I really need to know what the health plan is allowing, prospectively. And that information, by and large, is not available.

Another part of the denial here was internal guidelines that denied part of this service, which is appropriate, in that insurance companies do have the right, and should be looking, for medical appropriateness. And, yes, you can request those internal guidelines. If I ask them, they'll send them to me for free. But, again, in terms of my out-of-pocket expenses, without having more information about what's going to be covered or not, it's very difficult to predict.

So, I guess what I'm saying is the idea of transparency has merit, particularly if we can develop very good quality indicators, because we believe that that is at least, or more important than, pricing, and some good costs-of-care measures that are developed in a transparent manner. Like cost-of-care, some relationship between what resources are you using to deliver care to reach a certain quality threshold?

Going that direction I think makes sense, but just the idea of posting prices I think is going to be very difficult, partly because there is not a single retail price [inaudible] service.

LARRY LEVITT: And how many health plans will a typical physician be …

ROBERT DOHERTY: Depends on the market. You know,

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there are some markets were you have a dominant insurer that may have 60, 70, 80 percent of the market and of course, there's Medicare, which is huge [inaudible] internal medicine, but there are others where you've got a lot of different payers.

But, then, even within the health plan – you take a Blue Cross/Blue Shield plan which has been dominant in many markets – they have different products. They've got point-of-service plans, they've got in-network, they've got HMOs where you can't go out of network – and all of those vary in terms of their pricing structure, what the rules are if you go out-of-network and all those kinds of things.

LARRY LEVITT: Jerry Anderson, let me bring you in step back a little bit. And thinking about it, if one goal here is to moderate health care costs, is price the right thing, or an important thing, to be focusing on?

GERARD ANDERSON, Ph.D.: Well, certainly. I mean, it's either price or quantity and we've for the past 15 years almost really focused almost exclusively on quantity. I mean, we have really tried to get the length of stay in the hospital down as much as we can to get as many people out of the hospital as we can. We really focused almost all of our policy efforts both in the public side and the private side on the quantity side.

And we haven't spent much energy on the price side. And, as a result, our prices in the United States are much higher than prices in other countries and we don't have much

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price competition out there for physicians and hospitals to really compete on.

LARRY LEVITT: And you think if there were greater transparency in prices would that help to drive down prices and, in turn, costs?

GERARD ANDERSON, Ph.D.: If it was true, transparency, as we've already heard, it's exceedingly difficult to do it right but if it was done right, and people actually paid those, yes, it would have an effect. People would, in fact, feel many times outraged in how much they're, in fact, paying for certain types of health care and it would get their attention if they knew about it. But it's hard to get that information in a digestible way that they can possibility understand.

LARRY LEVITT: And you and Professor Reinhardt [ph] at Princeton have talked about an idea to standardize pricing in healthcare without necessarily standardizing the level of prices, but standardizing the way that hospitals or physicians or price – talk a little bit about how that might work.

GERARD ANDERSON, Ph.D.: Well, essentially, as for the uninsured and a variety of people, there are so many different arrangements that insurers have and doctors have, but there is no standard price. So one thing that you could consider is essentially say, "We charge at X percent of what Medicare pays, so we, essentially, charge 125 percent of the Medicare rate," or something, and that would give people one number to compare on. Right now you've got 30 different prices; probably you

don't have any one of those. Yeah ,they're the most common ones, but a lot of things that you need you wouldn't have. It's really hard for somebody to look at 30 prices when many of those things they'll never have and a lot of the things that are on that price list they will want to use. So you give them one number and say – a doctor says, I charge 20 percent more than what Medicare pays."

LARRY LEVITT: That's across the board? Any service that I offer …

GERARD ANDERSON, Ph.D.:; That's across the board. Essentially, the Medicare RV-RVS system is a fairly well-understood one, and a lot of insurers base their payments on that, so it'd be one number that people could understand. We have a lot of other things going on in our life.

LARRY LEVITT: We certainly do. Well, we've got a lot of question by email from people who at least are focused on this today. So, let's move onto those. We have one question from California, which follows up on the point Jerry was trying to make, which was, "What efforts can be made to help consumers understand the difference between charges and costs, the difference [inaudible] will pay to the average consumer? And, Jerry, may we stay with you, in the hospital context, which you certainly have expertise in. What is the difference between charge and cost?

GERARD ANDERSON, Ph.D.: Well, essentially, in California where the call is from, it's about four to one. So,

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the charges are four times greater than what are Medicare allowable costs, which are a little bit less than actual costs, but they're fairly close. So, hospitals in California have marked up their prices about four to one. In the typical hospital around the United States, it's about three to one and there are states like Wyoming and Maryland where the rate is only two to one. So, if you are looking and trying to compare charges, it's essentially a fictitious number for most people. And it really has very little meaning.

LARRY LEVITT: And the charges are what's commonly publicly available now in some states, right?

GERARD ANDERSON, Ph.D.: Yeah, in hospitals and increasingly on physicians. And, essentially, it's an activity that the 45 million uninsured pay, but it's a rate that virtually no one else pays. And so it provides very little information. I mean, Aetna pays a much lower rate to hospitals than actual charges for most everything.

