The Search for True Healthcare Transparency

A Comparative Review of Today's Healthcare "Transparency" Solutions – the Hits, the Misses and the Fails

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Transparency, the New Buzzword in Healthcare

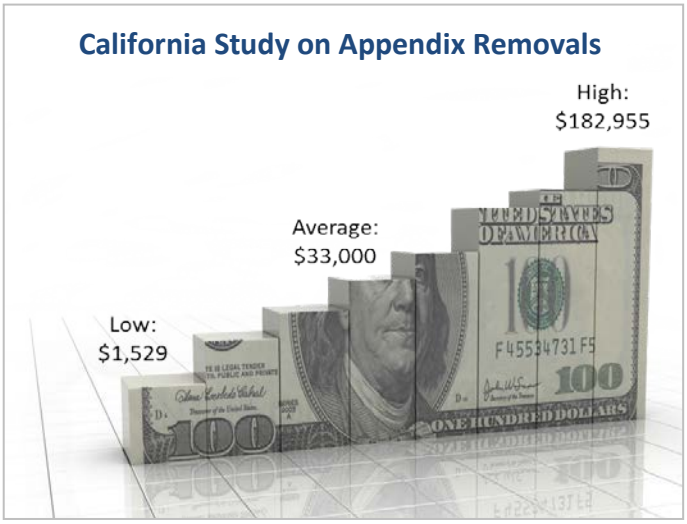
Healthcare price and quality have been nearly impossible to determine. Consumers could compare prices and quality of nearly everything they purchased, except healthcare – which truly has life and death implications.

Today, there is a new demand for healthcare transparency driven by:

- Employers' efforts to contain escalating costs
- High-performing providers distinguishing their efficiency (price) and proficiency (quality)
- Consumers seeking better value

Accomplishing this requires unearthing true and independently determined value – not just "secret" negotiated insurance rates, artificial fee schedules and quality metrics of questionable relevance.

Unknowingly purchasing healthcare with large price variations is a major cause of healthcare inflation and is estimated to cost Americans with employer-sponsored insurance as much as $36 billion a year.[1] A recent study published in the Archives of Internal Medicine revealed prices ranging from a low of $1,529 to a whopping high of $182,955 for an appendectomy![2]



The mystery of healthcare pricing contributes significantly to the escalating cost of healthcare burdening consumers, employers and taxpayers. Introducing transparency to the healthcare market will shrink price and quality disparities – saving employers and employees money while they receive better quality care.

Quality is as important a factor as price, yet most consumers do not incorporate it into their healthcare decisions, largely because that information is not readily available. Online opinions of physicians and hospitals generally focus on wait times or communication skills rather than clinical qualifications and outcomes. The former makes you comfortable or uncomfortable; the latter can be costly, even deadly.

So quality does matter. In fact, more than one quarter of inpatient stays experience a medical error: 13.5 percent of Medicare/Medicaid hospital patients experienced an adverse event (a serious event,

[1] Save $36 Billion in U.S. Healthcare Spending Through Price Transparency (White paper), Thompson Reuters, February 2012.

[2] Renee Y. Hsia, MD, MSc; Abbas H. Kothari, BA; Tanja Srebotnjak, PhD; Judy Maselli, MSPH. Health Care as a "Market Good"? Appendicitis as a Case Study; *Arch Intern Med*. 2012;172(10):818-819.

including death and disability) and another 13.5 percent experienced some other temporary harm that required intervention, according to the Department of Health and Human Services.[3]

Transparency – the Good, the Bad and the Ugly

The Good: Consumers want full transparency and with the convergence of technology, data availability and better analytics, it's increasingly available and affordable.

The Bad: With more companies entering the transparency market, each one defines transparency as they see it, causing confusion and making comparison difficult. Worse, some parties actively impede transparency by claiming data ownership and censoring data for their own benefit.

The Ugly: Many companies touting transparency merely slap the transparency tag on products having little or nothing to do with transparency. Or worse, advertise it but then suggest a plan to develop it; in another word, ***vaporware*****.** Perhaps most disturbing are companies selling their version of transparency while failing to disclose conflicts of interest.

Transparency Criteria

Optimal transparency solutions should, at the least, meet criteria in four categories: unbiased, credible, meaningful and measurable. This article examines findings from a comparative summary of "transparency" companies in these four important categories.

