

THE PRICE OF EVERYTHING AND THE VALUE OF NOTHING

Testimony of Walton Francis  
Consumer Advisor, Author, and Independent Consultant

Before the Joint Economic Committee  
May 10, 2006

I am pleased to be able to provide this Committee with my diagnosis as to where we are and where we need to go in providing information on the price and value of health care to consumers. I think that improving “transparency” (how about just plain “access”?) to price and value information on health care is the most important budgetary and economic issue facing America. It is vital to Medicare reform, and to avoid the train wreck of impending insolvency of that program, but more broadly vital to reducing the unsustainable and crippling problem that rising health care costs impose on all Americans in all income classes, whether they pay by taxes, premiums, cost sharing, or going “naked” without insurance.

During the many years that I have authored the annual *CHECKBOOK's Guide to Health Plans for Federal Employees*, I have watched in amazement the inability of either the market-driven Federal Employee Health Benefits Program (FEHBP) or the legislatively and bureaucratically micro-managed Medicare program to halt the seemingly inexorable rise in health care costs, year after year, at a rate higher than either inflation or per capita income. This doesn't mean that these programs are failures at cost control. Quite the contrary, they have in their quite different ways achieved cost containment results worth many billions of dollars annually. But what they are able to accomplish in the dysfunctional American health care “market” (*sic*) has been palliative, not curative.

If there is one point on which virtually all health care economists agree it is that the fundamental cause of the rise and level of health care spending is the prevalence of health care insurance that is not pure insurance, but instead prepaid, first-dollar health care. Even with modest copayments, most health care for most Americans is virtually free. Some call the resulting waste “moral hazard.” Others simply call it the results of demand and supply curves intersecting where the price to the consumer is set by payers near zero. Whatever one terms it, the result is immense waste. Shifting some insurance policies to a consumer-driven model with high deductibles and hence restoring some semblance of fiscal discipline is an important reform. But it is less than half the needed reform. And the bigger half is simply better price and value information for consumers.

Lady Windermere, in Oscar Wilde's play, said “a cynic knows the price of everything and the value of nothing.” Through no choice of their own, American consumers have been forced to become and remain something worse than cynics, allowed to know neither the price

nor the value of health care. The essential problem is that without price and quality signals, or incentives to use them, consumers have no way to compare either treatments or providers and to impose market discipline to reward efficiency and drive down prices and costs.

The presence of intermediary “middleman” insurance organizations both complicates and presents opportunities for reform. Those organizations have a strong incentive to control costs at least as well as their competitors, and they have price and outcome data. But they have to attract broad provider panels, and pay more, to compete in a world where customers do not directly obtain the savings from narrower provider panels and other economies. The 1990s rebellion over heavy-handed “gatekeeper” HMO requirements, that reversed the trend to HMO insurance and led to the vast rise in PPO insurance, illustrates the potency of the problem. In the final analysis, insurers are in a market where deep pocket payers--employers and taxpayers--routinely pay the going rate, however high that is, to maintain the status quo. Something has to change.

Meanwhile, there are roughly 45 million uninsured (most voluntarily so), and another 5 million or so who face significant cost sharing. In total some 50 million people have to cope with a market that provides virtually no functional price signals as to how to save money by choosing lower cost treatments or providers, and only weak quality signals.

In assessing this data chasm, its possible bridging remedies, and their possible outcomes, it is useful to draw sharp distinctions among various categories of information. Consider a consumer with a diagnosis that will involve high costs, such as childbirth, breast cancer, severe carpal tunnel syndrome, or prostate cancer. Suppose this consumer has no health insurance but an option to join or change plans in open season. Such a consumer would need need six categories of consumer information. Together with his or her own preferences, such information would enable an informed choice among options. Far more importantly, if all consumers had such information this would drive the health care market over time to more effective and efficient outcomes. The six categories are:

- (1) Alternative courses of treatment,
- (2) Likely outcomes of those alternative treatments,
- (3) Monetary and other costs of such treatments on average,
- (4) Costs of using particular providers,

- (5) Quality and outcomes using particular providers, and
- (6) Estimates of which health insurance plan is the best buy, taking into account both premiums and out-of-pocket costs, for the next plan year.