LARRY LEVITT: And, Bob Doherty, is that true amongst physicians as well, that there is a walk-in rate or a charge that …

ROBERT DOHERTY: I mean, I think they try to have a retail fee, although I think nowadays it's less meaningful because – see, Medicare is price controlled, so physicians have no discretion in Medicare other than whether they choose to be a participating physician and set the allowables [inaudible], or they're not, but still their rates are regulated.

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For the private sector, yeah, most of them, if you ask "For your top 10 procedures, what's your charge?" they could give you a charge. My point earlier is that it doesn't tell you very much about what that means in terms of your cost of care or what the insurance company will allow or what your out-of-pocket expenses will be.

Another major concern that we haven't discussed that I think is important is [inaudible] high-deductible plans may introduce some price sensitivity, which could be a good thing, but there are studies that suggest that high deductible plans may also cause the individual to forego preventive care and primary care services. So it can actually be counterproductive in that sense.

And then the other issue is, I think, price sensitivity works better when you're looking for an elective procedure. We can use the example of Lasik which there is price sensitivity; it's advertised all the time. But if you're in the last few months of life where we're spending most of the healthcare dollars, and you're caught up in a system where you're sick and maybe first [inaudible] physician, maybe in the hospital, maybe you're in a hospice, and you're bouncing around, I'm not sure that people are going to pay very much attention to price at that point in their lives. It's kind of, "Let's get through this, try to get the care we need," try to make those very difficult decisions the patient or family or caregivers have to make at that point in time.

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And, so, if we think this is going to be a huge boon to lowering health care costs, I'm skeptical, because so many of those costs really happen at the end of life when you're making some very difficult and very emotional decisions and I don't think price shopping or [inaudible] price is something that's going to weigh heavily on people's minds at that point.

LARRY LEVITT: Chuck Cutler, consumer directed health plans are still relatively new, but is there any experience from the Aetna perspective that suggests how people do behave?

CHARLES M. CUTLER, M.D.: Yeah. You know, I think we are concerned about unintended consequences, as Bob mentioned, and we've actually been looking at the utilization of people in our consumer-directed plans. And, fortunately, we're not seeing the theory that you describe with people using less preventive care services. Admittedly, it's early and it's something that we're going to have to follow for a period of time.

We also need to pay attention in how these are structured. So we've taken an active role with treasury, arguing with them about the rules about what needs to be in the fund and what not, so we've actually worked with treasury to get changes to allow first-dollar coverage for some of those things which we think are necessary that shouldn't be in the fund. So, medications for chronic illnesses like diabetes would be a good example. So, we need to pay close attention to how they're structured.

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On the cost charge dilemma, I think that may be some inside baseball for people who are in the plan or hospital business, but not so much for consumers because they don't care what it costs the hospital, they care what they're going to have to pay out of pocket. Where it becomes interesting is where we start looking at patterns of care and identify where the profits are because there is no consistent relationship between costs and charges for a lot of services. So what we're finding is, as we talk with physicians about improving efficiency of their practice, that some of the things that are causing the inefficiencies may have a higher charge-to-cost ratio. That's where they're making some of their money. So, we need to figure out other ways of paying so that it's financially viable for the physicians to do the things that add the most value and that's something else that we're actively engaged in as well.

GERARD ANDERSON, Ph.D.: Well, I think what you've got is a very different thing between what Aetna's done and put on their web site, at least for their members, essentially what it actually costs Aetna to provide care for somebody. Whereas, if you go on the hospital websites and a number of the state associations, what you'll see is actual charges, which are four times what most insurers in California actually pay. So, providing that information out there to the consumer provides them very little information. So, you are doing the right thing, I think. Most of the hospital associations are really

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providing information, but it has relatively little value, in terms of comparative shopping, to a consumer.

ROBERT DOHERTY: I just want to make one comment, though, about high-deductible plans again. Patients who are near the end of life or patients with multiple chronic diseases are probably already using the deductible. So, part of the question becomes, again, this sort of transparency consumer-directed movement. How useful is any of this when you've already met your deductible because either you're at the end of life or you're a patient with congestive heart failure or diabetes, three or four medical conditions, you've already met your deductible …

LARRY LEVITT: Which means you're not paying …

ROBERT DOHERTY: … [inaudible] price sensitivity any longer because, basically, then you're within the insurance coverage, what they'll allow for those services, maybe they'll be denials based on medical necessity criteria, it's a different world.

And, again, if you'll look at where the healthcare spending is going, patients with multiple chronic diseases, 66 percent of Medicare dollars go to patients with four or more chronic diseases, probably similar in the private sector, and the end-of-life care, the amount of money we're spending. So I guess the point of my skepticism is not to say that informing patients isn't good. I think we all want that information. But the idea that it will dramatically lower health care

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spending in this country, I'm a skeptic, partly because so much money we're spending is on very sick patients with multiple chronic diseases and people at the end of life.

LARRY LEVITT: And, Chuck, is there a typical patient who you think is the best target for the transparency initiative? I mean, is it the person with a couple of primary care visits a year, the chronically ill patient with diabetes or asthma or the person with a one-time catastrophic illness?

