'Price-Tagging': Key to Consumer-Driven Care?

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WASHINGTON — Price transparency for physician and hospital services is a key element in the Bush administration's vision of "consumer-driven" health care, and the administration is prepared to push for mandatory price-tagging if doctors and hospital administrators won't voluntarily provide the information.

Speaking at a health care congress sponsored by the Wall Street Journal and CNBC, Al Hubbard, assistant to President George W. Bush for economic policy, issued a kind of ultimatum to the clinical community: "Make pricing information available without being forced. We have allies in Congress who are very much inclined to be prescriptive with legislation to impose pricing and quality standards on the health care community."

Comprehensive and accurate pricing for health care services are essential for the efficacy of health savings accounts (HSAs) and other market-driven solutions to health care spending, said Mr. Hubbard, who is also director of the National Economic Council, at the meeting.

He cited LASIK (laser in situ keratomileusis) surgery as a prime example. "Fifteen years ago, LASIK cost about $2,500 per eye. Because the service is an out-of-pocket expense, now the cost is under $1,000 per eye. That's what would happen in the rest of health care if people were price-sensitive consumers," he said. "You cannot be a wise consumer if you don't know the prices or the quality of the goods. Right now, providers do not make that information available, and a lot of hospital executives don't believe pricing information should be available."

Mr. Hubbard's remarks followed a video address by President Bush, in which the President underscored his commitment to HSAs as a key instrument for change. He estimated that more than 3 million Americans will be enrolled in HSAs this year, a number he hopes to see vastly increased over the next few years.

The President underscored the "simple and clear philosophy" that underlies his solution to the health care problem: "The American medical system should be run by doctors, patients, and consumers, not the federal government."

It was easy for Mr. Hubbard to talk tough at the meeting. According to the conference organizers, physicians represented only 4% of attendees, and there were few doctors in the room during Mr. Hubbard's address.

One physician, an anesthesiologist, did stand up to challenge the administration's fixation on price-tagging. He cited the potential dangers that could arise if "consumers"—that is, patients—began choosing health care services based on price postings. He stressed that the medical community itself is far from having accurate quality measures to determine standards for best practices. Without clear and science-based quality standards, pricing information would have little value because patients would not be able to determine what they would be getting for their money. Further, shopping for health care based on price could encourage substandard care and suboptimal clinical outcomes.

He also pointed out that a higher-priced physician practice or hospital may be incurring those higher costs because they are treating a sicker population. Likewise a practice or hospital with lower outcomes scores may be handling sicker patients. Price tags and raw outcomes data alone would not reflect this, unless accurate risk-stratification measures were also incorporated.

Mr. Hubbard acknowledged that there's much work to be done in developing meaningful outcomes standards and risk assessment tools so that consumers can "compare apples to apples." At the same time, the administration seems unwilling to wait around indefinitely while practitioners and hospitals figure out how to prove their worth.

Several in the audience pointed out that the "shop-around" approach is likely to break down around episodes of emergency care, critical care, and sudden onset of disease. An individual having a myocardial infarction isn't likely to consult the Internet to find out which area hospital offers the best dollar value.

Mr. Hubbard agreed that emergency situations are an exception to the consumer-driven rule, but he insisted that "there's no reason we should not be able to have bundled pricing from our physicians and hospitals on all nonemergency care. We want you to treat your patients/customers exactly the way you want to be treated when you consume a product or service."

Whether a mandate for pricing transparency is truly in the offing remains to be seen. What is clear is that the Bush administration views HSAs and other strategies for shifting greater cost and greater health care responsibility onto consumers as the only viable strategy for the nation's health care financing woes.

During a separate session at the meeting, Jack Brennan, CEO of the Vanguard Group, the nation's second largest mutual fund company, and Jim Guest, president of Consumers Union (publisher of Consumer Reports), reviewed the potential strengths and weaknesses of consumer-driven health care plans.

Mr. Brennan said that Vanguard offers its 12,000 employees a consumer-driven health plan option, and has for several years. However, no more than 10% of the company's employees have chosen it. "I'd say there's a bit of a reluctance, but it is a start, and I'd like to see more," he said.

