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Transparency in Health Care: What Consumers Need to Know

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THE HONORABLE ALEX M. AZAR II: I'm delighted to be here to talk with you about what the President and Secretary Mike Leavitt are doing to transform our health care system.

America has the greatest health care in the world. We have the best hospitals, doctors, and researchers. We lead in the development of new medicines, devices, and procedures. Our health care companies have the freedom to compete. But as good as our health care system is, it can be even better. A more transparent market can allow Americans to get better quality care, with fewer errors, for a lower cost.

Take the price of health care. Americans currently spend about \$1.9 trillion on health care. That's 16 percent of our GDP. What is problematic about this is that health care spending is growing at a rate that poses challenges to the rest of our economy. It is growing more rapidly than the general rate of inflation, for reasons that are not always intrinsically related to the value delivered by the system. In nominal terms, health care spending is growing three times faster than wages, for example, and by 2015, it looks as though we will be spending 20 percent of our GDP on health care. Medicare alone accounts for about an estimated 3.2 percent of this year's GDP and is projected to consume 11 percent of GDP by 2080.

A related problem is that quality of care can be uneven. In America, one can receive the finest medical care the world has ever known, or one could be the victim of an easily preventable medical error. And the

Talking Points

- Consumer-driven health care begins to encourage more cost- and value-sensitive decision-making in decentralized, individual-level decisions, putting some reality into the rhetoric of empowerment.
- Something approaching 50 million Americans have an incentive to seek and, if need be, pay for price information. This includes the uninsured and those in high-deductible plans. The uninsured have the highest deductible of all—every dollar they are charged—and the highest coinsurance rate of all—100 percent.
- When the distortions of government and the third party-payer system aren't involved, the system actually works to create value-based competition that benefits consumers—the health care market responds to economic laws just as all other markets do.
- In a free market, where consumers make their own decisions, technology and techniques rapidly improve. Quality rises and prices drop. In short, freedom fosters prosperity.

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quality of care that one receives is not necessarily correlated to the price paid for that care.

America will not be able to remain the dominant economic power in the world if we continue to devote such a large percentage of our GDP to one sector of the economy while other leading powers spend half that. The system is far from perfect and must change. People divert resources from other desired expenditures into health care because of its high cost; they worry about the continuation of their health insurance; employers struggle under the weight of health care expenditures; our system doesn't deliver uniformly high-quality care; there is no clear connection between cost and quality of health care provided; and in many cases, mom and pop grocery stores use more efficient and up-to-date information technology than do our medical providers.

What's wrong with our system? We think it can be summarized with four basic truths:

- Our system is price blind,
- Our system is quality silent,
- Many of its incentives are in the wrong place, and
- The most expensive medical device in the American system is the pen in the hand of a doctor.

We need to transform our system so people know what they are paying for health care, so they know whether they are getting good quality health care, and so they have a reason and ability to care.

How did we get here? This is obviously an oversimplification, but the problem is in many respects an outgrowth of two developments in the 1930s and 1940s in America: the development of health insurance by providers and World War II wage controls.

Before World War II, Americans paid cash for doctor visits—these visits were house calls, by the way—and if they had any insurance, it might be hospital indemnity insurance or sickness insurance against disability. Hospital insurance and sickness insurance functioned as true insurance: Policyholders hedged their bets against their health risks. Employers didn't factor into the health care equation.

Then Blue Cross and Blue Shield, thanks to special advantages many state and federal government officials gave them, began to dominate the market, and what Blue Cross and Blue Shield offered was less like true insurance and more like what we have today. Blue Cross, for example, offered prepaid health care, which is equivalent to insuring your car for gas and oil changes but was a popular idea during the Great Depression and was obviously popular with the providers who owned the Blues.

Legislation governing nonprofit organizations, including both Blue Cross and Blue Shield, mandated that they make customers who consumed little health care subsidize those who consumed a great deal of health care by charging the same for both. They also paid hospitals on a cost-plus basis rather than market-determined prices. These practices were all incorporated into Medicare and Medicaid, and they persist in many respects today.

In 1942, Congress and the Roosevelt Administration made it a crime for employers to offer higher wages, except with special government permission. Under these wage controls, businesses suddenly couldn't compete for workers by offering better wages. But the market always finds work-arounds to controls like these, so employers resorted to non-wage forms of compensation like medical insurance and prepaid health care, pensions, and paid vacations. Thus began our system dominated by employer-sponsored group health insurance.

On top of this, the tax code subsidized employers' purchases of health insurance for their employees. In 1942, the National War Labor Board ruled that employers didn't have to pay payroll taxes on their contributions to employee health plans and that employees didn't have to pay income taxes on them either. In 1943, the tax court ruled that employer payments to commercial insurance companies for group medical and hospitalization premiums of employees were not taxable as employee income. The 1954 Internal Revenue Code codified this.

As any good economist will tell you, if you subsidize something, you will get more of it. As a result, those of us with employer-sponsored health insurance end up acquiring more health care coverage

than we otherwise would if we were bearing the full cost of our purchasing decisions.

In fact, what most of us have today isn't even health insurance. Insurance is for non-recurring, unpredictable events, but what we insure against are also recurring, predictable health care expenditures. That is prepaid health care, just like your cell phone plan and the early Blues plans. I have a much richer health insurance plan as a federal government employee than I would have if I were purchasing the insurance without the significant employee subsidy that I receive. As a result, if I stay in-network, I pay very little for any medical services or products. For instance, I pay only \$15 for most doctors' office visits.

If you told someone that for \$15, they could go into a grocery store and buy anything they wanted, they would walk out with the entire inventory of the store. This is normal human behavior. Well, this is exactly what our subsidized third party-payer health insurance system has created. We buy more insurance, both genuine insurance and prepaid health care, than we would if we were bearing the full cost of our decisions. This leads to more first-dollar coverage of health care, which, when combined with the lack of experience rating in pricing health insurance premiums to the individual in group plans, makes many of us often price-insensitive as purchasers of health care. As a result, our health system is simply not adapted to providing information to consumers about the prices of services or goods.