CHARLES M. CUTLER, M.D.: Yeah, I agree with Bob. I mean, I don't think that consumer-directed health plans is the cure-all for controlling healthcare costs. I think we need to look at this in multiple ways, that the consumer-directed plans affect the initial spend that people have, so, to the degree that that encourages people to switch from brand name to generic drugs, or to be more careful about their use of emergency rooms when they could visit their primary care physicians and so on. I think those are the kinds of changes that we'd like to see people make and I think that can produce significant savings.

In terms of whether it's going to affect catastrophic expense, I agree in that I think once you hit your out-of-pocket maximum, it's not going to control catastrophic expenses. We need to look at rational design for both the well people and the people when they start spending and in more catastrophic situations, again, to talk a little bit about what we're doing, we've looked at end-of-life care and what we've

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seen is that people, at the end of life, have various barriers to doing things which would provide them with better care, with good palliative care, and do it in a way that doesn't penalize them. So, we've actually also implemented an end-of-life care program that allows people to continue to get curative medicine. They don't have to give up hope. They don't have to give up their curative medicine, but they can continue to get palliative care at the end of life, because we think that's also a more rational approach. So, one cure doesn't work here; we need to attack the various problems.

LARRY LEVITT: Well, maybe our next show we can [inaudible]. [inaudible] bring our audience. We have enclosed are caller on line from Maine. Caller, please go ahead, if you're still there?

MALE SPEAKER: Yes. Hi. The gentleman from Aetna mentioned the amount that's posted is the actual negotiated amount. I was curious about providers' willingness to disclose that and really also Aetna's willingness inasmuch as the parties to a negotiation might consider it proprietary information and that if one physician knows that the physician down the street is going to be [inaudible] at X, that physician might say, "Well, I'm not going to participate in your network unless you also pay me that much."

And then, also, as far as Aetna's willingness, basically, to disclose to other carriers in the Cincinnati area what they've negotiated, what are the concerns about this being

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proprietary information and undermining negotiating ability?

LARRY LEVITT: Thanks for your question. We've got a number of email questions on this general topic as well. Chuck, first, did you talk to the doctors? I mean, did the doctors have to give their permission to have this disclosed? Or is this simply Aetna's information that they're disclosing?

CHARLES M. CUTLER, M.D.: Well, it's Aetna's information that we're disclosing, but we did talk with the doctors, as I mentioned, and we did explain what it was that we were going to be doing and we showed them the formats. I have to say that, other than having some very constructive suggestions about how we displayed the information, there was very little resistance to sharing the information. As the caller mentioned, I think some doctors saw this as a way of getting around antitrust concerns that the doctors have always faced.

Having said that, since then there's actually been very little or no movement for physicians to say, "Gee, I want to be paid as much as the next person." In fact, we've heard from some of the high outliers [ph] some concerns that their prices appear to be so much higher than the rest and is that going to have an effect on them. But, realistically, we haven't seen any significant movement in terms of recontracting [ph].

LARRY LEVITT: We had a similar question from an industry analyst in New York about concerns about competitive disadvantage. I mean, do you worry about – and the caller

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mentioned this as well – disclosing this not just to your members but to your health plan competitors?

CHARLES M. CUTLER, M.D.: Well, I mean, not that competitors couldn't get the information but it's not on the aetna.com web site open to everyone. In order to get the information either you have to be a participating provider, or you have to be a member, so it's on one of two secure web sites. If someone really wanted to, I'm sure they could collect the information in some way. So it's not that we're broadcasting the information.

Secondly, we feel that there are a whole series of things which go into the total price of care. In addition to the cost of the office visit it's all the medical management services; it's the other kinds of things that we offer as a health plan in terms of health plan value. In the end what we thought was that the risk of it having adverse consequences was less than the value of showing prices to people on being transparent. So one of the reasons why we did it one market was to give it three to six months to be able to evaluate what the effects were. And we feel comfortable now in moving ahead in other parts of the country.

LARRY LEVITT: Okay.

MALE SPEAKER: I have a question for Chuck. And, essentially, what it is is, if we look at high quality and what we see is people don't really go to the high-quality providers, because they don't always trust the measures, but the doctors

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who are perceived to be the low-quality doctors, they either leave that particular area or they do something differently. So the publishing of quality information has more of an effect on the doctors than it does a lot of times than on the patients.

Now, you said, some of the very expensive doctors realize that they're very expensive. Are you seeing any evidence that they're going to start lowering their prices as a result of being identified as, and knowing for the first time, potentially, that they are very expensive?

CHARLES M. CUTLER, M.D.: The short answer is no, but it's too early. But let me give you a different kind of example. One of the other things that we're doing simultaneously is having a selective network which is, in part, based on efficiency, which is, in part, related to costs. There we've had conversations with physicians who are apparently less efficient than their peers and we have talked with them, if they're not included in the network, about the reasons why.

What we're able to tell them frequently is reasonably specific, so they're not in the hospital if they're a surgeon frequently because they use inpatient surgery facilities when they could be using outpatient surgery facilities, for example, or they order duplicates of testing, or there are a series of reasons which are specific for that practice.

When we start having those discussions, then doctors do

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say that they'll change their behavior and, in fact, we've had a very nice experiment with the Virginia Mason Clinic in Washington that's totally revised how they provide care for low back pain in order to be more efficient.