Today, I will cover briefly the current availability of consumer information on each of these topics, recent progress and efforts under way, problems and opportunities in filling gaps, and long run consequences of filling those gaps. I will try to illustrate some of my findings and conclusions with examples using the diseases or conditions mentioned above, and a few other situations.

Current availability of Consumer Information. Consumer information across these six types today ranges from scarce to nonexistent to abundant but flawed.

There are innumerable books, articles, and learned opinions on (1) alternative courses of treatment. For example, for a woman expecting no complications of maternity, using a midwife represents a huge saving compared to hospital delivery. There is abundant information on the very low risks of delivery, and a slim but not insubstantial body of literature on the slightly larger risks of using midwives. For a woman with breast cancer, there is abundant literature on the various mastectomy and lumpectomy alternatives, taking account of different stages of disease progression. For prostate cancer, there are four major treatment modalities, one of which is benign neglect (old age will usually kill the patient faster than this cancer). For carpal tunnel syndrome, there are several inexpensive treatment options with expensive surgery the only effective option in many severe cases.

While medical science is constantly advancing, and there are huge gaps in information, to say nothing of diseases for which there are not yet any effective treatments (e.g., Alzheimer's disease), it is fair to say that consumers and their advisors (notably physicians) do not lack access to whatever information exists. One could fill libraries with medical advice literature, on or off the Internet, in books, articles, and snippets from disease-specific Web sites, and more.

The Internet has greatly advanced low-cost access to this information by consumers, through sources such as Medline, trusted Web sites such as WebMD, and forums for patient groups.

The Healthline Web site ([www.healthline.com](http://www.healthline.com)), of which you are hearing something today, is itself proof that treatment information is there—Healthline specializes in sifting through the vast Internet resources to find the best information. But even without the Internet, the information is available. Books and journals are available in public libraries and bookstores throughout America.

Likewise, there is abundant information on (2) likely outcomes of alternative treatments. This information deals not only with straightforward measures such as survival rates, but also with qualitative outcomes important to patients. Many women (though a small minority) positively prefer the experience of childbirth at home with a midwife. Breast cancer alternatives differ hugely in preservation of women's perceived attractiveness and potential complications. Prostate cancer treatments differ in major ways not only as to prognosis but also as to such complications as incontinence and impotence.

Access to treatment outcome information is almost as widely available at low cost as information on treatment options. There is far less outcome information, but consumers have access to whatever is known, in print or on the Web.

There is also a recurring problem with respect to outcome information, a problem that grows progressively worse as we move from overall outcomes to provider specific outcomes. Data that are not risk-adjusted or case-mix adjusted can be very misleading. Breast and prostate cancer outcomes depend on the stage of progression of the disease, the condition of the patient, and other variables. For example, in both of these cancers the age of the patient has a huge effect on whether or not drastic surgery is indicated.

Information on the (3) average monetary costs of treating diseases or conditions is, in sharp contrast, almost nonexistent for consumers. I have repeatedly used Internet search engines to try to find, for example, the cost of an appendectomy or childbirth. Google and other search engines will find thousands of "hits" when terms such as "cost childbirth" are entered, but the links found are invariably dry holes. A relative of mine recently had surgery for carpal tunnel syndrome. I ran a Google search on "carpal tunnel surgery cost" and obtained a half million hits. After skimming a few hundred of them I found none that provided any data whatsoever about price or cost, and gave up.

A major development in the last several years has been the provision of treatment costs on the Web sites of some major insurance firms. These include Aetna and Tufts, for example. Consumer-driven health plans such as Lumenos (see [www.lumenos.com](http://www.lumenos.com) for a useful demonstration) also provide such information, as you are hearing today. These information sources are tightly restricted to plan members, and hence unavailable to virtually all of the 50 million Americans who need such information for obvious financial reasons, and another 240 million insured Americans who might wish to impose lower costs on their fellow insureds, even though they save little or nothing. There are also some far small firms that are beginning to provide such data, though often restricted to enrollees (see, for example, [www.healthia.com](http://www.healthia.com) and [www.healthmarkets.com](http://www.healthmarkets.com)).

A recent *BusinessWeek* article (February 20, 2006) praised Aetna for the best consumer information on its Web site of three major insurance firms compared. I haven't reviewed all of these or other sources, but I certainly agree that Aetna is developing a fine set of information for its enrollees. However, the reality is that the Aetna Web site only covers about 60 conditions, albeit with different levels of severity for most of them.