I have a three-year-old son, who has an amazing propensity to need stitches. He cut his eyebrow open, and we brought him to the emergency room. Because it was a wound on the face, the attending physician asked us if we wanted to have a plastic surgeon called in for the procedure. I then asked what would have been a perfectly normal question in any other segment of our economy: "How much more will that cost?" They looked at me as if I were from Mars, telling me that they, of course, had no way of telling me that. I never was quite clear if they truly didn't know and had no desire to find out or if they knew but had no interest in telling me.

Then I asked another question that I naively thought was perfectly natural under the circum-

stances: "Would plastic surgery stitches be better than what the attending physician would do?" You see, while I am a health care regulator and am from a medical family, I am not quite up to speed on the latest in suture procedures. You can imagine the "response" that I got.

Well, lacking all relevant information, we went the conservative route and had the plastic surgeon brought in—who, by the way, did a wonderful and professional job. But as we were leaving, a nurse mentioned in a rather offhand way that the stitches were exactly what the attending physician would have done. And I can now answer the cost question: The cost difference was substantial.

You've all had an experience or many experiences just like this. It is absurd to me that one of the largest segments of our economy is organized and operates in such a way that consumers have no real ability to learn about price or quality.

Imagine you're shopping for a new music player. You go into an Apple store and tell a clerk that you're interested in buying an iPod. She suggests you purchase one of the latest iPods. You examine it and like it and want to find out how many songs it holds. You ask the clerk how long it lasts, how well it performs, and how happy other people are with it. But the clerk replies, "I'm sorry sir; you're not entitled to that information." You really want that iPod, though, so you decide to purchase it and ask her how much it costs. Again the clerk tells you, "I'm sorry sir; we can't tell you that either."

We don't learn about price because, with our subsidized third party-payer system incentivizing us to have close to first-dollar coverage and our custom of purchasing prepaid health care, many of us rarely have the incentive to demand this information. So the system isn't built to provide it.

As F. A. von Hayek said, "the price system [is]... a mechanism for communicating information." When you lack price information and price competition, you also impede one of the critical signals in an efficient market for communicating information about quality and efficiency. As a result, we as consumers have no way other than word of mouth and referrals to gauge the quality of health care that we receive and to choose providers—and any statisti-

cian will tell you how poor measures anecdotes are. Providers don't even have the ability to see how their care measures up against competitors in terms of quality.

To make matters worse, providers are not paid based on the quality of care they provide. The newly minted specialist right out of residency is often paid the same for a procedure as one of the world's leading practitioners. So all too often, providers in our system have to maximize revenue not on quality results—although of course I am confident that our providers do strive to provide quality care as a matter of professional ethos, ethics, and reputation—but on maximizing the number of cases they can handle in a day.

One of the greatest inefficiencies in our health care system is the lack of interoperable health records. How many times have you gone into the doctor's office and had to fill out a patient history questionnaire?

I recently went to my internist—who I think is one of the best and I have used for years—and I had to fill out my patient history form for what must be the seventh time. I did my best to remember my life's story, but as we all know, memory sometimes fails. In the course of talking through an issue with my doctor during the exam, I happened to mention something about one of my grandparents' health history. She responded, "Don't you think that was pretty relevant information to know?" Yes, it was. But while I most likely had put it down each of the six previous times I had filled out that form, I had forgotten this one time. Imagine a day when you only fill out that form once, and it is updated each time to go to a provider. The death of the registration form. Think of the errors to be avoided, and the efficiencies to be gained in all of our lives.

My father is a doctor. When I was in high school, my summer job one year was to convert his whole patient record system over from a straight last-name, first-name label system to a fancy new color-coded paper file system based on the first two initials of the last name of the patient, with another sticker for the last year the patient had been seen. Very cutting edge for the early 1980s, but that is still the system used in his office and almost every medical office in America. Why? In part because, even

decades into the computer and information age, he can't buy an electronic health record software program that he knows will communicate with and be interoperable with the education and human resources programs that will be used by the hospitals and doctors and clinics he refers to or gets referrals from or the insurance companies with whom he does business.

What do I mean by interoperability? Each of you has a cell phone in your pocket. Many of them were made by different vendors and operate through different network providers—but they all work. That's interoperability.

Many of you also have an ATM card in your pocket. You don't all use the same bank, but you are able to withdraw money from virtually any ATM in the world and deal with any foreign currency. Banks compete aggressively for your business and use the same system. That's interoperability.

Secretary Leavitt is currently leading a process to make this possible in health care by developing the interoperable standards that are needed for health information technology to work. The promise of health information technology will not be realized if we end up with a balkanized system where personal health information is not portable and accessible. We need standards for what information is to be included, what the fields are, etc., and we need a system for the certification of products that are interoperable under these standards. We are driving the process to develop these consensus standards and processes.

So you can see that, while our system does deliver the best, most innovative care in the world, there is much room for improvement. We're working on a number of critical initiatives:

- To allow risk to be pooled across state lines, with options such as association health plans;
- To bring about modern, prevention-oriented medicine;
- To reform medical liability to ensure prompt and reasonable compensation for medical injuries; and
- To focus on value-driven health care through the widespread adoption of interoperable

health information technology, price and quality transparency, consumer-directed health care, and incentives for quality care delivery.

I would like to focus on the last of these—value-driven health care—for a moment. We have all had experiences with just how expensive medicine can be: emergency room visits, drugs and devices, tests and procedures—and they add up quickly. They also can add up differently based on whether you're paying or an insurance company is. As I have noted, unfortunately, right now there is no way to know exactly what you are going to be charged or, even worse, if you are even getting the best quality care for the best price. It's a complicated and opaque system.

All consumers deserve to know the cost and quality of what they are purchasing, and health professionals deserve to be recognized and rewarded for the quality services they provide. We need to correct incentives so that consumers and providers benefit by making good choices and carry part of the burden of bad choices. For example, when doctors take smart steps like investing in an effective electronic record system or providing personalized support for patients with chronic illnesses to prevent complications, Medicare ends up paying the doctor less. The right incentive would pay more for better care, but to do that, consumers, payers, and providers need to know how quality is defined and who provides quality care.