So, I think we're taking small steps in a number of different directions and the key to me, actually, is engaging both consumers and physicians and looking at what they do to try and get that additional value, because, from the economist's point of view, disclosing of the high-cost doctors – and if they feel any pressure to lower their prices – that would be a positive thing in terms of [inaudible]. If they don't, however, change their behavior, then the disclosure of prices is just disclosing of prices.

ROBERT DOHERTY: I want to go back to the issue of quality [inaudible], because what I said before, I think there's too much emphasis on price disclosure by itself as being a very good way of introducing market forces or competition or consumer decision making in health care. I do think providing quality data is extremely important. And the American College of Physicians is involved in a [inaudible] effort through a group called [inaudible], Quality Alliance, which is a multi-stake holder group that includes physicians' health plans, including Aetna, large employers, ARP, to develop good evidence-based quality measures, get them out there and then actually develop models for recording that information back to the public.

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LARRY LEVITT: And then are you comfortable having physician-specific quality measures?

ROBERT DOHERTY: Yes, we're very comfortable doing that, partly because the process is transparent itself. There are no black box measures, everybody's at the table betting these measures and there's a pilot test going on at six sites around the country [inaudible] Quality and AQA are doing [inaudible] test ways of disclosing this information in a meaningful way to consumers. And my point is it's extremely important that the profession be at the table in developing the measures that'll be a multi-signal to process and especially as you move to cost-of-care measures. For people to have any confidence in those measures I think they're going to need to be developed in a transparent manner also, and not be black box measures that an insurance company has purchased where the physicians and the consumer can't see what is the basis for that measure.

The other point I wanted make is that a huge problem in this country with healthcare illiteracy. Not just illiteracy, but healthcare illiteracy -- people who can't even read the instructions on the back of an aspirin bottle. And we have a foundation that's working on a whole medication labeling project to deal with that. The challenge of trying to provide meaningful information about quality, cost of care, patient experience with care to patients who are medically illiterate is huge. And I think we shouldn't be overconfident that we

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know how to do that right now.

LARRY LEVITT: Let me ask you – we had a question by email from Kansas about this. What is the best way to present this information to consumers? On the Aetna – there is a demonstration on our website that links to an Aetna demonstration that the actual dollar amount for different kinds of visit and services is – I mean, I'm assuming you all did some research about, is that the right way? Should it be one dollar sign versus three dollar signs or?

CHARLES M. CUTLER, M.D.: Well, we did some research and what we found was that the formula that we're using was accessible to most people. I agree wholeheartedly with what Bob was saying about health literacy, which is a very serious issue which affects a larger proportion of the population than I think most physicians realize.

Having said that, I think there are limitations to what we can do with a web site presentation that may always pose some challenges for people with limited literacy. So, we need to take some steps in order to get the information out and, essentially, do the best that we can.

I also agree that we'd love to have quality information on a physician-specific basis and we do now have quality information for those physicians who have fulfilled the requirements for the Performance Recognition programs that NCQA runs. And that information is available on our web site and we're looking forward to the pilots with AQA and hope to have

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more information there as well.

We don't, as a health plan, want to develop quality measures. All the quality measures which we use and measures that we like to display are ones that come from the profession – either the colleges or national quality forum or HRQ or some other source – and, ideally, what we've heard in the research since we put the cost information, is that what patients really want is the other quality information that Bob talked about. One – although this usually doesn't come out first -- is the technical quality information. Usually what comes out first is the member experience with care information, which is even more difficult or more expensive to collect, but easier to understand by the consumer.

LARRY LEVITT: Bob, let me ask you. You represent internists and would you imagine there are even bigger issues among some of the specialties in being able to assess quality on a physician-specific basis and, in particular, being able to compensate for the fact that some providers may have a sicker than average population? And how does that show up in the quality measures?

ROBERT DOHERTY: Well, actually, it's very complicated for internal medicine because internists take care of so many patients with multiple chronic diseases, and so most of the measures you have right now are specific to a disease [inaudible]. So you may have three or four measures for diabetes. What you don't have are good measures that deal with

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the patient who has diabetes, asthma, congestive heart failure, and so forth, and try to come up with a reasonable number of measures, but also not overloading the physician in terms of how many measures he or she may have to report on.

We figured out that a typical internist might have to report on a dozen or so measures on a patient within a single encounter, depending on how many chronic diseases that patient has. So it's hugely challenging. And case [inaudible] does come up as a real concern that if you don't in some way, in the measure itself or in reporting on the measure to the consumer, take into account the difference the case makes, you create a conflict between the physician's ethical obligation that you take care of the sickest patient and not wanting too many sick patients in their panel that will then hurt them in terms of how they look on a quality measure or even more so on a cost-of-care measure.

LARRY LEVITT: Jerry, let me bring you in and talk about hospitals. We had a couple emails from Ohio and California again about what is the right hospital and how do you compare prices, even if it's the real price or the real cost for two hospitals, where one may be offering more, providing more charity care, which is then built into its cost structure, or doing more medical education, which is also built into its cost structure? What are some of the challenges in transferring this to the hospital?