Of the several conditions I have previously mentioned, the Aetna Web site divulges that the estimated cost of an uncomplicated pregnancy, with either vaginal or cesarean delivery, is approximately \$7,700 (\$3,600 for the hospital, \$2,600 for the physician, \$100 for prescription drugs, and \$1,400 for tests.) *You are reading this estimate today in a breakthrough public disclosure.* Just try to find such an estimate in any other document. You can find many Web sites that sell maternity insurance, but none of them estimate the cost without insurance. In preparing this testimony I ran a Google search on "maternity cost" that found almost 9 million hits and no discernable information on price or cost. Alas, Aetna provides no cost estimates for breast or prostate cancer (or for that matter, for any other cancer) or for appendectomy or carpal tunnel surgery, and no estimates for alternative treatment modalities, such as nurse midwives.

In other words, even for Aetna enrollees, the information is profoundly limited. For the rest of us even this limited information is simply unavailable. And this is the state of the market! In sum, *so far as I can determine consumers today cannot find reliable information on the*

*costs of major medical conditions and their treatments from any publicly available free resource.*

*Nor do consumers have ready access to information on the costs of most individual procedures.* Aetna provides some such information to its enrollees, but only for about three dozen of them. These are among the most common (e.g., “office consultation for moderate to severe problems” with a specialist, or “new patient office visit for moderate problems” with a generalist), but there are approximately 10,000 ambulatory procedures and the listed procedures are but a drop in that bucket. No surgical procedures are listed.

Turning to (4) information on the costs of using particular providers, information is even sparser. Perhaps the greatest innovation of the Aetna information for its enrollees is the provider-specific charge information available on its Cincinnati Web site. Assuming, illustratively, that Aetna has thirty percent of the Cincinnati market, and that this market comprises one million individuals, approximately one tenth of one percent of Americans have access to information on provider-specific prices. Even adding in Tufts and Lumenos and a few other firms, *as a practical matter information on the charges of specific providers is essentially unavailable to the public today.* There are a few seeming exceptions, such as California hospital charges, but as a practical matter that information is unusable by consumers (see the Anderson testimony referenced below).

Contrast this with the situation for medical procedures not ordinarily covered by insurance. Lasik is the fashionable example, but there are many others. See [www.beyourbest.com](http://www.beyourbest.com) for price quotes on breast augmentation (\$3,000), liposuction (\$2,000), and many other plastic surgery procedures at “guaranteed lowest prices.” Where consumers pay, price matters. Contrast medical procedures with other major purchases, such as automobiles or airline tickets or any of the thousands of goods sold on e-Bay or through department stores. Not only is price information routinely available, there are many services specializing in enabling consumers to quickly compare prices before making a choice (e.g., Orbitz and Travelocity, among many, many others for airline, hotel, and rental car prices). Imagine using Healthline not only to obtain treatment information, but also for price and cost information.

This is not a trivial gap for the approximately 50 million American consumers who shop for health care with no insurance or with insurance gaps. As notoriously shown by the recent California requirement that hospitals make their charges available to consumers, charges to uninsured individuals are typically double, triple, or quadruple the charges to clients of major insurers (a description of the utter irrationality of hospital charges as they have developed over time, and a good deal of sensible advice on price transparency issues can be found in the testimony of Gerard Anderson of Johns Hopkins University before the House Energy and Commerce Committee in March of this year, at <http://energycommerce.house.gov/108/Hearings/03152006hearing1813/Anderson2771.htm>).

The availability of information on the (5) outcomes of using particular providers is actually far greater. In one of its most important actions for consumers ever taken, the Centers for Medicare and Medicaid Services (then HCFA) made available about 20 years ago data on hospital mortality and adverse outcome rates for all Medicare-participating hospitals (i.e., virtually all hospitals), both overall and for a dozen or so major types of procedures. Originally CMS published these data. In the last decade it has simply made them available as data files. At least two organizations, Washington Consumers CHECKBOOK and HealthGrades, continue to use those files to make risk-adjusted data available, for sale (e.g. *Consumers' Guide by Hospitals*, by the editors of Consumers' CHECKBOOK Magazine, 2002, also available online and updated at [www.checkbook.org](http://www.checkbook.org)). While these data are not free, they are available to all American consumers.