Consumer Reports' Mr. Guest said his organization supports the general idea of "consumer-informed health care," but added that it is far too early to tell whether strategies like those advocated by the Bush administration will really deliver on their stated promises. ■

POLICY & PRACTICE

Bill Aims to Delay Imaging Cuts

Rep. Michael Burgess (R-Tex.), an ob.gyn., has introduced legislation to improve physician reimbursement under Medicare and delay cuts in payments for imaging services. The bill also would establish a system of quality measures to give patients more information about Medicare providers. The American Medical Association called the Medicare Physician Payment Reform Bill and Quality Improvement Act of 2006 an "important step toward replacing the flawed Medicare physician payment formula." The legislation would change formulas to end the "negative feedback loop that constantly creates a deficit in healthcare funding," Rep. Burgess said in a statement. It also includes a 1-year delay for planned cuts in Medicare payments for imaging services and requires the Institute of Medicine to perform a study on the question of whether imaging saves money. The quality measures would help beneficiaries decide whether a particular physician was worth paying a higher copayment to see. "If a patient sees that short waiting times equate to perhaps a $10 increase in their bill, they may decide that the money is worth it," the congressman added.

PAs Eye Specialty Recognition

Physician assistants are considering voluntary recognition for those practicing in specialties to denote their advanced knowledge. A task force organized by the National Commission on Certification of Physician Assistants is studying options after receiving comments on the issue during a forum it held on the topic earlier this summer. PAs find their supervising doctors often lack time to train them, forum participants said. The task force does not have a deadline, and it is only considering recognition—not certification—for specialties, Tiffany Flick, communications manager for NCCPA, said in an interview.

P4P Raises Pay in U.K.

A 3-year experiment in pay for performance boosted gross income for family physicians in the United Kingdom but may have made it too easy for the physicians to earn that extra money, according to a study by Tim Doran of the National Primary Care Research and Development Centre, University of Manchester (England) and colleagues. The $3 billion program was designed to boost family physicians' pay an average of 25% depending on how well they performed on certain quality indicators for 10 chronic diseases, including asthma, coronary heart disease, diabetes, and epilepsy. The physicians attained a median of 97% of the available points for clinical indicators—greatly exceeding predictions of 75%—and boosted their gross income by an average of $40,000. However, "the high levels of achievement might suggest that the targets were too easy to achieve," the authors said, adding that the monetary gains may have been offset by the money physicians spent getting ready for the program, including expenses such as hiring extra staff and installing electronic health records. The article appeared in the July 27, 2006, issue of the New England Journal of Medicine. An accompanying editorial agreed that the targets may have been set too low and raised the possibility that some physicians may have "gamed the system" by excluding patients whose care did not meet the performance criteria.

Paying Community Pharmacies

Independent pharmacies are seeking legislative help as they struggle with the increased workload from Medicare Part D. Many are racking up debt under the strain—an average of just under $70,000 per pharmacy, according to a survey of 5,000 members of the National Community Pharmacists Association. The Fair and Speedy Treatment of Claims Act of 2006 would require pharmacy claims submitted electronically to be paid within 14 days. The measure aims "to ensure that pharmacists are not forced out of business by inadequate, slow reimbursement and unclear claims processing," according to its sponsors, Rep. Marion Berry (D-Ark.), and Rep. Walter Jones (R-N.C.). Mark Merritt, president of the Pharmaceutical Care Management Association, responded in a teleconference by noting that pharmacy benefit management companies pay most claims from pharmacies within 30 days—standard in American business. The legislation also includes a $14 payment for filling a generic prescription and sets guidelines for medication therapy management programs offered by drug plans. Such programs aim to promote proper medication use in high-risk seniors. PCMA's analysis found that overall, the bill would cost the Medicare program at least $55 billion over 10 years and beneficiaries $30 billion. The measure had 144 cosponsors as of mid-July.

Poll: Live Unhealthy, Pay the Price

More than half of respondents to a Wall Street Journal/Harris Interactive poll say that people who smoke or choose not to wear seat belts should pay a higher health insurance premium than people who don't engage in those behaviors, but most people did not feel the same way about people who were overweight or didn't exercise enough. Only 27% of the poll's 2,200 respondents thought that overweight people should pay more for insurance than slimmer people; the same percentage favored having people who did not exercise regularly pay more. The amount of education the respondent had affected the responses he or she gave: Those with some college education were more likely to agree that those with unhealthy lifestyles should pay higher premiums, compared with respondents with a high school education or less. The poll had a 3.3% margin of error.

—Nancy Nickell

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