GERARD ANDERSON, Ph.D.: Well, essentially, what you

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want to start with is something like the Medicare allowable cost, which is a fairly standard way to calculate costs. And then if you want to pull out the disproportionate share kinds of activities for the – and on compensated care, if you want to pull out gradual [inaudible], you can do those things in fairly standard ways. But, essentially, what you want to do is give the patient a sense, at a DRG level, as opposed to what is normally done is giving information and an individual service by service. Most patients get on a charge master file about 20,000 different items none of which most of us can possibly understand.

But what we do sort of kind of understand is that you're going to have an appendectomy and that might be into a DRG, which they'll never really understand anyway, but the bundle of services that are a standard way that all hospitals understand is comparison of bundle of services. So that's where the hospital mystery is moving, is towards bundle of services, like a DRG and then it's got the challenge of trying to translate what a DRG is to the American public.

LARRY LEVITT: We don't have that on the physician side, right? I mean there's no equivalent to a bundle of services that you get when you walk into a physician's office?

ROBERT DOHERTY: Well, I think it depends. I mean, major surgery has always had a 90-day global surgery period, so there is some bundling on the surgical side. We actually have a proposal for what we're calling a patient-centered services

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home, which will be a model for chronic disease where physicians organize their practices to provide patient centric services, self-management for patients' followup, evidence-based clinical [inaudible] and support and so forth. But we are recommending, actually, pilot testing of that with Medicare and other payers and paying a global fee for those patient-centered services, and those practices will also be accountable and transparent in the sense that to qualify for this different payer model, they would have to meet certain standards to show they could deliver patient-centered chronic disease services up front, and then they would report on quality of care measures for chronic diseases and, once their available, cost of care [inaudible] measures. So there will be accountability both at the front and the back end.

So there's movement in that direction and we think that model could have tremendous potential not only to increase transparency, because you have this front-end information, does the practice qualify, plus the measurement at the back end and paying them on a global fee for a lot of those services, but also it's oriented to that patient population I mentioned before who are chronic disease patients and are very expensive patients to take care of.

LARRY LEVITT: And, Chuck, was there any – I mean, there's, I imagine, many different goals in transparency, one being to sort of nudge the marketplace, nudge physicians, the other being to give patients some expectation of what they

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might have to pay when they walk into the doctor's office.

We had a couple emails, one from a reporter in Buffalo, about, is there any way to bundle the services together to give patients that better sense of, "Okay, I walk into the office for X type of condition; what can I expect to pay?" Is that something you all have looked at trying to do?

CHARLES M. CUTLER, M.D.: It is and, again, we learn as we go and I'll just give you one anecdote. The person at Aetna who is in charge of developing our consumer-directed plans got a statement of benefits in the mail and, fortunately, I think ours is more easily understandable, because her husband said, "Gee, what is this $90 visit to the doctor? I thought a doctor visit was $10?"

So, people have this sense that the co-payment is what something costs. And what we're trying to do, in part, was to introduce a greater understanding of what things cost. So the people have an appreciation for the services and I think, actually, an appreciation for the physician. I think it's worth more if you understand what it is, but it also, we hope, will drive more appropriate behavior.

Now, having said that, I agree with Bob again that just understanding what an office visit costs won't tell somebody with diabetes what it's going to cost them for the year in order to be able to get their care. The challenge that we have there is how do we put all that together and attribution rules and all sorts of other important issues that we need to

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consider.

If we can come up with other methodologies, especially payment methodologies, which allow us to do that more easily, that’s wonderful. The example that I gave you with Virginia Mason has led us to a kind of service splicing for the range of services that they provide in a bundle, rather than for each individual service, which allows them to do it in a financially viable way and allows us to do it in a way which costs us less than it would have previously.

So, what I'm hoping is that more of these kinds of discussions will occur between physicians and hospitals and health plans so we can come up with a new strategy that will both be more transparent and also allow us to price more appropriately.

ROBERT DOHERTY: When you’re talking about cost of care, too, it’s not just the cost to the physician. Take the case of a diabetic. And if the physician can help that diabetic control their blood sugar, preventing complications that lead to amputation and hospital admission, there is a savings in terms of cost of care and certainly improvement in quality of life for that patient. So if you’re just measuring cost on the physician’s side without taking into account the impact on other parts of the healthcare economy and the other sectors, like the hospital side, it’s going to be misleading.

So, again, it’s going to be very difficult because you have the whole attribution issue to show that what the

physician is doing directly had an impact in terms of avoiding complications leading to hospitalization, which you may not know for four or five years down the road. But it's a very important part of this because we if you really want to create a more efficient healthcare system you need to find a way to take that into account.

CHARLES M. CUTLER, M.D.: We can always globally decapitate [ph] physicians for (laughter).

LARRY LEVITT: [inaudible] we've been down that road, and you could do that, but what Bob was suggesting is that not only are they saving physician time but they also are saving hospital time, so then do you take some money out of the hospital sector when they're able to be more efficient? How do you handle that? Because you've got them responsible for a lot of the expenditures, a lot of the prescriptions drugs, a lot of the hospital care, all those things, but [inaudible] specialty care if you're an internist, but, at the same time, do you take money away from those other providers if the internist does a particularly good job? I mean, that's politically really hard to do and, essentially, to establish that it's the internist who should get rewarded for all that good activity.

CHARLES M. CUTLER, M.D.: Or penalized on the other side.