While the risk of an adverse outcome is certainly the single most important measure of hospital quality, there are many others. CHECKBOOK surveys physicians to see which hospitals they rate highly. In effect, experts are used to rate other experts.

More recently, CMS has led a major reform effort to initiate the collection of data from Medicare-participating hospitals on a set of quality measures that focus on the most common hospital procedures, and those shown by research to be among those most prone to failure. For example, the failure to provide Aspirin to patients admitted with a heart attack is a major and not uncommon quality failure. As another example, this initiative also addresses one of the most vital steps owed to all patients: whether they are given discharge instructions when they leave the hospital. With collaborative partners, most notably the Hospital Quality



Alliance and the Agency for Health Care Research and Quality (AHRQ), CMS now makes available a wide range of performance measures (see <http://www.hospitalcompare.hhs.gov/>). These measures are also used in “Pay for Performance,” a major initiative now set in statute that conditions up to 2 percent of a hospital’s payment from Medicare on its performance on measures of quality in comparison to other hospitals. Expansion of Pay for Performance in traditional Medicare is arguably as, if not more, important to future restraint on the growth of health care spending than the addition of Medicare Advantage plans as alternatives to traditional Medicare.

Early reports show that this collaborative but competitive system has had major effects in upgrading the quality of hospital performance. The consumer information is not just static, read by some consumers and ignored by most, but a spur to improved performance by hospitals that cannot afford, literally and figuratively, to be regarded as inferior.

CMS also now publishes on the Web comparative data on the quality of performance of other providers, such as Nursing Homes and Home Health Agencies.

There are more specialized efforts that indicate both the potential and the problems of developing outcome/quality measures for providers. For many years the United Network for Organ Sharing (UNOS) has devoted substantial resources to developing measures of patient and organ survival, by institution, that would not only allow consumers to compare outcomes and quality, but also provide them risk- or case mix-adjusted data that would account for the differences among hospitals in the severity of patients that they serve. In the world of transplants, sufficient expertise and consensus has been developed to allow a robust system of comparing provider outcomes for each type of transplant ([www.srtr.org](http://www.srtr.org)). Any transplant candidate can compare the performance of every transplant center in the United States before deciding where to “list” for a transplant.

But there are few if any other complex medical procedures for which comparable data are publicly available today. One notable bright spot is the Pennsylvania Health Care Cost Containment Council, with quality information on a number of procedures including provider-specific data on coronary bypass surgery (<http://www.phc4.org/default.htm>).

The big gap in quality-related outcome data has been in the performance of individual physicians and physician groups. While CMS and AHRQ are diligently working to develop outcome-related measures of ambulatory quality through the Ambulatory Care Quality Alliance (AQA) (see [www.ahrq.gov/qual/aqastart.htm](http://www.ahrq.gov/qual/aqastart.htm)), the only widely available quality measures today use such crude measures as board certification or disciplinary actions, or what is arguably the best measure of all: ratings by other physicians. For example, CHECKBOOK publishes what is essentially a national system of physician ratings, by specialty, in *Consumers' Guide to Top Doctors* (2002, updated on the Web at [www.checkbook.org](http://www.checkbook.org)). The *Washingtonian* magazine, and other publications, also use surveys to rate physicians in particular metropolitan areas.

*In summary, quantitative measurement of quality and outcomes for ambulatory care providers generally, and physicians in particular, remains a work in early stages of progress. Performance of several other major types of providers, such as hospitals, is further advanced. But progress is certain to be slow, expensive, and complex.*

I have for almost three decades provided consumer information on (6) comparing health plans, in my annual *CHECKBOOK's Guide to Health Plans for Federal Employees*. My Guide provides information to approximately 8 million Federal employees and retirees on which of the health plans they can join provide the best value. In essence, this is simply a matter of comparing the total costs of consumers of enrolling in plan A versus plan B, assuming that each plan pays the promised proportion of medical bills incurred. The *Guide* performs this calculation, and shows every year that family enrollees who select the best deals available can save (a) a thousand dollars a year or more by choosing an HMO, and which HMOs provide such savings and how much savings, or (b) a thousand dollars a year or more by choosing the lower cost PPO or FFS plans, and which ones provide these savings and how much. These dollar savings estimates take account of both premiums (a “for sure” expense) and expected out-of-pocket costs at various spending levels.

