

Research Brief

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A Health Plan Work in Progress: Hospital-Physician Price and Quality Transparency

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Responding to large employers' interest in greater health care price and quality transparency, health plans are developing consumer tools to compare price and quality information across hospitals and physicians, but the tools' pervasiveness and usefulness are limited, according to findings from the Center for Studying Health System Change's (HSC) 2007 site visits to 12 nationally representative metropolitan communities.

Many large employers view price and quality transparency as key to a broader consumerism strategy, where employees take more responsibility for medical costs, lifestyle choices and treatment decisions. Some health plans believe providing price and quality information to enrollees is a competitive advantage, while others are skeptical about the benefits and are proceeding cautiously to avoid potential unintended consequences.

Health plans are in various stages of making price information available to enrollees. Plans generally provide some type of price information on inpatient and outpatient procedures and services from data based on their own negotiated prices or through aggregated health plan claims data obtained through a vendor; few plans provide price information on services in physician offices. However, the information provided often lacks specificity about individual providers, and its availability is often limited to enrollees in specific geographic areas. Health plans generally rely on third-party sources to package publicly available quality information instead of using information gleaned from their own claims or other data. Health plans' ability to advance price and quality comparison tools to the point where a critical mass of consumers trust and use the information to choose physicians and hospitals will likely have considerable influence on the ultimate success of broader health consumerism efforts.

Health Plans Ramp Up Price and Quality Transparency Efforts

As support for tightly managed care waned in the late-1990s, employers and health plans began to address rising health care costs through a "facilitated consumerism" strategy.¹ With such an approach, patients theoretically are motivated to "shop" for high-quality, low-cost health care, in part, because they are paying a larger share of the costs of care.² By providing access to provider price and quality information, health plans are looking to encourage enrollees' use of physicians and hospitals deemed high performing in terms of quality and efficiency.

The focus on price and quality transparency gained momentum when President Bush issued an executive order in August 2006 directing federal agencies that administer health care programs to share price and quality information with enrollees. Soon thereafter, the Department of Health and Human Services (HHS) incorporated price and quality transparency as key pillars in its "Four Cornerstones" initiative for health care improvement, along with health information technology and value-based health benefit designs, such as health spending accounts. This federal initiative also was intended to encourage similar private-sector transparency commitments by employers and health plans.

Health plan price and quality transparency efforts are largely in the early stages of development, and, according to initial studies, the efforts are largely underdeveloped with limited impact. A 2007 evaluation of health plan performance by the National Business Coalition on Health, for example, reported that while health plans had progressed in measuring quality, the information was not being made available to enrollees. The evaluation also reported that price transparency efforts were just beginning. Another study evaluated the first-generation of consumer-directed health plans (CDHPs) and reported that plans performed poorly on the provision of cost and quality information to aid consumers in selecting providers and treatment options.³ A study of large employers suggested that provider quality information is not widely disseminated to employees or commonly used to influence employee choice of providers.⁴

Despite the early evidence of limited impact, there is significant health plan activity around transparency, according to findings from HSC's 2007 site visits, which examined health plan motivations to provide price and quality information,

the types of information currently available, and the challenges plans face in providing this information (see Data Source). Given the recent heightened attention to transparency, this research brief assesses the current state of health plans' efforts to provide price and quality information to their enrollees.

Consumerism Strategy, Competition Motivate Health Plan Efforts

Health plan motivations to provide health care price and quality information come largely from employers' push for their employees to become more active and better-informed consumers. Particular pressure comes from large, self-insured employers that have recently begun offering CDHPs—typically high-deductible insurance products tied to a health spending account. Health plan executives reported feeling an obligation to provide information to CDHP enrollees, particularly about price, since these enrollees face higher expenditures at the point of service. Health plans recognize that, while take up of CDHPs has been limited, consumers enrolled in preferred

provider organizations (PPOs) and health maintenance organizations (HMOs) also are bearing more health care costs in the form of higher deductibles, coinsurance and copayments and would benefit from price and quality information. However, some plan respondents acknowledged they would be more willing to wait to provide price and quality information if they did not offer CDHPs.