LARRY LEVITT: Or penalized.

CHARLES M. CUTLER, M.D.: Well, I should say, in full disclosure, I'm an internist, so obviously I think that the

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internist should be rewarded in some way, and in fact, internists are. You know, if you look at the experiment in Bridges to Excellence, the longest experience right now is in Cincinnati and Louisville and Bridges to Excellence is a program where physicians are paid $100 per patient in their practice if they have met the performance recognition requirements. And, so, the doctors who have met those requirements are actually being paid more and the preliminary results that I've seen from Bridges to Excellence shows a net cost savings, in part for the reasons that you described. So it’s not that we’re taking money away but, because they’re getting better care they’re avoiding complications, they’re ending up in the emergency room less and they’re ending up in the hospital less and they're having less unnecessary testing.

So, I think there are some good examples that we could build on that would lead down that road. In some of those, not all of those, in fact, Bridges to Excellence is a good example where it’s not necessarily based on disclosure or transparency, but simply a better structure for the system and better management relationships between plans and providers.

LARRY LEVITT: Which really leads to the question of who should pay for better quality? Is it what we’ve done in a lot of our pay-for-performance and other types of activities is ask doctors to take a withhold and then if they do better they get it back or they maybe get a little bit more. But that’s essentially asking doctors to pay for it, but if we believe, as

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we've been talking about now, that you, essentially, get fewer ambulatory care-sensitive conditions, fewer preventive hospitalizations, all sorts of things, maybe it's the insurance company that actually benefits from those things?

CHARLES M. CUTLER, M.D.: Or employers.

LARRY LEVITT: Or employers.

CHARLES M. CUTLER, M.D.: [inaudible].

LARRY LEVITT: Yeah, but I think there are two ways to look at that. One is those employers who are participating in Cincinnati and Louisville and the other Bridges to Excellence activities are actually doing that as incremental payment, so it's not a withhold, it's incremental to what the doctors would have gotten.

On the other hand, I'll tell you that I have had conversations with employers who said, "Why are we paying doctors to do something that they should have been doing as part of their base reimbursement?" So …

ROBERT DOHERTY: Par of the answer to that is to do it well requires you have systems in place. Most of this is not, as ILM talks about, is not having human failure, it's not having systems. So, when you talk about the diabetic patient, it's having the evidence-based guidelines at the point of care, it's having systems to follow up with them on a regular basis, to make sure they're getting the foot exam on a regular basis, all those kinds of things. Those are systems issues and there is a cost to a practice of developing that infrastructure to do

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that well. And that's where the issues of reimbursement come in. To expect people to report on the measure without having the systems in place to deliver care consistent with what's being measured is a real obstacle that has to be overcome, and there needs to be some funding for that.

LARRY LEVITT: I want to bring our audience back in here. We have another caller on the line, this time from here in Washington, D.C. Are you still there?

MALE SPEAKER: I am.

LARRY LEVITT: Okay, go ahead.

MALE SPEAKER: This is Joel Finkle [ph]. I am Washington correspondent for AAFP News and I have been covering the healthcare field long enough to wonder whether transparency, as good as it sounds and as popular a word as it is in Washington right now, isn't just another dead-end solution that we've seen before, like the managed care model or the gatekeeper models, which were sold to the government and to the public, but never really addressed the fundamental factors that are driving healthcare costs. So, I'd like to ask the panel whether this is different than those previous panaceas and, if so, how?

LARRY LEVITT: Thanks for your question. And, Jerry, maybe I'll start with you. Is this just this year's model?

GERARD ANDERSON, Ph.D.: Probably it's this year's model unless – I sound like an academic here – but unless we get the methodology right. And right now I think we're many

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years away from having the methodology right. I mean, you've heard [inaudible] just talking today for the past half hour about how difficult this activity is to do and we at Johns Hopkins and a lot of other academic places are working on this, but trying to bundle services, trying to deal with somebody with multiple chronic conditions, dealing with multiple doctors, the permeantations [ph] and commutations [ph] and measuring accountability for price, for all the services they do for quality is really, really hard.

LARRY LEVITT: And that's where the money is, in health care.

GERARD ANDERSON, Ph.D.: And those are the people where the money is. Most of the people just have one thing wrong with them or, fortunately, not anything wrong with them, but most of the dollars are in the multiple chronic conditions and that's really hard to do and we've been working on it for 20 years and we're not even close.

LARRY LEVITT: And, Chuck, is it just a fad or do you think we're here to stay for a while?

CHARLES M. CUTLER, M.D.: Well, I don't know. I've been in managed care for so long I've been called both a Communist and a Capitalist, so I see this, again, as an evolution. I think it's a step forward. And I don't think it's *the* solution, but I think it's part of the solution. And I agree with what Jerry said. We have to do it right.

I would take exception to some of the other premises

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that the caller raised, though. I mean, I don't think managed care was a failure. If you look at the cost increases over time before the introduction of managed care, I think there's been a significant impact. If you look at various quality measures, if you look at the HEDUS [ph] measures. Since HEDUS started there are huge increases in the quality of care as measured by HEDUS.