The *Guide* also rates plans on several quality measures. In the early years, I focused on “quit rates” as a measure of service. Office of Personnel Management data on disenrollment rates grew increasingly unreliable over the years, and I had to abandon this measure (which, incidentally, required complex statistical adjustments using multivariate regression analysis.)

In more recent years we have included customer survey data on satisfaction with plans. Unfortunately, such data as currently published suffer from two inherent defects: (1) only a relatively few plan enrollees face life- and wallet-threatening events, and hence the most severe cases get negligible weight in overall ratings that count all consumer equally, and (2) elderly enrollees on average rate health plans far more highly than younger enrollees. As a result of these defects, and the failure of national accrediting organizations to address them by appropriate statistical techniques, customer satisfaction data as published today are extremely weak as measures of plan quality.

Another major approach to health plan comparison has been pioneered by CMS. For prescription drug expenses, which for most people are stable from year to year. CMS has developed a “Plan finder” tool (see plan comparison at [www.medicare.gov](http://www.medicare.gov)) that shows how much each participating Medicare prescription drug plan costs enrollees for the drugs they use today. Like the *Guide*, this tool takes into account both premium and out-of-pocket costs. Unlike the *Guide*, the approach is “current usage” specific rather than actuarial. In essence, it assumes that drug costs will usually not change, while the *Guide* assumes that future hospital, medical, and drug costs are only partially predictable, and always subject to random events. Both approaches have substantial strengths, and both approaches have saved millions of enrollees a great deal of money by steering them to plans that are better buys.

The CHECKBOOK *Guide* is available for a fee; the Medicare Plan finder at no charge. Historically, the *Guide* was sold in paperback to individual employees and retirees. However, at present the majority of Federal agencies provide “free” copies to all employees. Unfortunately, most agencies do not broadcast the availability of the *Guide* effectively, and lose the very substantial savings they could realize if a larger fraction of employees realized how much they could save and chose plans with lower employer as well as employee premiums.

For both Medicare and the FEHBP, data are available showing that *even with a minority of consumers using plan comparison information, consumer choices among plans to select better buys save billions of dollars to both enrollees and payers.*

Unfortunately, plan comparison tools such as these have only limited applicability. The vast majority of Americans do not have available a wide range of plans. Federal employees and retirees typically have about 15 or 20 plans to choose from. Medicare beneficiaries typically have about 40 or 50 plans to choose from. Most workers are provided at most two or three plans by their employers, such as one HMO, one PPO, and one fee-for-service plan. Since one of these three plan types is usually strongly preferred for reasons other than cost, the effective range of choice is usually one plan.

*As a result, until or unless most Americans are given a broader range of insurance plan choices, powerful plan comparison decision tools such as these are of limited help in improving the health care market.*

Problems and Opportunities in Filling Gaps. As the analysis above suggests, the availability of consumer information varies significantly by category.

Arguably, the most important gaps to fill are (a) data on provider payments or prices by procedure or condition or both, (b) the same information on a provider specific basis, e.g. “what this doctor would charge compared to that doctor,” and (c) data on ambulatory care provider quality and effectiveness.

**Are the consumers there to use the information?** Most consumers have no incentive to seek information on costs, and to reduce costs by shopping, in a world of first dollar coverage. Nonetheless, with approximately 50 million people having a vital interest in keeping their costs low, it is clear that there are plenty of willing consumers of price information, if there were not other barriers to its dissemination. All 290 million consumers have a substantial interest in quality and effectiveness information.

“Consumer-driven” health care through high deductible plans and Health Savings Accounts adds to this potential demand, and brings a substantial number of higher utilizers (sicker and older) and well-educated consumers to the missing market for price information. But growth in consumer-driven plan enrollment is neither necessary nor sufficient given the substantial numbers of consumers who need such information already. *What is needed is rapid rather*

*than glacial movements by the insurers, both public and private, who have the data on payments and outcomes.*

**Overall payment and price data** are simultaneously easy and difficult to provide. Every insurer in American knows what it pays each physician in its network. The data could be made available on the Web virtually overnight.