What we are calling for is a transformation in our health care system in the United States towards value-driven health care, but change is hard. There are many interests vested in the status quo. Many players are more interested simply in shifting costs from themselves to other participants in the system.

Legislation is one way to change the system, but as Secretary Leavitt has said, "When it comes to health care, we don't have a lack of political will, we have too much." This has led to the standoffs for 40 years in thinking about health system reform. Many well-meaning doctors, hospitals, employers, insurance companies, patient groups, and quality advocates have tried to push for the needed transformation, but they haven't been able to achieve change.

What's been missing? The government hasn't been at the table. Between Medicare, Medicaid, the Veterans Administration, DOD's Tricare, and the Federal Employees Health Benefits Program, the U.S. government directly or indirectly insures approximately 125 million people's health care, or 40 percent of those who are insured in the United States. What if we were to harness that market power to drive towards more efficient, effective, and consumer-focused change in our system? To enable and empower the free, competitive market with the kind of information that competitive markets need to function efficiently?

That's why President Bush recently signed an historic executive order to empower Americans to find better value and better care by increasing the transparency of our health care system. The executive order directs federal agencies that administer or sponsor federal health insurance programs to:

- Encourage adoption of interoperable health information technology standards,
- Increase transparency in quality,
- Increase transparency in pricing, and
- Provide options that promote quality and efficiency in health care.

Health information technology: The executive order makes clear that we are committed to using the power of the federal government as a purchaser of health care to drive towards an interoperable system of health information technology. The order requires federal government agencies that sponsor or subsidize health insurance as well as federal government contracting parties, as they adopt, update, or acquire health information technology, to incorporate interoperable health information technology.

Quality transparency: We are funding six regional pilot quality collaboratives that bring together providers, insurers, employers, and consumers in an area to share information to aid in quality-of-care improvement. These initial efforts were good, but any individual insurer will see only a small slice of a provider's practice. It makes the extrapolation of quality results difficult, if not impossible. But if you add the weight of the federal government's health programs to that effort, you will get a much more

complete picture of the quality of care delivered, making analysis, reporting, and quality improvement possible.

We will begin with those six initial sites and expand to include other regional collaboratives. We will ask those who contract with or have agreements with our insurance programs to provide information to these collaboratives regarding the quality of care delivered.

The federal government will not be setting the quality standards for our system. These standards must be standards that the providers themselves believe accurately reflect quality care. Thus, we will be working with provider groups who are developing consensus standards for both doctors—the Ambulatory Quality Care Alliance—and hospitals—the Hospital Quality Alliance. This collaborative approach is critical, since if the providers themselves don't buy into the quality standards, the system simply won't work.

Price transparency: One of the reasons that useful price information is so hard to come by is that there are so many events in a single episode of healing—from the anesthesia before the surgery to the physical therapy sessions afterwards. Right now, all of the information on each part is often completely disaggregated or compiled inconsistently and hence cannot be compared even if it were made available to consumers.

So that consumers can have a better sense of what they are actually expected to pay for, we're working with insurers to organize cost information in the same way—around the single total cost of an episode of care. Then we can ask those who do business with us to provide average price information to their consumers regarding these bundled services. We will do this in a way that takes into account the concerns of providers and insurers regarding the sensitivity of the actual negotiated rates between them. Instead of seeing many nearly incomprehensible bills, consumers will be able to see their cost for a single healing event.

Medicare, Medicaid, the Department of Defense, and the Office of Personnel Management are compiling non-personalized claims information and will release that information to these collaboratives in

sufficient detail to provide a statistically reliable foundation of transparent price and quality data to every hospital, doctor, and participant in the collaboratives that wants to see them.

HHS is now posting county-level, specific hospital payment range and volume information on 30 elective procedures and other common hospital admissions in Medicare. The new information will be posted on the Internet at cms.hhs.gov and is a snapshot look at the range of the amounts that Medicare paid for a variety of treatments provided in 2005 to seniors and people with disabilities. In addition, in August, CMS released the prices that it pays to ambulatory surgical centers for common procedures. In the fall, CMS will release pricing information for physician and hospital outpatient procedures.

Efficiency and quality: Finally, the executive order provides that we will develop and identify approaches that encourage and facilitate high-quality and efficient health care. We hope to be able through our programs to pay providers based on performance, and we will require those who do business with our federal health insurance programs to do the same. We will encourage health savings account plans and other consumer-directed health plans, with higher deductibles and lower premiums so that consumers have the incentives to become knowledgeable consumers of their own health care.

We are using the power of the federal government as a purchaser of health care to generate this information and to bring about these changes. We are also working with major employers and asking them to make similar commitments in contracting with their own insurers and providers. Together we can truly transform the system.

What's the endgame here? Our goal is to enable Americans to access basic information about the health care they consume so that they can become more engaged, savvy purchasers. And as consumers become increasingly savvy and engaged, they expect more choices, more responsibility, and more control in every aspect of their lives. Right now, consumers can track down all sorts of information on Google. They can use Travelocity to find cheap

flights to anywhere in the world. They can trade all manner of goods via eBay. They have tremendous amounts of price and quality data on all sorts of things—except for health care.

Our vision for health care is to fix that and give Americans the tools they need to become educated consumers. Within two years, we expect to measure pockets of quality against price and to see value-based competition in several markets around the country on several procedures. Within five years, we believe the term “value” will have earned its place in the health lexicon of America and that we will be using it on a regular basis. Within ten years, we hope that a system of value-based competition integrated with health information technology will have truly emerged.

As we create this pool of price and quality information, we see a day when a health care consumer planning a hip replacement will be able to go online to a Web site provided by their insurer or by some other private party. This Web site might tell them which hospitals in their area perform hip replacements, what distance they are, what quality rating each hospital has received through any number of private-sector rating entities, how many hip replacements that facility has performed in the last year (a key indicator of quality), what the average total price range of a hip replacement is in that facility, and what that consumer could be expected to pay out of pocket given his or her health plan.