And, lastly, I think that while the gatekeeper model may not have been done right, I think what we're seeing in terms of the medical home and some of the things, actually, we've talked with the AAFP about, is the need for a primary care physician who has a long-term relationship with patients and who will help them navigate the healthcare system effectively.

And, we should try to experiment with ways of making that viable and feasible for health plans and for physicians, but I don't think that I would give up on a primary care model by any stretch.

LARRY LEVITT: And Jerry talked earlier when we started the conversation about that our focus has been on the quantity side of healthcare. Obviously we've been talking a lot today about the price side. Has there been a backsliding on the quantity side, in terms of cost and since managed care started to lighten up a little bit?

CHARLES M. CUTLER, M.D.: You know, I think there has been a significant increase in quantity, but largely in areas

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that are new. So, we're seeing, as Medicare reported as well, huge increases in the use of imaging, for example, in new technologies, some of which are duplicative and some of which may not be necessary.

On the other hand, if you look at common things, like the bed days per thousand that we see now, compared to what we saw 20 years ago, I don't think there's any question that the hospital days are significantly less than they were previously, length of stay for bypass surgery when I was a resident was there weeks and now it's five days or six days. And some of that was driven by DRGs, providing incentives for hospitals to do things differently and some by managed care.

So, I think, in terms of appropriate utilization, that I think there have been huge improvements in appropriate utilization among those things which are established. I think we're still struggling with new technologies and how best to use them.

LARRY LEVITT: Bob Doherty, you've spent your life here in Washington. What's your sense of how this is viewed on the policy side?

ROBERT DOHERTY: Well, I would not call it a panacea and I think that's become clear through the discussion today. Transparency, whether it's pricing, quality, patient experience or some combination, I think we've talked about some combination, is not by itself going to solve all the problems of chronic diseases, end-of-life care, all those kinds of

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issues, it's not going to deal with the cost shift when it happens, because we have such a large uninsured population, which I don't work for the hospitals but when we talked about their pricing structure, we're talking about the cross [inaudible] because there are so many indigent patients they take care of. There are huge problems and if we expect that transparency by itself is going to solve all that or be the magic bullet, I think we're going to be disappointed.

Having said that, I think it's here to stay. I think we are in a time where people expect to get information. You expect to get it when you're buying a car, you expect to get it when you're buying a house, you expect to get it when you're enrolling your kid in summer camp, and I think people are going to expect it and they're going to be able to get information about the quality of care that their physicians and other healthcare professionals provide, as well as to the extent that we can overcome these hurdles, some reasonable measures in the cost of care.

LARRY LEVITT: So, that's separate from what's going on in health care; that's just a byproduct of …

ROBERT DOHERTY: … of the society we live in. and I don't see that turning back. And I think it's something that the healthcare professions will embrace if it's done right.

CHARLES M. CUTLER, M.D.: I think for me the real challenge for the next 15 years or so is to see if prices actually go down in the healthcare sector. And what I see is

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the private sector not doing very much right now to bring prices down. And I tend to focus more on hospitals than I do on physicians, but I look at the MedPAC reports and if Medicare's rates are a hundred, the private sector right now is paying about $125, $130, used to be paying only $110, $115, so, for the last five years, the differential between what Medicare is paying hospitals and what the private sector is paying hospitals is growing. And if I'm looking for this price transparency and other things to bring prices down, I would expect it then to go back down over the next five years. And so, for me, the market test is the differential between what Medicare pays and what the private sector is paying for health care.

LARRY LEVITT: And, Chuck, I mean as a health plan, how come you can't do that?

CHARLES M. CUTLER, M.D.: Well, I think the health plans would argue that Medicare's rate increases have been so minimal that they're cost-shifting to the health plan and that health plans and private employers are making up the difference, in addition to the growing uninsured and that health plans and employers are making up those differences as well.

So, I think there certainly are a number of examples where, if you look at individual services, by doing things more efficiently, by shifting things to the outpatient setting, that there are lower costs for those individual services.

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For our other services which continue to be provided in the same setting, so, deliveries in the hospital, for example, I think we're suffering from some of that cost shifting and if Medicare continues to ratchet [ph] down its prices, I think it will continue to be challenging for the private sector.

LARRY LEVITT: I still wonder why you're paying 30 percent more than the Medicare program is doing and why are you feeling a need to do that?

CHARLES M. CUTLER, M.D.: See, I think we ask the hospitals that we contract with that question on a regular basis and, again, there are a number of factors: one, Medicare, the uninsureds, consolidations in hospitals. I think we would say – many health plans would say – that hospitals have a lot of negotiating leverage these days and unless we and our employer clients are willing to walk away from some hospital to get better negotiating leverage, it's going to be tough.

And so that's where the price transparency, if it's going to work, is going to come in. By disclosing those prices you may have greater leverage and, for me, that's the market test of whether this price transparency will, in fact, work. And where I see it working, mostly, is in the private sector because, as you say, Medicare sets the rates anyway.

LARRY LEVITT: [inaudible] not to put you on the spot too much, but you've been studying this for a long time. If we were going to focus on price – you're God [ph] for a moment – in the U.S., what is the best approach?

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CHARLES M. CUTLER, M.D.: Well, essentially, what I think is it's something like what Medicare does. I mean, is a rate that essentially is fully disclosed to everyone and, to the extent we can, a bundled group of services. So, for me, that's the simple answer.