However, what each insurer pays is a trade secret. If competitors learn the payment rates, they could offer slightly better rates to attract preferred providers, or bargain harder with providers, or both. Providers know what they charge patients (usually different rates depending on which insurer is involved). However, they have an equally grave problem. It is not in their interest to make it widely known that they have settled for price X from payer A and price Y from payer B. Payers can use this information to ratchet down rates. A major firm, Subimo, today makes a great deal of its revenues from the sale of price data to insurance companies and, to a far lesser degree, to consumers ([www.subimo.com](http://www.subimo.com)). While Subimo and others could prosper from a different business model (imagine free price information with revenue from advertisements paid by low cost providers), there may be legal and other impediments to such a transformation.

The one player with no self-interest barrier to wider disclosure of payment information is HHS. HHS provider payment systems are calculated using statutorily mandated formulas and procedures, and within specified geographic areas are “one size fits all.” However, HHS faces a potential barrier in disseminating physician (but not hospital) payment information by the contractual agreements, long since struck, that commit it to using proprietary medical procedure codes that have been copyrighted by the American Medical Association (AMA). The AMA position, enforced by a willingness to impose major legal costs by suing alleged violators, is that “Common Procedural Treatment” (CPT) codes can only be used with AMA permission. Such AMA permission is never given to anyone who would publish procedure prices for broad consumer use. This posture is largely rationalized by the traditional ethical strictures against price competition in medical care. Other motives can be inferred.

In a case decided almost a decade ago, the AMA position was upheld against a private publisher by the Ninth Circuit Court of Appeals (*Practice Management Information*

*Corporation v. American Medical Association*, 121 F.3d 516 as amended at 1333 F 3d 1140). The Supreme Court denied cert.

HHS could practicably publish consumer-friendly versions of its physician, outpatient, and inpatient payment schedules. These schedules are currently online, but require fairly substantial computer expertise to download and translate into understandable units, such as “What does it cost in dollars in my area and nearby?” Therefore, as a practical matter they are currently unavailable to consumers. Unfortunately, it is possible that the physician procedures would have to be recoded and presented in terms of ICD-9 or ICD-10 codes (alternatives to CPT) to meet legal concerns. This in turn raises issues about which codes would be used in practice and hospital management and billing systems, and some very expensive changes. I think that these issues could probably be decoupled, and the public information provided without depending on future code system decisions, but the job may be harder than I predict. One option might be to publish information coded under all three systems simultaneously, which would work for most procedures, but would require a good deal of work.

Procedure payment amounts are arguably not as useful as estimates of the costs of treating a disease or condition, but these serve different purposes. A consumer seeking to save money could seek a low cost obstetrician and low cost hospital as separate decisions, constrained only by physician privileges. Moreover, in the case of hospitals the CMS reimbursement system is primarily based on condition (“Diagnosis Related Group”) and hence avoids most of the problems posed by itemized charge systems. The bargaining mode for a woman seeking a good price for maternity care should be “Let’s start with the Medicare payment that you already accept.”

Providing disease and condition-specific cost information taking into account all types of provider and service is harder, since it requires an additional step. However, it is possible to search any major public or private insurer’s payment records to find one or several common clusters of services. Presumably, this is what Aetna did to create its estimate of maternity costs.

In either case, what might otherwise be a gargantuan problem is greatly simplified by starting with relatively limited numbers of procedures and disease. The most common 100 physician, 100 outpatient, and 100 inpatient procedures, and the 100 most common diseases or conditions, would be a relatively easy starting point.

This in essence is what Aetna, Lumenos, and some other insurers are doing. The problem is that they are providing the information only to their own customers, who represent only a small share of those facing strong incentives to use price information. By definition, none of the uninsured has access to information limited to those enrolled in a company's insurance plans.

**Provider-specific price, charge, or payment rates** are arguably both the most needed and most difficult information to provide. However, they are quite likely to emerge over time as a by-product of shopper behavior using system-wide rates. Competition begets competition and there is no reason why we could not expect to see in the future advertisements such as “Use Doctor A and Hospital B for your pregnancy and delivery and get the bargain rate of \$6,300, 20 percent off and \$1,400 less than the average cost of maternity care.”

But we need not await that development. A consumer with access to Medicare payment rates, knowing that the great majority of providers accept these rates for Medicare patients, wields a potentially mighty club. “Hospital B (or Doctor A), why shouldn't you give me the same deal you give most of your other patients? If you won't I can try one of your competitors.” So far bargaining tactics have met with limited success, but consumer efforts have barely begun, and the Medicare payment rates are a vital tool for future bargaining.