Many health plan respondents, particularly those representing large national insurers, reported embracing consumerism, including price and quality transparency, as a way for health plans to create new value for their employer clients. They see engaging enrollees and providing information as a way to remain competitive against other health plans and are positioning themselves in the market as consumerism leaders. Some plans are betting on price and quality information becoming more important in the future. As one respondent said, "We have to look futuristically. Even though it's [consumer use of price and quality information] 15 percent now, if it's 20 percent next year, we need to be out there and have experience on how consumers are using tools to continually make the navigation an ultimate experience."

Other health plan respondents, particularly from small, local plans, reported feeling obligated to provide price and quality information because of the national transparency push, even if they are skeptical about the strategy's potential benefits. As one plan executive said, "Our main motive is defensive in nature. There is a lot of media and hype driven by our competition about it, without—in my estimation—full disclosure about the information's shortcomings." According to benefits consultants, the amount of information available has increased tremendously in the past two years because health plans believe they need to offer something to be competitive.

Data Source

Every two years, HSC conducts site visits in 12 nationally representative communities as part of the Community Tracking Study to interview health care leaders about the local health care market and how it has changed. The communities are Boston; Cleveland; Greenville, S.C.; Indianapolis; Lansing, Mich.; Little Rock; Miami; northern New Jersey; Orange County, Calif.; Phoenix; Seattle; and Syracuse, N.Y. The sixth round of site visits was conducted between February and June 2007 and a total of 453 interviews were completed with representatives of health plans, hospitals, physician organizations, major employers, benefit consultants, insurance brokers, community health centers, consumer advocates and state and local policy makers. Twenty-nine additional interviews were conducted between October 2007 and January 2008 to explore price and quality transparency issues in more depth. These additional interviews were conducted with representatives of national, Blue Cross Blue Shield, regional and local health plans, large employers, as well as with benefit consultants, insurance brokers, a health information vendor, and other knowledgeable market observers.

Price Transparency

Health plans are in various stages of making hospital and physician price information available to consumers via plan Web sites. Larger plans, particularly national insurers, have progressed further in developing price information than many local or regional health plans, although the utility and availability of the price information is still limited. Several national health plans and a regional plan reported providing some type of price information based on their own data—usually negotiated prices with hospitals and physicians—and are making this information available to enrollees in specific geographic areas on a rolling basis.

More commonly, however, plans that offer price information use vendors, such as Subimo, that aggregate claims data from multiple health plans. Some regional and local health plans whose product mix is dominated by HMO products do not provide price information to enrollees. Respondents explained that such information is not in demand because most HMO enrollees are exposed to little point-of-service responsibility for costs other than fixed-dollar copayments.

Health plan executives generally agreed that the most useful price information would incorporate consumers' individual benefit structures—their deductible and coinsurance rate, for example—and insurers' negotiated provider payment rates because patient out-of-pocket costs vary based on these factors. As a benefits consultant said, "What these carriers do not do at this point is this: say that you may be covered with a \$300 deductible and 80 percent coinsurance, and I may be covered with a \$30 copay. You and I will get the same answer [about the cost of a procedure.] You won't see how much you will pay in a format that is customized to each enrollee's benefit structures. Price information is sparsely available, and where it is

available, it's of relatively low utility for the average member."

Few plans provide price information that is customized to reflect individual enrollees' benefit design. Only one health plan interviewed—Humana—reported having Web site capability to allow for individual customization of price information based on an enrollee's deductible, copayments and out-of-pocket maximum. Several plans reported being in the design stage and hoped to offer customized price information in the near future, particularly for CDHP enrollees. While a few plans provide deductible accumulators to help members keep track of out-of-pocket expenditures, these tools typically are not linked to price information. However, some health plans appear to be moving in this direction. The Wisconsin Association of Health Plans, for example, recently announced that 17 health plans in the state have agreed to estimate individual enrollees' potential out-of-pocket costs for certain tests or procedures upon specific request, beginning Sept. 1, 2008.⁵

Generally, health plans that offer hospital price information provide average prices or a range of prices for the most common inpatient hospital services and procedures in certain geographic areas, typically based on zip code, city or state. Plans provide price information for such common inpatient procedures as angioplasty, heart bypass surgery and knee replacement surgery and for such common outpatient services as laboratory and diagnostic tests. The number of procedures and services with available price information varies widely across plans—from 20 to more than 600—though most plans generally provide price information for between 20 and 50 procedures or services.