ROBERT DOHERTY: And I think, on the physicians' side, linking it in some way to the resource base [inaudible] relative value [inaudible] here does make sense, because at least there is a process to establish relative values and, actually, the price paid for a lot of procedures did come down, initially, when that system was folded in. There are some reasons that it stalled in recent years and some efforts to change that, so I think some way of price sensitivity to that relative value scale I think makes sense on the physicians' side, again, if we're just dealing with the price side.

CHARLES M. CUTLER, M.D.: I think this is part of a multi-pronged strategy. We need to have transparency so consumers understand what they're paying. We need to have measures of quality and experience with care so consumers have more complete information. We need to engage physicians and hospitals in looking at what they do so they can be more efficient over time. And we need to have ways of rewarding those people who do better, like pay-for-performance. So I see this as one important component, a consumer-directed component, but only part of the picture.

LARRY LEVITT: Let me ask you, [inaudible] we're coming

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to the end of the hour – just to return to transparency – now, as we're coming to a close, as you roll out these efforts, my first question is do you anticipate expanding this beyond the communities that you're going to next month?

CHARLES M. CUTLER, M.D.: Yeah. Again, with each new experience we learn some more things and we'll make some tweaks, so it may not be exactly the same thing in all communities. We'd like to share more complete information, more quality information and efficiency information. But, yes, our plan is to do this in a kind of a progressive way so that this is the next group that we'll be making public and that we'll make more public after that.

LARRY LEVITT: And what will you be looking at to track the [inaudible] effects and track the …

CHARLES M. CUTLER, M.D.: Well, some of the things that we talked about earlier today, one is, is the information accessible to most people, do they understand it, and do they find it valuable? Are people using it?

LARRY LEVITT: Have you done surveys or consumer focus groups?

CHARLES M. CUTLER, M.D.: We did focus groups, both before and after the experience in Cincinnati. But that's one market and so relatively small exposure. We've done some work since then about what we're going to show with the next generation but, again, it's like any sort of testing you may get a small amount of information from a focus group of ten

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people, as we roll this out and get more experience and do more surveys and we ask for feedback on our web site, then we'll get more information and we'll fine-tune it.

LARRY LEVITT: And what, ultimately, would be your measure of success and if you had to pick two or three things, looking back, how would you decide whether it's successful or not?

CHARLES M. CUTLER, M.D.: Well, I think what we'd want is people to make informed decisions about where to get their care and that doesn't always mean choosing the lowest price. It may be that they are choosing a physician based on a lot of reasons but understanding the price is important to them. So, the transparency piece, even though we're only talking about costs today, because that's what's available, we hope, by having more information like quality and experience with care information, we'll allow people really to make an informed choice about the value they're getting from their health care.

LARRY LEVITT: And Bob Doherty, we talked a little bit about what's going on in Washington. You've had conversations with the administration on their transparency initiatives. The next six months to a year what should we look out for, whether it's legislation, or …

ROBERT DOHERTY: Well, CEMUS [ph] is moving forward on doing things it can do under current authority to disclose pricing.

There's actually the Health Information and Technology

Bill, that's supposed to go to the floor of the House tomorrow. I heard that there is going to be something in there disclosing hospital pricing, which I understand is being opposed by the hospital lobby, but you're starting to see Congress step in.

But I still think a lot of the action is going to be in the private sector. I think you're going to see medicine continue to work with employers and health plans to develop good evidence-based quality measures. Once you have the quality measures in place, then your next logical evolution is to figure out how do we measure costs? That is, how do you drive people toward physicians who provide consistently high-quality care, but are judicious in their use of resources?

And that's really very [inaudible]. But I think you start with the quality measures because, really, you try to drive people principally based on quality; also we do believe good quality often will result in cost savings and certainly [inaudible] patients satisfaction of the care that they get.

LARRY LEVITT: And on the quality side, from your perspective, what should the administration, CMS, Congress be doing to nudge that along?

ROBERT DOHERTY: We're actually testifying for the Health, Energy and Commerce [inaudible] Thursday and we are supporting moving forward on Medicare pay for reporting program as early as next year. For ambulatory care, there are 26 measures that have already been approved by the Ambulatory Care Quality Alliance and we would support moving forward on a

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voluntary basis, initially, with a reporting program with a similar link to payment for physicians who report on those measures.

LARRY LEVITT: Jerry, you get the last word here. As the academic in the room, how should we be looking at these transparency efforts and measuring or assessing there?

GERARD ANDERSON, Ph.D.: Well, I think it's all that we have talked about but, for me, if you're looking for one thing, it's "Do prices go down?" I mean, the prices are very high in the United States compared to other countries. The private sector in the United States is paying higher prices than the public sector is paying for services. If this activity is going to have an impact, it's going to drive the prices down, and I think it's going to drive the high-cost providers' prices down in one of two ways: either people stop going there or those providers say, "Yes, we're just substantially more expensive, and we can lower our prices in order to be competitive with the other providers."

LARRY LEVITT: Okay. I'm Larry Levitt. You've been watching kaisernetwork.org. Thanks to our panel of experts and thanks to you for joining us. We'll see you next time for "Ask the Experts."

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