These Web sites won't be run by the federal government. What the federal government is doing is generating the information to allow this market to work more efficiently, to empower consumers, to make the health care system value-driven and more efficient.

Some may say that consumer empowerment can't work in health care, that the decisions are too complex. I beg to differ. When the distortions of government and the third party-payer system aren't involved, the system actually works to create value-based competition that benefits consumers—the health care market responds to economic laws just as all other markets do.

In a free market, where consumers make their own decisions, innovation in everything from capi-

tal structure to packaging to materials tends over time to drive real price down and quality up. Look at shoes, computers, and dishwashers—or face lifts, nose jobs, and LASIK. With all of these, providers are able to compete for business, and people pay out of pocket. The technology and techniques rapidly improve. Quality rises and prices drop. Look at LASIK—between 1999 and 2004, the average price per eye dropped about 20 percent. In short, freedom fosters prosperity.

I have faith in Americans' ability to make the best choices about their own health care in a competitive marketplace. By keeping that as our guiding principle, I believe that we can foster a health care system that is efficient and effective and help Americans live longer, healthier lives.

—*The Honorable Alex M. Azar II is Deputy Secretary of Health and Human Services.*

THOMAS P. MILLER: Last May, the Joint Economic Committee organized a hearing on many elements of this issue, and you can find that on the JEC Web site; Walton Francis was one of the folks testifying. You can also check out Michael Porter and Elizabeth Teisberg's *Redefining Health Care* or my shorter and more mixed review in *Health Affairs* in the September/October issue.

The problem with the current system is that it's a high-cost system. The high costs are good—we get a lot of good things—but it's not matched by better value. This causes problems in terms of affordability for health care, access to it, opportunity costs because the additional dollars we spend on health care might be going for something that could also be valuable as opposed to everything going into the health care sector.

We also have inconsistency in quality. We have peaks of excellence in our health care system but inconsistencies in where and when you get it. With respect to recommended care, the statistics are that a little more than half the time you might get the right stuff. Medical errors can be a problem. They can be a little overstated, but it's a real impact in terms of wrong delivery of care at the wrong time. It's a very complex system to navigate around; even very informed people find it hard to make heads or

tails of what really matters and what's going on. It's less than an easy system to engage compared to other consumer goods.

There are poor incentives. We pay for stuff that is done; we don't necessarily focus on whether it's worth what is being paid, what it produces, outcomes rather than inputs. And we have inadequate information. We just don't know enough about what works and who performs better if not best. We lack sufficient data, effective measures, and standards. Even when it exists, it's not widely available or usable at the consumer level.

Why would adding improved consumer information to the health care toolkit matter? Third parties could certainly use some first-party help. In the post-managed care world, we found that various third parties—whether it's an insurer, an employer or payer, sponsor of a plan, government program administrator, politicians micromanaging on occasion—have given us the system we have, so let's at least think about giving a chance to consumers to perhaps make some of the same mistakes, different ones, and perhaps find out different results by having their hand engaged in the process more than they have in the past.

Consumers might begin to accept the limits on less than "everything right now at no cost" if they could understand better what the actual cost and quality trade-offs are and then could find more effective ways to optimize their choices within whatever constrained set of resources they may have. Consumer-driven health care, a relatively recent entry into the field, begins to encourage more cost- and value-sensitive decision-making in decentralized, individual-level decisions, but we're not there yet. We talk about empowerment, but information is all about putting some reality into the rhetoric of empowerment. Just giving folks more cost-sharing with some money funded into an account doesn't tell them how they're going to make better choices and end up better for it as a result of being more engaged in their health care. That's the information component.

There's also an issue of trust and legitimacy. Not only do we have folks not necessarily trusting insurers to tell them what exactly is right, or their employers, or a government program, but if we are

going to have new information intermediaries or other of these past players providing this information, it's got to be done in a more transparent, more verifiable, trustworthy manner so that folks who want to engage that information think it's actually worth their while.

There are spillover effects in terms of the kind of competition that could ensue from greater information. More comparative information, as we know in other sectors of the economy, fuels competition, improves the overall level of services, but there's also a kind of dynamic effect on the provider's side, the supply side. It's somewhat "performing to the test," but there's also a positive effect within the physician and hospital communities if they know on a relative yardstick they're not doing as well as someone else: Even if it's not being pressed to the consumer level in terms of taking their business elsewhere, it's likely to have some positive effects there. Also, as health care is increasingly complex and needs to be customized, the more you can drill that information down to a form in which people can actually use it would be very valuable.

We have some degree of transparency in health care, primarily at the hospital level, but it's more of a rear view than a leading indicator of what's ahead. So we need to go beyond that, which is kind of an open door policy.

The Bush Administration's Transparency Initiative is an executive order on the heels of some earlier provision of information on paying for procedures, what the reimbursements were in Medicare and the Federal Employees Health Benefits Program. It was issued last August, focusing on quality transparency, mostly through trying to measure the quality of services provided to beneficiaries in federal health programs, but hopefully enough claims and data aggregation so that it means something on another scale.

Pricing transparency was the greater focus: the prices paid for procedures by providers to beneficiaries and enrollees in the plan. It's unsure as to whether we're going to step up to the really important level, which is the overall cost per episode. It's one thing to know the individualized list price for a procedure; it's another thing to know what it means over the entire continuum of care. In the same way,

there are hopes of eventually getting to overall cost of treatment for chronic conditions. These are possibilities, though, but they're not exactly on the board as yet, and I don't know that they're going to be promoted as aggressively as the price side.

There was another component of this—to promote care, quality, and efficiency—but if you really look between the lines, it basically says that as long as they provide you with a consumer-driven health care plan product, that's good enough for us. So we probably need to go a little bit further in that regard, but that's the scope of the executive order—and, of course, the phase-in of interoperable health information technology, which has been an initiative of the Administration for some time, and trying to leverage that through other people participating with the federal programs.

This Transparency Initiative complements other earlier initiatives: consumer-driven health care, Medicare, health IT. It reinforces the emphasis on trying to switch to more of a market-driven approach to health care and health services and leveraging the federal role as the first big mover in the field. You really can't transform the health care system with half of it doing something else.