Several national plans and one regional plan interviewed reported providing facility-specific price information, which enables enrollees to compare costs across hospitals within a certain zip code or geographic

area. Prices for inpatient and outpatient procedures and services typically are presented as the average total cost or the range of costs for a bundle of services, which are services from all providers involved in an episode of care—the treatment of a condition from the initial encounter with a health care provider through the final encounter. For example, the Anthem Care Comparison demonstration tool enables enrollees to compare the cost of common procedures at specific in-network hospitals

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and outpatient facilities in a geographic area of their choice. To illustrate, the cost for outpatient knee surgery for cartilage repair using arthroscopy at Kettering Medical Center in Dayton, Ohio, including physician fees, hospital facility costs, anesthesia, pathology labs, and other ancillary service costs, ranges from \$3,437 to \$4,200; members can compare the cost of this knee surgery across different hospitals and other facilities in the Dayton area.⁶ Anthem also has a link to information to help guide consumers on how to apply their copayment and coinsurance to the range of costs provided so that they can estimate the out-of-pocket costs they would face.

Health plan executives said that the bundling of services into an episode of care and the use of average costs or the use of

symbols, such as multiple-dollar signs, to indicate how the price of a service or procedure at a hospital compares with others in a geographic area helps to keep the payment rates health plans have negotiated with hospitals and other facilities confidential. As one health plan executive explained, “By combining the data into ranges, we’re not specifically listing any particular reimbursement rates. Instead, we are giving members a general idea without breaking confidences of existing provider arrangements.” This is important both to comply with the terms of their provider contracts and to limit the potential for the information to lead to

dle of services for a common diagnosis, such as a sinus infection, which would include the physician office visit, lab tests and other services required to treat the condition.

Some plans do not provide specific physician office visit price information but rather use efficiency designations for physicians who meet certain criteria. UnitedHealthcare, for example, designates physicians in selected specialties with one star if they meet the quality threshold and two stars if they meet the plan’s thresholds for both quality and cost efficiency, the latter defined by United as using the least amount of medical resources to treat a

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higher negotiated prices in the future, since providers receiving lower payments may demand payment comparable to what their competitors receive.

Few health plans reported providing price information for physician services; when they do, they generally provide the average cost of physician office visits in a particular geographic area, sometimes by city or zip code, and these costs are not specific to particular physicians. Some health plans make a physician fee schedule available to consumers or post the average price for common office visits. However, most respondents agreed this was less helpful information since fee schedules typically contain thousands of services and consumers are unlikely to know which services they will need. Further, some health plans have most of the physicians in the market on the same fee schedule, so the information’s only use is to identify which practices have negotiated higher rates and by how much. Humana presents price information for physician services as the average cost for a bun-

medical condition to achieve a desired outcome and/or quality of care.

There are several factors that limit the utility of price transparency at this point. One is the prevalence of benefit structures that make consumers insensitive to price differences across providers. Even in high-deductible plans, for example, limits on out-of-pocket liability reduce consumers’ incentives to compare the costs of inpatient care. A health plan executive said, “Hospital price information is of little interest to members...we run deductibles of maybe \$1,000 to \$3,000, and every inpatient stay blows through that deductible.” For physician services, differences in out-of-pocket costs to enrollees among network physicians tend to be small, if any. When patients use an out-of-network physician, however, along with typically facing higher coinsurance rates, patients also run the risk of balance billing, where the provider’s charge exceeds the health plan’s usual and customary allowance, leaving the patient responsible for the difference.

Quality Transparency

Compared with price transparency, health plans are further along on quality transparency, in part, because provider quality information is valuable to all consumers since hospital and physician performance is not linked to specific benefit structures. Nevertheless, health plans are proceeding cautiously in providing quality information because they fear pushback from providers if they attempt to place a “poor quality” label on a doctor or hospital. Also, plans’ individual claims data offer only limited quality information. Therefore, most plans rely more heavily on nationally reported quality information from third-party sources, such as Medicare and others.

Most of the quality information plans are providing pertains to hospitals rather than physicians. This reflects both the greater availability of third-party hospital data, as well as more widely accepted quality measures for inpatient care that are collected and reported by organizations independent of health plans, which mitigates concerns by providers and others that health plans might provide information biased in favor of health plans’ interests. As one benefits consultant said, “For example, with the tools that will invariably be used, the carrier is saying, ‘this is not how [a private insurer] decided how to rate a hospital. This is a measure that is approved by JCAHO or CMS [Centers for Medicare & Medicaid Services].’”