Monocle Health Data conducted a study of seven companies alleging to provide either price and/or quality transparency of some sort. We developed and applied 25 criteria in the four categories named above. We did our best to verify accuracy and graded each company by these criteria using a simple three-tiered grade.

- Plus – the capability was confirmed
- Unknown – capability could not be determined
- Minus – the capability did not exist or there was a clear deficiency

This study includes 200 footnotes documenting the findings. If you are interested in using our proprietary transparency comparison format or want more info, you may request it through info@monoclehealth.com. There is no charge. The following is a summary of significant findings.

[3] Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries. Department of Health and Human Services. November 2010.

Unbiased

1. **Three of the seven were founded, owned or controlled by insurance companies or healthcare providers.** This creates an inherent conflict of interest. What is most disturbing about these three is their lack of, well, transparency. They don't reveal their potential conflicts. With a little research we found the conflicts, but no customer should have to work that hard—especially for a service that purports to give customers the full truth. These three companies' conflicts were numerous and included:
    - Being founded by a consortium of state hospital associations;
    - Partially owned by a well-known hospital system;
    - Owned by a company marketing U.S. provider networks;
    - Publicly stated plans to offer its own provider network; and finally,
    - Owned by a global medical tourism company representing its own network.

2. **Two of the seven promoted a provider network from which they receive compensation.** Any time a seller claims to sell a "truth" product such as transparency, other sources of compensation from influential parties in the transaction should be divulged. In fact, for many industries it's the law (think auto dealer rebates and real estate agencies). The conflict isn't just the unseemly hidden compensation. In order to make networks attractive, their reps sell on access first and foremost, not quality or price. And there's the rub. When networks include 90 percent of providers in the market, in the best case scenario, the network includes the best 50 percent and worst 40 percent of providers. And we all know about the wide disparities in healthcare price and quality. Broad network access by definition, engenders disparities.

    If a transparency company is selling access to a preferred network, it no longer has an incentive to reveal disparities (aka deficiencies) within its network. They're paid to sell their network – not reveal provider-specific performance. And if they can get you to pay an access fee for the privilege of ignorance, well, they see that as an even more profitable sale – at your expense.

3. **Three of the seven accept advertising revenues from providers as a primary source of revenue.** Any transparency solution accepting ad revenues from those it's supposed to evaluate without bias should be taken off the list of legitimate transparency solutions; they're just one level away from "pay-to-play."

Credible

1. **Pay to play – Two companies use third-party sources that charge providers to participate in their "quality" assessment or to be more prominently displayed.** And if the provider doesn't pay the participation fee, it receives a "no score" which translates to a failing score. You can't buy credibility. Worse yet, much of the data used in these companies' "transparency" tools are from their own databases—not independent, recognized organizations.

2. **Most companies did not use independently verified, fact-based information that has been cross-referenced from nationally recognized organizations.** In fact, two of them used opinion surveys as their primary transparency tool, emphasizing the patient experience while ignoring independently verified, fact-based information. Opinion surveys are nice but patients want the best care possible, not just a pleasant experience, despite the trendy (and misleading) exclamation, "It's all about the customer experience!"

3. **Healthcare price and quality transparency is not the primary business for four of these companies.** Those four companies' primary businesses range from hospital consulting to selling networks to medical tourism to selling mobile apps. If a company's primary business isn't transparency, you know the business has other priorities that can change quickly – unbeknownst to the customer. If you want dedicated transparency services, free of conflicts, you're most likely to receive that from a company dedicated to it as a primary business and core competency.

4. **Use of appropriate comparative data – amazingly, six of the seven transparency companies failed this test.** Most incorrectly compare Medicare data to commercial populations; use generic UCR fee schedules instead of the average cash payment; use market ranges instead of provider-specific data; or use an overall quality score that isn't disease or procedure specific. Consumers have a right to know more than just whether a hospital earned a superior overall score; they have a right to know the score for treating their specific illness, and to know where each provider ranks for treating that illness.

5. **Verifiable information from multiple credible sources and not just a company's own database.** Proprietary algorithms are one thing, but referencing a company's own database as a valid source is intellectually dishonest. If the transparency company won't or can't provide auditable detail to support its findings, it lacks credibility. Keep in mind that data from at least two credible organizations is needed to validate conclusions. Only one transparency company met this standard.