On the other hand, the federal role moves slowly. Everybody has to be on board; you have to get everybody around the table. It doesn't have the nimbleness and the flexibility and the experimentation you might have in the private sector. So it's trying to be a collaborative with other stakeholders. There was actually a line in the executive order saying this will all be done without incurring additional federal cost. I find that more of a hope than a dream, but we'll see if that can actually be done. At some point, you do have to pay for things.

Early assessment: The federal program prices are a nice opening measure, but they are just a crude start. These are not market-based prices in almost every case. There's a little bit more in the FEHBP. They're negotiated rates; they're telling you an initial setting of what might be a price for something, but far from what you'd like to know if you're out in the wider marketplace. Measuring the all-in market-based cost per episode or conditions? Much further away. How much transparency will really be provided to the public after this is aggregated at the

federal level? That remains to be seen. How much data-sharing will actually occur with private payers? Private information may come in, but the question is what will come back out that private payers can use differently than federal programs do?

But you work with what you have, and you attract some attention to the issue, and it's a start. On the IT side, my skepticism is just that building better, newer, and faster technology pipes is terrific; it's important; but it doesn't ensure that we will use effectively what's in those pipes. So we've got to think about the incentive structure around that information, whether we're getting information flowing through the high-speed highway in the way we want: more relevant measures.

What do we need to know about what consumers really need to know and how can they learn it? The unit and the level of measurement really matter. There are real distinctions between health plan choice information, which we've had for some time—it could be better—and what we fundamentally need, which is better point-of-service decision information. It matters where you go to get your health care, what you do when you're told “follow this treatment,” how it's followed up; that's what is going to turn around the delivery side more than even the aggregation of choices within an insurance bundle. That deals with the front-end discretionary care, the things that consumers can use.

There are other important costs and issues, which are pointed out by critics of transparency who say, “What about those high-cost cases, emergency situations? You don't have time to put thought into it.” Then you need a bundled choice, and that's best done through insurance. But it means that we need better differentiated insurance options prospectively, more transparency about that, that not all insurance is the same; they do things in different ways. And if we can make those choices more transparent, that's more than just knowing what your premium is and what your cost-sharing is and what the covered benefits are. It's how are you going to deal with that \$50,000, \$100,000 episode of care, and why are you better than another insurer in doing that? How do you go about it? What incentives do you provide?

We need physician-identifiable information. We have decent information on hospital-level perfor-

mance on the quality side—not on the cost side, which is much more of a murky area—but there is variation within hospitals among the physicians. So if you don't know who is really making the decisions—what's that unit of analysis of the decision-maker, what their patterns are—even though you might, in the aggregate, think it's a better quality hospital or a more affordable hospital, it may not matter in terms of what's facing you in a particular set of decisions, and you want to make the relevant decision-maker, through this information transparency, more accountable. It also means the consumer is more accountable for making the decisions because you live with the consequences of what you decide when you have options.

An early assessment is that price alone draws attention, but it's not enough. We need the all-in cost by diagnosis or episode of treatment. We need to know a lot more about effectiveness. That doesn't mean that you've checked off all the boxes in terms of the latest recommended guidelines about what processes you go through, what we can measure in terms of the tests that we're provided. It really comes down to a better measure of the outcomes. What matters to people is whether they end being healthier or not as ill or somewhat better off, not that they did different things to you that a committee happened to recommend.

Efficiency is the same way in that regard. We want to know comparatively the resource use for one provider as opposed to another, not just the initial list price. Where you start isn't where you finish. Consumer satisfaction is often neglected by the esteemed bodies that think about what the best quality care is, but in fact there's a conflict sometimes between what a consumer cares about and what experts think they need to know. Now it's a balance between those two, but we should not neglect the fact that if you're not happy as a consumer, that matters too, and the dimensions of that on a subjective level.

We need better information but not perfect information that would stop us in our tracks. We need to drop the pretense that we're going to have predictive certainty and all this information is going to be precise, that there is this perfect quality threshold you have to meet or you don't meet. There is a con-

tinuum. In addition, it's the probability of this information. Nobody hits 100 percent every time out, but there are tendencies and trends, and that's what you're trying to give people: a better gauge as to, relatively speaking, where they are going to end up on these different types of measures across a range.

The continuum of cost and quality means that it's not necessarily only high-quality care that you pay for; you pay for the best value care that you can get. If you have fewer resources, you may not be able to shoot at the top, but you want to optimize that mix of cost and quality, and different people end up in different places.

Data aggregation is very important. You want to collect it once, use it often. The problem here is that the private sector could do this more nimbly and effectively, but they don't have enough denominator size and critical mass in terms of data. That means you have to get it out of the federal government, and electronic health records are a tool in this, but not an end in itself. We need to expand access to the Centers for Medicare and Medicaid Services physician-identifiable data.

Senator Judd Gregg introduced legislation last month; I recommend that you look at it carefully. It would provide a way to open up the vault for the CMS physician-identifiable claims data with appropriate safeguards through intermediary organizations that could provide some analysis of cost and quality and then, what's even better, make that more broadly transparent to the public as well as the requester.

Common data, common measures, don't require comprehensive consensus care standards. Different folks may end up in different places, and we'd like to have some competition in that regard. We want some plurals in competition and not to oversell sameness.

We want to link this to provider incentives because if the payment isn't there, people won't pay as much attention to it. We want to emphasize the trust factor. The challenges are that this data information is power; some folks are not eager to pool and share it. I think also that you want to watch out for administration creep in this regard.

Most of our health policy disagreements are being reimported back into what is said to be the

information debate. People who have fought about other things are fighting about it in the context of information or trying to achieve their goals by saying it's all part of information, and that goes everywhere from trying to redesign the entire health care system to fighting over consumer-driven care.

—*Thomas P. Miller is a Resident Fellow at the American Enterprise Institute.*

DAVID B. KENDALL: I think the first thing we have to do with health care is admit we have a problem—a big problem—so I'm here to echo and put a little more edge on what Tom just said.