Several plans reported providing information to enrollees on hospital quality using data from The Leapfrog Group’s Hospital Quality and Safety Survey. This survey relies on self-reported hospital data on the Leapfrog Safe Practices Score, which includes 30 practices endorsed by the National Quality Forum as reducing the risk of harm to patients. Health plans also use hospital quality measures from the Hospital Compare program administered by CMS, which displays compliance rates

for process measures for four conditions: heart attack, heart failure, pneumonia and surgical care improvement. Hospital Compare consists of 26 process measures related to these four conditions and relies on hospitals to report information for both Medicare and non-Medicare patients. Although reporting is voluntary, participation rates are high because of payment bonuses for participation. Hospital Compare also provides data on 30-day risk-adjusted mortality rates for patients admitted for heart attack and heart failure; claims and enrollment data for fee-for-service Medicare are used to determine this information.

Few plans attempt to give hospitals an overall quality score because of validity concerns about quality measures and concerns that averaging quality scores across distinct service areas will mask information about specific areas or domains. More frequently, plans provide facility-specific data on selected quality metrics, such as mortality, morbidity, average length of stay, volume and complications—measures determined by leading external quality organizations. For example, CIGNA provides quality ratings at specific hospitals by condition or procedure, such as pneumonia or total knee replacement. To determine these ratings, the plan weights and combines the following measures: complications, mortality, Leapfrog Group patient-safety data, overall CMS hospital quality measures, and CMS condition specific rates. The type of measures provided may also depend on the procedure. For example, mortality rates are important indicators in cardiac care, but less so for certain orthopedic procedures where mortality rates are so low that little meaningful variation is seen.

Health plan respondents reported more progress on making information available to enrollees on hospital performance than on physician performance. Physician

quality information is often limited to designations of physicians accredited by the National Committee on Quality Assurance (NCQA) for meeting specific criteria for the care of patients with back pain, diabetes and other targeted conditions. Plans also use other NCQA tools, such as the Healthcare Effectiveness Data Information Set (HEDIS), which focuses on the extent to which physicians provide services as recommended by clinical guidelines, such as a beta-blocker drug treatment following a heart attack, periodic breast cancer screening and comprehensive diabetes care. Some plans report HEDIS measures at the physician-practice level, and a few plans report HEDIS measures for individual physicians; more plans said they are planning to make HEDIS data for physicians available to consumers in the near future.

Most plans reported using a health information vendor to aggregate or manage all of these measures and data sources. Subimo—now part of WebMD—was the most frequently cited vendor used. Subimo offers numerous health care-decision tools that aggregate and organize publicly available data. The most frequently mentioned tool was the Hospital Advisor, which provides quality information on 5,000 hospitals and 100 common conditions and procedures. The information is a compilation of CMS data, Leapfrog survey results and all-payer discharge data from selected states, as well as information submitted by hospitals to Health Forum—a subsidiary of the American Hospital Association responsible for generating and publishing hospital industry data. The Hospital Advisor tool is searchable by facility and procedure and is customizable in terms of geography and the user's priority ranking of certain measures. HealthGrades is another information vendor that respondents mentioned; it rates hospitals using

a five-star rating system on mortality and complication-based outcomes, primarily using CMS data.

Many plans apply some combination of these third-party quality measures to measures from their own claims data or do so through a vendor. For example, one local health plan reportedly provides quality information based largely on publicly available Medicare claims data, but also uses its own claims data to fill in gaps for pediatric and obstetric services. Other plans do not use any of their own data,

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 and some simply provide links on their Web site to outside organizations—such as Leapfrog, CMS or HealthGrades—providing quality information.

Physician quality information provided by health plans to enrollees, like physician quality information generally, is in its infancy. As one benefits consultant reported, “On the physician side, the quality information that carriers make available ranges from none—which is most common—to information of limited utility.” Plans providing physician quality information usually base it on board certification and NCQA recognition. For selected specialties, some plans apply claims data to measures determined by the relevant national medical specialty societies.