Meaningful

1. **Only one of the seven transparency companies used severity adjustments of appropriate data populations using at least <u>two</u> recognized severity-adjustment methodologies.** Four of the seven didn't demonstrate any severity adjustment capability. Severity adjustments allow for valid comparisons on a disease-specific, provider-specific basis so individuals can find providers who treat similar patients proficiently and efficiently.

2. **Provider price rankings <u>and</u> quality ratings for both chronic illnesses <u>and</u> episodic care for hospitals <u>and</u> doctors on the same platform was offered by only one of the seven companies.** The standard approach was to provide a price for each procedure, office visit, prescription, lab test, imaging procedure, etc. and let the user compile the total cost – if they can. With chronic illnesses comprising two-thirds of all benefit costs, it is critically important to rank and rate providers based on price and quality on a severity-adjusted basis for managing a chronic illness, including all costs for treatment, over an entire year.

3. **In- and out-of-network provider comparisons were offered by only three of the seven companies** (see Unbiased above). A meaningful transparency solution should provide consumers with ratings and rakings on providers who are both in- and out-of-network. Any "transparency" solution that excludes out-of-network providers isn't transparency, it's self-serving censorship detrimental to the consumer.

   This is particularly important with high-deductible plans. I'll give my personal experience: Pfizer sent me a Lipitor $4 copay card. I took it to CVS Pharmacy and was told that under my health plan, I would have to pay $250 for using a brand medication instead of generic – but they'd gladly reduce this by $4. I thought this surely was a mistake so I called CIGNA and was told its in-network pharmacy's interpretation (CVS) was correct. CIGNA doesn't tell consumers that it's cheaper to fill prescriptions at out-of-network providers.

   Excluding out-of-network providers isn't transparency; it's charging users for the privilege of buying high-cost services from in-network providers. Perhaps it's time to question the value of networks – and any transparency solution that ignores out-of-network providers.

4. **Robust analytic report package updated monthly.** Six of the seven companies don't offer monthly analytic reports. Another transparency requirement should be timely reports generated from robust analytics and the ability to "drill down" into the data to see exactly why and how each provider earned their ranking and rating. You deserve to know the supporting facts – after all this is transparency. True transparency is driven by analytics and subject matter expertise, not just a provider directory lacking supporting analytics.

Measurable

1. **Only one solution ranks by price and rates quality by quartile.** Almost all of the transparency companies use a three-, four- or five-star rating system. Unfortunately, since half of the transparency companies in this study also sell networks, the rankings and ratings are largely meaningless – they only rate in-network providers and almost all of the providers are rated as average or better. This is unrealistic. In fact, the biggest disparities between provider price and quality performance are in the bottom 50 percent. Consumers deserve to know true rankings and ratings so they can avoid the bottom 50 percent of doctors and find a doctor in the top 50 percent who best meets their needs. Ranking doctors and hospitals by quartile gives consumers a short list of the best doctors, for specific diseases, to choose from – not just an endorsement of another network.

2. **Only one solution offers an on-line, interactive data cube** to support users requiring sophisticated analytics. This enables a robust, flexible, user-friendly reporting package that's population-specific to each employer and allows employers to establish dashboards and benchmarks for health plan performance and their vendors (e.g. network performance, disease/medical/case management). Five companies did not offer any reporting package.

3. **Only two companies offer a savings measurement tool**. One company provides an ROI worksheet using employer-specific assumptions to calculate savings. An important transparency feature is the ability to project accurate ROI and savings using employers' own assumptions – before and after engaging the transparency company. Savings projection tools, along with the analytic reports, give the employer actionable intelligence to identify areas of improvement and measure vendor performance.

Summary

The rise of healthcare transparency is inevitable – it epitomizes the old saying, "How do you keep them down on the farm once they've seen the big city?" Consumers are slowly realizing that not only should they be able to see price and quality information on healthcare providers, they have the right to see accurate, meaningful information.

The healthcare industry is on the cusp of tremendous change brought about by the adoption of healthcare IT solutions. The ability to extract data which can then be shared with consumers will forever change the way healthcare quality is measured, and create new pricing metrics that extend far beyond in-network and out-of-network.

For more information contact info@monoclehealth.com or go to www.monoclehealth.com, register, and submit your request.

Note: Michael Cadger is founder and CEO of Monocle Health Data, a healthcare price and quality transparency company that was included in the survey. All reasonable attempts were made to ensure the survey was accurate and objective at the time of this publication. We encourage you to independently verify all information and will be glad to assist.