I want to start off, before I get into the transparency discussion, by giving you my sense of where we are and where we want to be—at least where I'd like to be—with health care. As Tom mentioned, we have rapidly escalating costs, an average of 11 percent over the last six years. The curve is going down, but it's now going to cost the average American family \$11,000. I can't afford that; I don't know about you guys. It's a lot of money.

We have widespread reports of unsafe, low-quality, and wasteful health care. Three-quarters of a million people are injured or die from problems due to drugs; these are called "adverse drug events." What hospital that you know of tells you before you go into the hospital how many adverse drug reactions happened last week? It doesn't exist. As Tom mentioned, the chances of getting the right recommended care is about 55 percent on average. But who in this room knows what your chances are when you go to your doctor for your care?

Researchers at Dartmouth estimate that 30 percent of the cost of caring for people with chronic illness is wasted in Medicare. How many people in this room, if you were talking to your mom or your dad, would be able to tell them where the most efficient chronic care is in their community?

That doesn't mean we don't get something out of our health care system; we're obviously getting some value. In fact, a recent study by David Cutler says that since about 1960 the additional cost of the seven to eight years we have added to our life spans through health care contributions is about \$20,000.

We're spending about \$20,000 per year to get additional life span; that's a pretty good deal.

Cutler and others attribute a lot of this to low-cost things like statins. So the question is: How can we get more value for less money, and why can't we do a better job of estimating the value of new health care innovation and products and make sure they are widely used? Statins, one of the cheapest things that we have going and very good in terms of increasing life span, is only used by half the people who could benefit from it.

Finally, I wouldn't be a Democrat if I didn't mention the unequal access to care and the high disparities that result—disparities not just in terms of racial characteristics, but disparities in terms of the differences between the uninsured and the insured. We know that Americans who lack coverage do not get the non-emergency care that adds to life span overall.

Where do we want to be? I do think we could all agree that we want a health care system that's more attuned to consumer preferences, like convenience. I'm actually for health care right now, when I need it, because I think that's more efficient in the long run. We want a patient–doctor relationship that is personalized based on the best available evidence, that treats the patient as a whole, not for what can be billed, and is free from the bureaucratic hassles and obstacles that pervade both our public and private health care insurance programs.

We want continuous gains in value, much like the computer industry, which provides every day a better, cheaper product. Why not in health care? And we want no health care disparities due to the lack of access to health care insurance. I don't know if anyone in this room can agree with that last one, but if we could, we could have a deal here.

The President's executive order on transparency is something I'm sympathetic to. As a longtime advocate of transparency, especially on the quality side, I can't help but say it's good. Health care is very opaque; we have no idea in terms of economically whether we're getting a good deal, whether we're getting it personally or clinically.

It's important to mention in this whole discussion about transparency that it is not just the

patients who are in the dark; the doctors are in the dark. I was out at a medical society meeting in the West, and their whole strategy for the next couple years is going to be trying to collect the data that the insurance companies already have about them so they can figure out what's going on. The doctors don't have the data, so the transparency is not there for anyone.

Here is the problem with what the President is proposing: It's just too simplistic. Let me share with you a personal anecdote. I was trying to prove that I was still able to play with my youngsters, and in a game of Capture the Flag I ran straight into a wall rather than capturing the flag. The 15, 16 stitches were not a problem—that was good emergency care; got it all stitched up—and the kids were very impressed with my commitment to the game, but I couldn't lift my arm above my shoulder; it was just stuck there.

So I got on-line. I knew I was going to have a possible rotator cuff tear. I was going to have to have an MRI. I had a 30 percent co-pay; I was pretty motivated to find out what the costs were going to be. So I started calling around, and it's the story you've heard a lot of times. Maybe you have dealt with this yourselves: You just can't find out that information. "We'll get back to you in a couple weeks with that." Or there's one person there that can tell you this information about the radiology fee at the hospital, but they're only there one day a week.

I found a place that would at least package the price of the radiology fee with the MRI. That was good, and I went to them, and I didn't need any surgery. The only problem was that the surgeon kept saying, "Just keep coming back to me. Do your exercises—we don't even need a physical therapist—and as long as you're getting better, everything will be fine." Three or four or five times, at 50 bucks a shot, I'm going back to this guy to tell me I'm doing fine. I already knew that! He wasn't taking any accountability for what he was recommending.

That's what this is really about. Transparency is really about accountability, and that is where we're missing the boat in a discussion that seems to be tactical about price transparency. Tom brought up a lot of meaty issues, and he's right: We need to focus on this stuff. But I also think we need to reframe the

debate: Who is accountable for cost and quality? I managed competition for many years, and we were going to make the health plans accountable for that. It turns out we didn't want that model; let's try something else. But who is accountable? That's a key question.

The answer so far from the current leadership in Washington, D.C., is health savings accounts empowering consumers, which is fine; but I need to remind people that even with the health savings account with a \$3,000 deductible, 80 percent of the health care costs are still paid by a third party. There's just not much market clout there. Even if you took the President's latest proposal on expanding health savings accounts, which Congress didn't enact this last week in the Ways and Means Committee, and projected it out, we'd end up with 8 percent of the country in a health savings account. That would mean that only 2 percent of total market expenditures in health care would be funneled through a health savings account. That's not much of a market share to move anything.

It is more if you count—and we should count—various other consumer-driven accounts like flexible spending benefits and so forth. But still, the number is not there because you've got two big things. You have high-cost cases when you have an acute situation, and you have high-cost cases when there's a big chronic illness that goes over time. That's where the money is, and that's what we have to figure out how to deal with.

What do the insurance companies say, since they're the ones who are on the hook right now? What do they do when they are confronted with 8,000 billing codes from doctors and thousands and thousands more from hospitals, from medical labs, from pharmacists, and so forth? They're doing what Tom was talking about: They're trying to aggregate—they're called "episode groupers"—all these individual billing charges into logical groups that fit what happens to a patient. There are a couple of them. There's ETGs, Episode Treatment Groups, which United Health Care has, and there's one by MedStaff.