Only a few plans, however, offer substantial quality information on physicians. Insufficient numbers of cases available in any single insurer's claims database for a physician limits what plans can derive from their own data, a problem that is

particularly acute for plans with small market share in a given area. As a representative from a small, local health plan said, “It’s hard to say you are publishing information that has something to do with the quality of care provided when providers’ patient volume [from the health plan] is less than 10 percent of their total patient volume.” Many plans do not believe their volume of claims data is large enough to support the production of accurate quality information for individual physicians. Plans also are hesitant to assess physician quality because of the possibility that small patient sample sizes and differing methodologies can yield different health

tion measures into the quality information they provide because “the number one way to select physicians is word of mouth.” For example, WellPoint is working with Zagat—a company best known for restaurant guides—to survey patients’ satisfaction with their physicians and post the reviews on WellPoint’s Web site. Additionally, CMS recently began providing patient satisfaction information on the Hospital Compare Web site based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospital Survey.

Although plans continue to expand quality information using plan-specific hospital and physician performance mea-

are attempting to address these challenges. A number of health plans have joined regional quality information collaboratives to pool private data with Medicare claims data to produce more accurate, comprehensive measures of quality at the provider level. One national effort to address the issues of quality measure reliability and the proprietary nature of health plan data is a data aggregation initiative, launched by America’s Health Insurance Plans Foundation (AHIPF) and funded by the Robert Wood Johnson Foundation (RWJF). The goal of this initiative is to develop standard health plan measurement methodologies and aggregation approaches that link to CMS and HHS efforts to provide select communities’ performance data. The Consumer-Purchaser Disclosure Project is another national quality measurement collaboration supported by four national health plans—Aetna, CIGNA, UnitedHealthcare and WellPoint. This initiative, also funded by RWJF, seeks to create a national set of principles to guide how health plans measure physicians’ performance and report the information to consumers.⁸

Health plan respondents were particularly concerned that enrollees may interpret high price as a proxy for high quality and shift to higher-cost providers, thus raising costs, but not necessarily improving quality.

plan quality ratings for the same physician, raising broader concerns about plans’ credibility in assessing physician quality.

An overall lack of consensus on how to measure physician quality, particularly at the specialty level, also is a barrier. As one regional plan executive said, “We are using cost efficiency ratings for all 18 physician specialties, but with quality, we could only come up with 12 specialties...It is much harder to come up with quality measures based on claims data alone and have those measures be valid, noncontroversial measures.” Despite these limitations, some plans have moved forward with using the quality and efficiency information they do have to create high-performance networks or other performance-rating programs for physicians. Physicians, however, often are skeptical of these programs.⁷

Many plan executives reported considering the incorporation of patient satisfac-

surement data, how far down that path they might realistically go remains to be seen. Health plan executives often said they believed quality measurement would be more reliable if aggregated at a level beyond any single health plan, but that is difficult because of the proprietary nature of individual health plan’s data. Overall, respondents were generally skeptical that any real progress could be made by individual plans to assess quality because of limitations in developing quality measures, such as relying on claims as their primary data source and the small sample size available to individual plans based on their data alone. Moreover, a few health plan respondents view quality transparency as an important competitive advantage in differentiating themselves from their competitors, thereby limiting the likelihood of collaboration.

Health plans and other stakeholders

Transparency Risks and Challenges

Plans are carefully weighing the advantages of providing price and quality information against potential pitfalls. Plan executives perceive one of the biggest risks to be the misinterpretation of price and quality information by consumers. Health plan respondents were particularly concerned that enrollees may interpret high price as a proxy for high quality and shift to higher-cost providers, thus raising costs, but not necessarily improving quality. Respondents reported trying to safeguard against this by providing at least some quality information to accompany any price information provided.

Another challenge health plans face

is assessing enrollees' access to and use of the price and quality information provided. According to most respondents, plans generally do not track the extent to which members access information. A few plans reportedly track the percentage of enrollees registered to use members-only Web sites—the location where most plans' price and quality information is displayed. However, most of these plans reported low registration rates—5 percent to 15 percent of enrollees. As one health plan executive said, "We generally found that people don't use health plans' secure Web sites. This stuff isn't on public sites, and if it isn't on public sites, then the information isn't used as much as we would like." Health plan respondents reported limited investment in informing enrollees of the availability of such information, which may reflect, in part, the rudimentary state of most plans' price and quality information. But, the low use may also indicate a lack of consumer interest in such information.