Meanwhile, Aetna, Tufts, and others are experimenting with providing provider-specific payment rates to their enrollees. Armed with three pieces of information—average rate for a procedure in the network, average rate outside the network, and the precise rate charged by Doctor A and Hospital B—enrollees are given the vital information they need to decide whether, and how hard, to shop further around.

**Data on provider quality and effectiveness** is the most difficult challenge by far. Without these data consumers cannot complete the “value” equation.

HHS, primarily through AHRQ and CMS, is devoting immense intellectual capital with its alliance partners to creating such information. There are valuable systems already in place for some dimensions of hospital and nursing home quality. Other and more ambitious efforts are underway through the Hospital Quality Alliance and the Ambulatory Care Quality Alliance. I am sure that Dr. Carolyn Clancy is addressing those in her testimony today in great detail. Dr. Mark McClellan, the CMS Administrator, has testified several times on these issues before other Committees of the Congress.

One of the biggest problems in developing such measures is that without case-mix adjustment they may often mislead. The best surgeon may take the hardest cases and wind up with success rates lower than those of the average surgeon. Statistical validity also requires a significant sample size (rarely fewer than 25 or more cases) and many procedures are not performed in high volume by most physicians. There are also substantial issues in developing actual quality measures, especially for procedures that do not usually lead to simple outcomes. For these and other reasons, efforts to create quality and effectiveness information that will be genuinely useful to consumers must be measured in years, and will indeed never be complete.

Luckily, we already have a good deal of information on both ambulatory and inpatient quality. It resides in the heads of physicians and other health professionals, who observe their peers directly and through their informal information networks. It is made available to consumers through direct advice from their own physicians on questions such as “Which specialists would you recommend as the next step for me to take, and how would you compare them?” It is also available through publications such as CHECKBOOK’s *Consumers’ Guide to Top Doctors*, which surveys physicians themselves as to whom they would recommend most highly in other specialties.

Health plans make decisions on which physicians and other providers to enlist as preferred providers, based on both willingness to accept the insurer’s payment rates and appraisals of performance. These appraisals may be crude and simple, or may reflect statistical analysis of insurance records over time, but in either case serve as an important check to weed out poor performers. Thus, simply using preferred providers is an easy quality (as well as financial)



rule for consumers. (Unfortunately, some of the very best physicians often opt out of such panels over payment levels—a problem that would lessen over time if plans would be more flexible in paying more for higher quality, which in turn requires new quality measures.)

There also remains the possibility of using insurer data to provide more information. For example, simply knowing the volume of a certain procedure performed is often immensely valuable to the consumer because for a large number of procedures research has shown that high volume correlates strongly with quality. Such information is readily available in Medicare files. For many procedures (though a small proportion of the universe of procedures) the information could be reasonably used with minimal statistical refinement. According to recent press reports (Robert Pear, in the *New York Times*, April 10, 2006), employers are now pushing HHS to disclose these and other Medicare data on physician performance. Unfortunately, it appears that HHS feels constrained by a 1979 court case that interpreted the Federal Privacy Act as preventing the release of records identifying individual physicians. However, that case dealt with an entirely different situation that could not arise under current Medicare payment procedures. It is also arguably irrelevant given that the Congress has since 1979 mandated a wide range of quality measurement and improvement efforts by CMS. CMS now has a legal duty to use information on provider quality, and without public access to that information, the performance of CMS itself cannot be evaluated. Under the Freedom of Information Act, an evaluative purpose arguably trumps the Privacy Act. Moreover, the 1979 decision was a District Court decision, never affirmed by higher courts. The outcome of further legal analysis, or court action, remains to be seen.

Consequences of Filling These Gaps. Some analysts denigrate the value of making price, payment, and quality, information available to consumers. They argue, for example, that most medical care costs are spent on high-cost cases that are fully insured, and that as a result market forces will be greatly attenuated. These pessimists may be right. Even if they are right these reforms should be made, however, simply because some 50 million Americans will get substantial benefit.