Several of these groups begin to look at the data and say, "How do you analyze this stuff and see what happens to a patient with diabetes over time?" As it

turns out, that's a pretty good system, but there's a lot of trouble with it. For one thing, for a typical diabetes patient, variation in the cost can vary a hundredfold. You can have a very small amount of money that a person with diabetes has in a given year, or you can have a huge amount of money that a person has if they have complications and have an advanced stage of diabetes. You can't easily price a three-month care for diabetes without taking that into account, and some of the technical issues that Tom was talking about. But it's a very promising thing, and we should encourage this.

Let me finish by suggesting how solutions might emerge. As Tom mentioned, we should not just make the information available; we should actively try to manage it on a community-wide basis. We should have a government agency that's in charge. We should take Medicare and put it in charge of putting information out there in a way that physicians and hospitals can use it. Before we get to a consumer market, doctors are going to have to price things, and they can't price anything unless they have the information about what they themselves are doing.

Second, we need to enable excellence. There are a lot of measures of performance or quality that will not be used today because it's a "one size fits all" approach to quality measurement. Stuff that comes through the National Quality Forum is good, but there's a lot more information that could be disclosed. Were they to come forward and be held accountable on more precise measurements, and if we could get access to that information today, we wouldn't have to wait for everyone to have to adopt this.

That's what I call enabling excellence. We need to create the conditions that allow the providers to come together. Virginia Mason Hospital in the Seattle area has adopted the Toyota model for process improvement, and they are promising their payers that if they give them some flexibility to manage costs without having to do the individual billing system, we will hold our price increases constant for five years. If you give the providers some flexibility, they can produce excellence at a lower cost.

I think we need to develop pay-for-performance much better. Right now, as I said, it is one size fits all. It's working only in a small percentage of the

overall revenue of a physician or hospital. We need to make it 100 percent, but we can work our way up there. If I had had that shoulder injury and had been able to choose a package price for my condition, I would have loved that. Knowing what the quality indicators are of how I was going to do, how fast I was going to recover: I would have loved that. In order to get to that point, there are a lot of technical issues that you have to get through. Without putting the patient at risk, it would be better to get the third-party payers doing this at least at the same time, if not actually leading it.

Finally, the goal should be to get to cost consciousness at the point of service. There used to be the days when you had an indemnity plan. We would have a health care plan, and if you had this problem, you would get \$50,000 for the payment of that plan. It wasn't quite that simple, but it was a lot simpler because health care and medicine was a lot simpler back then. Today, it's much more complicated; but we should work to the point where you can make, at the point of service, a cost-conscious decision and essentially have that opportunity to buy your health care coverage directly, with the help of the insurance company but without them deciding what it is going to be.

—David B. Kendall is a Senior Fellow for Health Policy at the Progressive Policy Institute.

WALTON FRANCIS: I want to cover three main themes briefly and pose a question. First, I think it important to think clearly about the government role. Second, I want to touch briefly on five real-world efforts that have successfully transferred information to consumers. Third, I'd like to mention some real-world barriers that hinder efforts to make the advances we need, both on price information and provider effectiveness information. Finally, I'm puzzled why we haven't gotten greater consensus from both liberals and conservatives on the need to move aggressively on transparency.

Government Role. In an exchange of e-mails before this event, David Kendall raised a question as to the proper role of government in this entire endeavor. We could have a theoretical discussion on this or a practical one. I'll focus on the latter.

The reality is that, for whatever reasons, the private sector hasn't delivered anything like the panoply of information that consumers should have and use. The President's executive order on transparency simply, and I think rightly, says "get on with it" without delineating in detail how this is to be done or exactly what is to be done.

My take on the government role is that government is vital to (1) making information available to the private sector. Much of the most important information lies in the hands of government. For example, Medicare claims files are to this issue as Saudi Arabia is to oil. *CHECKBOOK's Consumers' Guide to Hospitals* is a crystal-clear example of reliance on Medicare data.

Government can also be (2) a catalyst or even a useful bullyboy. The organ transplant registry I'll discuss was the product of many years of hard work by oversight units in the Department of Health and Human Services and depends in part on a regulation that was bitterly fought by the transplant surgeons.

What government cannot ordinarily do well is (3) package and present the data in ways that work for consumers. A famous recent example is that the FEMA Web site *ready.gov* was so bad that staff at the Federation of American Scientists created a far superior site at *reallyready.org* to correct not only its errors, but its useless advice. The original government-created hospital quality guide was so bad that when a Health Care Financing Administration administrator killed it, there was no reaction but sighs of relief. It involved a bookcase full of volumes that presented outcome data on every hospital in the country accompanied by letters of rebuttal and explanation from almost every hospital. The transplant outcome data that I admire are on a Web site that is, regrettably, most difficult to penetrate.

On the other hand, the government can sometimes present information amazingly well. The CMS Web site to help consumers choose a good Part D plan, called "Plan Finder," is easy to use, clear, and simple and has effectively helped somewhere close to 10 million people save a lot of money choosing lower-cost drug plans. It was certainly a key factor

in the 10-year mid-session review estimates for the Medicare Part D drug plan coming in around \$100 billion less than forecast just last year. So I wouldn't rule against government presentation of quality and price data, so long as it makes the underlying data available to private entrepreneurs like me.

What has to be resisted is (4) government or quasi-government regulation of information provision. The National Committee for Quality Assurance recently published a report called "Protecting Consumers in an Evolving Health Insurance Market" in which NCQA actually calls for state insurance commissioners operating under the auspices of the National Association of Insurance Commissioners, as well as accrediting bodies like NCQA, to regulate the provision of price and quality information by health plans. For a body that is supposedly promoting the interest of consumers, that publication is the exact opposite of one that it should have published, but didn't, on "Empowering Consumers in an Evolving Health Insurance Market."

Real-World Efforts. I think I can claim the record for the longest-standing health-related consumer information publication in history. This November, Washington Consumer *CHECKBOOK* will publish the 28th annual edition of *CHECKBOOK's Guide to Health Plans for Federal Employees*. This little book rates the performance of every plan in the FEHBP in saving enrollees money. We now sell this information on the Web, and the version at www.guidetohealthplans.org is actually better than the printed book.