When price and quality information is accessed, plans believe that enrollees often are unclear about how to evaluate it or determine what it means. Many plans reportedly have tried to display information simply, using symbols such as a star, dollar sign or a ribbon to designate quality and/or price ratings, as opposed to more detailed information. As one national plan executive described the issue, "One of the things that is a challenge to members is if you say something is 0.6, is that good or bad?"

Health plans also are concerned about providers' reactions to the information provided enrollees, fearing pushback. But according to plan respondents, the most common reaction by providers to date has been indifference. Low usage and the absence of economic incentives to encourage enrollees' use of the information to select providers have led to providers paying little attention to these tools. In some markets, providers are reportedly complete-

ly unaware of existing health plan transparency programs.

In general, physicians have responded more negatively than hospitals to the price and quality information plans provide. According to respondents, the most common reaction by physicians is to question the credibility of the data. In part, this is why health plans say they are using outside vendors and tools—to try and maximize data credibility. Including both cost and quality information is also done to deflect

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provider arguments that transparency programs are designed solely to direct patients to "cheap doctors."

Another issue that providers have protested is that each plan has its own methodology to assess efficiency and quality. Health plans risk loss of credibility with providers when assessments vary across plans or from one year to the next. As one health plan executive said, "...In the end, providers will always have more credibility with patients than health plans or employers. If you put information out there and providers tell their patients that the information is meaningless, most members will believe that and our efforts are wasted."

Health plans' provision of price and quality information to enrollees is seen by some to involve various legal risks. A few respondents expressed concern about what would happen if the data were inaccurate and led consumers to choose a poor-quality doctor, whose care resulted in an adverse outcome. Also, providers

often have specific clauses in their contracts with health plans that prevent disclosure of certain information, such as payment rates. Additionally, some plan respondents mentioned the experience in Washington, where the medical society sued Regence BlueShield over attempts to exclude physicians from its network based on quality and efficiency measures. An investigation by the New York State Attorney General into plan quality and efficiency designation programs posed risks of penalties for inappropriate

approaches to measurement. However, the ensuing settlement resulted in specific guidance to plans about how they should assess provider quality and efficiency and provide that information to consumers.

Implications

Most supporters of health care consumerism regard choosing providers on the basis of price and quality to be a critical component of the approach. With consumers needing help in accessing and using price and quality information, many health plans, especially national insurers, are seeking to become the valued intermediary that provides enrollees with this information in hopes of gaining a competitive advantage. Because health plans have negotiated prices with providers and can bring expertise to analysis of price data, plans have the potential to provide information that reflects rates actually paid and to translate that information into likely out-of-pocket costs for an episode of care based on each mem-



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The nation is still far from price and quality transparency information influencing consumers' health care decisions in a meaningful way.

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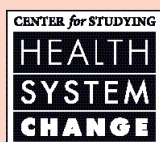
ber's benefit structure. Plans generally have not achieved this potential and vary widely in their efforts to make price information available to enrollees. For quality data, plans appear primarily to be a conduit for information developed by governments and other third-party sources.

None of the respondents interviewed believed that price and quality information is being used extensively by consumers today, in part, because few consumers have incentives in their benefit structures to encourage cost comparisons, but also because this represents a major paradigm shift for consumers. While some health plans have developed high-performance networks that encourage enrollees to choose physicians who score well on quality and efficiency measures, enrollment and consumer experience with these products is limited.⁹ Few respondents had confidence that the quality information now available is close to what consumers need to make informed decisions. Whether the usefulness of the tools will evolve rapidly enough to better realize the vision of consumerism over the next few years is uncertain.

While the federal government has led the vanguard of price and quality transparency, it has resisted public release of Medicare physician claims data, which would allow private insurers to develop more meaningful information on physician performance.¹⁰ Federal and state governments also could contribute to transparency efforts by convening public-private partnerships of insurers, employers, providers and other stakeholders to develop common quality measures and to facilitate the pooling of data to increase sample sizes for analysis, thereby enhancing the overall validity of these efforts. Despite efforts in this direction, the nation is still far from price and quality transparency information influencing consumers' health care decisions in a meaningful way. ■

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