But the pessimists are most likely wrong. Market forces, if unleashed, will drive behaviors of consumers and providers, and insurers, in ways that we simply cannot predict. It is not just a matter of a minority of consumers haggling and bargaining with a minority of providers:

- Some providers may seek the opportunity of using market information to position themselves as cheaper and better (“I am Doc Sawbones and I score 99 percent on the official government quality measure and charge only three-fourths of the average payment rate.”).
- The invention of lower- rather than higher-cost technology may be spurred. Why pay for the \$20,000 pacemaker from your health saving account or on your credit card when there is a \$10,000 model available that has fewer features but is more reliable?
- New forms of low cost health care organization may arise (we may need to look no further than the health care centers that Walmart is installing).
- Medicare is already moving in a significant way to “Pay for Performance” for hospitals rather than “one price fits all.” This has revolutionary implications if it can be expanded to more Medicare payments, to other insurers, and to additional measures of hospital outcomes. Few conceivable payment systems are more lunatic than those so widely used today by Medicare, Medicaid, and most private insurers, that in effect pay more for less effective service.
- Quality and outcome measures are particularly important for insurance reform. Consumers can select providers based on reputation. Third party payers need more objective, measurable information.
- Consumer advice on dealing with health problems would be able to include comparative information integrated in ways that steer consumers to high value courses of treatment, and help them control costs.
- If price information becomes widely available as a point of comparison, providers may elect to bundle services at a discount.
- Providers may simply be forced, by the existence of lower cost competitors, to accept lower payments. We see this already in the growing numbers of American patients going to India or the Caribbean to obtain high quality care at a fraction of the price in the United States. What happens to overall spending when consumers see that high quality alternatives are available at half or less the going rate?

All these potential effects loom larger because of the unsustainable growth rate of health care spending in America. We need not dwell on the impending Medicare insolvency data (estimated as 2018 for the hospital trust fund in the just-released Trustees report) to consider

that the average cost of a family health insurance policy providing first dollar coverage is today approaching \$10,000, and that the average cost of a Medicare beneficiary for hospital care, medical care, and drugs already exceeds \$10,000, and will within a few years exceed the cost of the average Social Security benefit.

At the same time, the Dartmouth experts estimate that one-third of Medicare spending is wasted on unnecessary care (E.S. Fisher *et al*, “The Implications of Regional Variations in Medicare Spending,” *Annals of Internal Medicine*, February 18 2003, <http://www.annals.org/cgi/content/full/138/4/273>).

We cannot predict how rapidly or how far direct market forces using price and quality information will operate to reduce the growth in health care costs or improve health outcomes. But we cannot afford not to try. The other alternatives such as direct rationing, triple-digit premium increases (in contrast to the double-digit increases we see today), or draconian tax increases, are unpalatable in the extreme.

It certainly appears that the current Administration “gets it.” Drs. McClellan and Clancy have worked tirelessly and effectively for years on these issues. The White House has opined forcefully. HHS Secretary Leavitt recently assembled hundreds of executives of his Department to issue his top priorities for the next three years, and number one on the list was “Health Care Value Incentives” aimed at restraining the growth of health care costs “because consumers [should] know the comparative costs and quality of their health care.” However, I do not think that this is a partisan issue. In the usual disjuncture between public policy reforms and subsequent outcomes, it is likely that the next Administration, of whichever party, will not only endorse, but get much of the credit for the reforms begun in the first years of the 21<sup>st</sup> century.

As a concluding comment, there are a number of bills pending in the Congress that deal with these issues in one fashion or another. Former Speaker Gingrich has mentioned the possibility of “right to know” legislation that would require doctors and hospitals to post prices. (For hospitals, that would stimulate immediate change because hospital charges generally bear little or no relation to either their costs or what insurers pay them.) Congressman Shadegg is sponsoring a bill that would enable health insurance to be sold

across state lines, and make other reforms that would open up consumer-driven insurance to millions of consumers, including many of the currently uninsured who are prohibited by State law from buying the insurance plans available to most Americans. There is a companion Senate bill. And both the Ways and Means and Senate Finance Committees are considering pay for performance legislation. I have not studied these bills and have no specific recommendations on details of legislation at this time. However, in the light of the substantial legal difficulties that HHS faces in releasing payment and performance information in a form that would either be directly useful to consumers or be useful after analysis by expert researchers, I suggest that if any bill nears enactment it include provisions that will help in overcoming any legal barriers.

Disclaimer: I have affiliations with three organizations mentioned in this testimony, Washington Consumers CHECKBOOK, the Centers for Medicare and Medicaid Services, and the United Network for Organ Sharing. Nothing in my testimony represents the views of any of these organizations, or relies in any way on information that these organizations do not provide to the public at large.