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Obamacare's New Wave Of Transparency

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IN A 1913 Harper's Weekly article titled "What Publicity Can Do," U.S. Supreme Court Justice Louis Brandeis made his famous statement that "sunlight is said to be the best of disinfectants" in arguing for greater disclosure of bankers' securities commissions to investors. Now, 100 years later, the Patient Protection and Affordable Care Act, or Obamacare, hopes to apply Brandeis' basic idea — that greater transparency leads to better outcomes — to the health care industry.

Many Coloradans have likely heard about Obamacare's new health insurance exchanges (such as Connect for Health Colorado) that seek to apply an Expedia-style solution to the health insurance market to lower costs, in part, through greater price and benefits transparency. A recent analysis in Forbes found that Coloradans covered in these insurance exchanges could see their premiums drop by an average of 34 percent.

Many Coloradans may not be aware of the number of other Obamacare reforms that seek to use greater transparency to deliver better health care outcomes. The Open Payment program, accountable care organizations, the Physician Compare website and the recent disclosure of Medicare hospital charges are just a few of the "sunshine" initiatives being undertaken by the federal government. All of these initiatives will likely have some impact on the heath care marketplace, although it is still unclear how much this greater push for transparency will impact providers and health care consumers.

Open payments

Obamacare's Physician Payment Sunshine Act, which the Centers for Medicare and Medicaid Services now calls "open payments," requires that manufacturers of drugs and medical devices annually report to CMS payments made to, and other financial relationships with, physicians and teaching hospitals. CMS will collect information about these financial relationships and begin publishing the information on a website in late 2014.

Collaboration among physicians, teaching hospitals and industry manufacturers can be critical to the development of life-saving products. Sometimes, however, financial relationships between these collaborators can lead to conflicts of interest, which can compromise research, education and clinical decision-making. The goal of open payments is to give health care consumers greater access to information regarding these conflicts of interest.

In the short term, it seems unlikely that many health care consumers will know about these transparency reports, and perhaps far fewer consumers will use this information to alter their health care

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decisions. Case in point: if you've recently had an MRI, CT or PET scan in your doctor's office, did you read that written notice disclosing the doctor's ownership interest in the MRI, CT or PET scan? Probably not. This "in office" services disclosure was mandated under Obamacare, but it is unclear what kind of impact (other than increased paperwork) it is having on the health care marketplace.

These new transparency reports do seem likely to result in increased regulatory scrutiny for physicians and hospitals that have financial relationships with manufacturers. Although CMS has stated that disclosure of payments does not mean the parties were engaged in any wrongdoing, it is clear that disclosure will not protect them from liability under other fraud and abuse laws, such as the Anti-Kickback Statute and the False Claims Act. These transparency reports could become a boon for investigators looking to uncover the next big health care scandal. As a result, it seems possible that this open payment program, although perhaps designed with good intentions, will spell the end of important collaborations between physicians, teaching hospitals and industry manufacturers.

Accountable care organizations

Obamacare's new accountable care organizations are groups of doctors, hospitals and other health care providers that voluntarily agree to be responsible for all the health care needs of a group of patients and to be paid through "shared savings" if the ACO lowers its growth in health care costs while meeting performance standards on quality of care. Under CMS' Medicare Shared Savings Program, Medicare ACOs are required to publicly report certain information, including organizational and contact information, shared savings and losses information, and results of quality measure reporting.

CMS has stated that public reporting can promote more informed patient choice, help improve quality and lower the cost of care through the sharing of best practices. Some critics of ACOs note they have heard this pitch before: It was called "managed care" or HMOs in the 1990s; it led to unpopular methods like "rationing" and "gatekeeping;" and it failed pretty miserably. CMS believes that ACOs are better structured than HMOs because they allow for patient choice of providers and impose quality of care standards.

Only time will tell whether ACOs will lead to better outcomes for health care consumers. At this point, the results seem mixed. CMS recently announced the 2012 results for "pioneer" ACOs, a select group of 32 organizations that agreed to higher financial incentives and higher risk than the traditional shared-savings ACOs. CMS' report showed that of the 32 pioneers, 18 had savings and 14 generated losses in 2012. Of the 18 that saved money, 13 had a high enough savings margin that they will get money from Medicare. Of the 14 that generated losses, two groups had high enough losses that they will owe Medicare money.

Practically speaking, ACOs face a number of barriers that could prove difficult for some groups to overcome. The ACO needs to be able to pay the large, up-front costs with adopting an electronic health record system so that providers can communicate efficiently. Aligning multi-specialty providers, which is necessary to provide patients with the continuum of care, can be challenging when there are income disparities between specialties and how physicians can get paid. Moreover, for Medicare ACOs, there is no patient requirement that they only use "in network" ACO providers, yet ACOs still are responsible for the quality and cost of patients' care.

Physician compare

Mandated by Obamacare, the Physician Compare website includes information on physicians enrolled in Medicare in order for patients to take a more active role in their health care decisions. Currently, consumers can view basic physician information, such as the physician's specialty, location and hospital affiliations. A physician's profile page will include information on participation in Medicare incentive programs on quality reporting, electronic prescribing and use of electronic health records. In 2014, quality-of-care ratings for group practices will be added, and a similar system for individual physicians will be included in the future.

It seems many people agree that transparent health care information is useful for a wide range of stakeholders and can help a patient make informed health care choices. Physician-affiliated groups, such as the American Medical Association, have continued to identify inaccurate information on the Physician Compare website. These groups are rightly concerned about the accuracy of physician performance metrics, including disclosure of which criteria are used and how the criteria were developed.

Physicians will have the opportunity to review their data for 30 days before it is posted to Physician Compare, but no one knows yet how difficult it will be for physicians to appeal for changes to their data. In addition, it seems reasonable to assume that there will be difficulties in trying to make somewhat complicated quality-of-care information comprehensible and useful to patients, while acknowledging the information's limitations.

Disclosure of hospital charges

Although not required under Obamacare, but perhaps inspired by its transparency initiatives, in May 2013 CMS took the unprecedented step of releasing hospital billing data for the 100 most frequently billed discharges. This data represents about 7 million discharges at 3,300 hospitals in 2011, or about 60 percent of the overall Medicare in-patient discharges.

The results were surprising. For example, one hospital in the Denver metro area may charge a patient with a parasitic disease $116,000 more to treat the condition than another Denver hospital. Hospitals in the Denver metro area routinely charge 25 percent more than state averages, with the exception of Denver Health. These reported charges are based on a hospital's "chargemaster," which generally serve as negotiating tools with private insurers who end up paying only a portion of those prices. Of course, those without health insurance are forced to pay these full retail prices.

Advocates of greater health transparency may view this data disclosure as a good first step in shedding light on the disparities between hospitals' charges. However, more data would be helpful to get a better picture of the "true" hospital prices, including disclosure of the average amount hospitals charge for routine procedures.

Some states already require this type of disclosure, including Colorado. The Colorado Hospital Price Report is a joint project of the Colorado Hospital Association and the Colorado Division of Insurance, which annually publishes information about hospital charges and insurance reimbursement rates for the 25 most common procedures performed in Colorado hospitals. By the end of 2013, the All Payers Claims Database will be available to consumers to compare the costs of major medical procedures at hospitals and outpatient centers across Colorado. In this regard, Colorado is certainly on the leading edge of this new wave of greater price transparency. •

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