I draw no particular moral, but simply observe that health plan comparison can be done wherever there is a large enough market to justify the time and investment in reviewing insurance policies, in creating models that compare expected costs under different plans, and in presenting the data and related information in ways useful to consumers. In the world in which we find ourselves, with every employer's health plans unique in benefits, cost-sharing, and premiums, there aren't many comparable opportunities.

One result of my *Guide* is that when consumers use it, both the enrollees and the government save money—lots of money. It is the bane of my life that

the human resource bureaucrats who make government purchasing decisions in most agencies neither grasp nor care that if only one employee in 5,000 uses the *Guide* to choose a low-cost health plan, the agency saves far more in premium subsidy than it spends making the *Guide* available.

The Scientific Registry for Transplant Recipients is an HHS-sponsored Web site that provides terrific quality information. It displays case-mix adjusted outcome data for every transplant center in the country. There are big differences. If you need a kidney, liver, heart, or other organ, these data can save your life.

The registry is the product of more than a decade of research on ways to adjust the raw data to reflect different case mixes at different centers. This is essential because the very best transplant centers generally treat the sickest patients, who are literally at death's door, and necessarily get worse outcomes as a result. So it represents a huge investment in intellectual resources. It also involves a great deal of consensus building and collaboration by stakeholders—matters emphasized in the executive order. My only criticism is that you have to drill down to find the most useful data. It is not a consumer-friendly Web site.

Consumers' Guide to Hospitals is another terrific CHECKBOOK product. It tells you how likely you are to survive if you go to any hospital in the country, for a broad range of conditions, in comparison to other hospitals. It is case-mix adjusted, it is available on the Web, and it relies almost completely on Medicare data. These are the same data that used to fill a bookcase when published by then-HCFA. The government stopped publishing the books but was willing to provide the data to CHECKBOOK. (I would add, in the interest of a different kind of transparency, that the HealthGrades Web site also uses the same data.)

Developing quality measures for physicians is the toughest job under way, and just beginning, but it is vital for developing a real consumer-driven market. CHECKBOOK has come up with a clever alternative. Rather than measuring physician quality directly, *Consumers' Guide to Top Doctors* asks other physicians—peers—which doctors they would

most recommend. There are flaws in this method, but it provides arguably the best currently available data on physician performance. Note that it is an approach that does not rely on government-supplied or government-sponsored information.

The Part D Medicare Plan Finder Web site was developed in CMS under the direction of Mark McClellan. Like *guidetohealthplans.org*, it rates insurance plans in terms of the most important bottom line: dollars spent by enrollees for both premium and cost sharing. Its methodology is quite different and tailored to prescription drug users. Also, like my *Guide*, it saves both consumers and government (as a plan sponsor) lots of money. Give it a try at www.medicare.gov.

Real-World Barriers. There is an information market failure caused by health insurance itself. When my plan pays 90 or 100 percent of the cost, I have little incentive to seek or use price data, and the market has little incentive to provide it. It is not easy or inexpensive to develop case-mix adjusted quality data. Deciding what measures are useful and creating data for them is a major problem and one that requires not just intellectual capital, but also consensus-building procedures.

Privacy remains a problem, particularly for government data. The problem is not patient privacy, but provider privacy. Thirty years ago, then-Secretary of HHS Joe Califano tried to publish data on how much money doctors were making from Medicare, by name, for political purposes. A court slapped him down, and that case and others less directly relevant make it very hard for the government to publish data on individual physicians or make it available to the private sector to publish.

The American Medical Association's monopoly on coding medical procedures is another big problem. It is hard to publish data on prices if even the names and categories of medical procedures are proprietary and copyrighted. The AMA makes a lot of money from CPT codes and has historically been hostile to publishing price information.

The development of tiered pricing arrangements is another problem. Preferred provider rates are trade secrets, and health plans have been willing to

share them with enrollees in their plans, but not yet with the public at large. Health care providers don't want either quality or price data public for obvious reasons. In addition, there is a medical tradition that competing on price is somehow unethical.

The entrepreneurial sector has been strangely slow in sponsoring or publishing data. I think there are fantastic opportunities that haven't been recognized. One simple example lies in Medicare physician payment rates. Those rates are widely used as a starting point in private plan preferred provider decisions. They are useful to any consumer who is willing to ask his doctor why he can't get the same Medicare rate that the doctor accepts for his elderly patients. They are publicly available, but they have never been packaged in a consumer-friendly way. Possible AMA copyright problems arise, however.

I am pleased to hear that Senator Gregg has introduced legislation to deal with some of these barriers. We certainly don't need to remain under any legal impediments.

The Strange Politics of Transparency. When I recently testified before the Joint Economic Committee on these issues, I made much of the point that there is an elephant in the room. Something approaching 50 million Americans have an incentive to seek and, if need be, pay for price information. This includes the uninsured and those in high-deductible plans. The uninsured have the highest deductible of all—every dollar they are charged—and the highest coinsurance rate of all—100 percent.

The biggest scandal over price information to date was a scandal that should excite liberals everywhere. A few years ago, Yale University Hospital charged an uninsured black man the retail rate for a procedure, triple or quadruple the preferred provider rate it accepted from health plans. Then it hounded him when he couldn't pay and was going to force him to sell his house to pay this punitive rate. This case made national news and generated a big change in Yale policy.

You would think that liberals and conservatives alike would agree on the need for far better consumer information to deal with cases like this, and for the 50 million who are uninsured or subject to high deductibles. Also, consumer information is cheap, at least by the standards of health care spending.

Yet somehow we haven't gotten either a social or intellectual consensus on the priority that transparency should get, particularly for price information. The published academic literature is full of truthful but irrelevant arguments that many consumers don't comprehend complicated information very well and will simply be confused by any quality information. Price information is scarcely ever mentioned, except to assert that it is useless in a world dominated by insurance. Why is it Heritage, and not Brookings, that is hosting this conference?

—Walton Francis is an economist and author of CHECKBOOK's Guide to Health Plans for Federal Employees.