

STATEMENT FOR THE RECORD
OF THE
AMERICAN COLLEGE OF PHYSICIANS
TO THE HOUSE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH

Hearing on Price Transparency

July 18, 2006

The American College of Physicians (ACP) -- representing 120,000 physicians and medical students -- is the largest medical specialty society and the second largest medical organization in the United States. ACP is pleased to share its recommendations with the Subcommittee on how best to guide consumers' choice of physician through price transparency.

In the first section of this statement, ACP discusses the potential advantages that price transparency offers to patients. In the second section, ACP offers recommendations on what is realistic *at this point in time* in terms of disclosing fee information to patients. The third section discusses the obstacles inherent to transparent physician price information. Finally, due to ACP's concern that price, alone, is a poor proxy for determining the total cost of care and informing consumers' choice of physician, ACP recommends that Congress look beyond the disclosure of unit pricing and consider new payment models that provide consumers with a more meaningful picture of a physician's performance.

For definitions of terms often used in the context of this discussion, please refer to **Appendix A**.

I. ACP's Support for Transparency

ACP is committed to the goal of transparency for health care pricing. For years, ACP has encouraged its members to discuss with patients the fees charged for their services-- in advance of rendering services, whenever possible— with the qualification that the fee charged for an office visit or other service does not necessarily predict the *total* cost of care. ACP also recently developed a policy monograph on consumer-directed health plans, which pointed out that consumers must be provided with accurate, accessible, and understandable information in order to make well-informed health care decisions. This position statement calls on employers, health insurers, and regulators to make sure that valid and reliable information and appropriate decision-support tools are made available to consumers. It also states that public policy and private sector responses are needed to

guide the development of standardized measurement, data collection and dissemination, and decision-support tools to assist consumers to navigate an increasingly consumer-oriented health care system.

II. Recommendations on What is Realistic at This Point in Time

The following subsections make recommendations on how price information could be disclosed on a voluntary basis and in a user-friendly manner to the following groups: Medicare patients; patients with typical managed care or PPO plans; and self-pay patients.

Medicare Beneficiaries

ACP believes that public access to physician pricing for Medicare patients can best be achieved by modifying the publicly accessible physician fee schedule database(s) available through www.cms.hhs.gov. Medicare pricing for physicians that participate in the program is currently accessible in a format that is understandable to industry professionals, but not to patients. This system would have to be modified and available through a website maintained for Medicare patients, such as www.medicare.gov. To make the website patient-friendly, ACP recommends the following:

- Patient first enters zip code;
- Patient has the option to view all prices for physician services for his or her Medicare geographic-adjusted area or to search by specific physician service/procedure;
- The prices should be displayed in the following format:
 - Lay person description of service/procedure;
 - Current Procedural Terminology (CPT) code;
 - Medicare allowable amount, with typical Medicare payment (80 percent) and typical patient co-payment (20 percent);
 - Medicare limiting charge amount, which pertains to unassigned claims submitted by non-participating physicians, with typical Medicare payment (75 percent of Medicare allowable) and typical patient co-payment (difference between 115 percent limiting charge and 75 percent of Medicare allowable);
 - Indicate if the service is Medicare non-covered, i.e. never covered by Medicare regardless of the patient's condition, with a statement that physicians can charge the patient their established fee even if it is more than the Medicare allowable.

While this information would not differ from one physician to another within a Medicare geographic adjustment area, it would enable patients to compare Medicare prices to physician retail prices and to amounts paid by private insurers, if available.

Patients Enrolled in Managed Care or PPO Plans

While Medicare generally pays a single amount for each service (adjusted slightly by geographic area) to all physicians, patients in managed care or PPO plans need to be

informed about the discounted rates that health plan members actually pay, since the maximum allowable payments are determined by the provider's contract with the insurer. The out-of-pocket cost to patients enrolled in managed care or PPO plans for a specific service or procedure is the co-pay or co-insurance for covered benefits or the retail price for non-covered benefits that the patient elects to receive.

To best inform a consumer's choice of provider, private insurers must make consumers aware of the actual negotiated rates it pays its physicians for individual services. Information about what an insurer will reimburse is currently available to the consumer retrospectively, or after care has been received, and often only at the request of a member. ACP recommends that this information be made available prospectively so that the consumer can make a well-informed decision. Insurers should work with physicians to determine the actual out-of-pocket cost to the consumer and to determine how best to present this information.

ACP recommends that the Administration review private sector initiatives for guidance on how best to provide consumers with price information (see **Appendix B**).

Self-Pay Patients

To give self-pay patients access to physician charges, ACP could recommend that its members make their retail price public for the 10 services/procedures most commonly furnished by the specialty of general internal medicine (using Medicare national aggregate billing data) or for the 10 services/procedures they personally furnish most often by posting the information on their website, if applicable, and/or disseminating it on patient request. ACP prepared a template that could be shared with our members for use by those who choose to make their retail prices widely available (see **Appendix C**).

CMS could also make this information available through its publicly accessible Participating Physician Directory (PPD), which enables patients to identify physicians who participate with Medicare. The PPD is currently available through www.medicare.gov/physician. In 2003, CMS proposed that physicians have access to their individual PPD record so that they could self-report whether they are accepting new patients. CMS could expand the PPD to include physician self-reported prices for non-Medicare patients. CMS likely would want to house this modified PPD database elsewhere, such as on the U.S. Department of Health and Human Services website, since the prices would reflect the physician's retail prices and be irrelevant to Medicare. CMS should provide a template that physicians could use to report their prices.

Further, ACP believes that CMS could expand the modified PPD that contains physician prices to include additional information on services that a patient may find valuable. Physicians could self-report information such as whether they maintain an in-office laboratory; whether they accept Medicaid as a secondary payer; whether they provide minor clinical services via e-mail; and whether they provide transportation services. Physician self-reporting of this additional information should be voluntary. This

information could supplement physician-specific quality data and would likely be easier for the patient to understand.

Although the actual amount that a physician charges is most valuable to patients who pay for services out-of-pocket (including those with indemnity or high-deductible health plans), patients with other insurance products—such as Medicare or a private HMO—may also find this information valuable to compare what their insurance pays toward the physician’s retail price.

III. Obstacles to Transparency

Although ACP offers these short-term strategies, we remain concerned about the complexity of providing patients with the information and decision-support tools they need in health care. Introducing transparency into the medical marketplace depends on a convoluted set of circumstances and challenges, each of which hinder the effectiveness of some or all of the aforementioned strategies:

- Physician fees for a specific service or procedure have little relationship to the total cost of care. Knowing how much an internist charges for a “typical” office visit, for instance, does not tell the patient anything about what level of office visit may be required, what tests or procedures may have to be ordered, or what other costs could be incurred for referrals to other physicians or health care facilities.
- The costs associated with an entire episode of care would be a more relevant indicator— but such cost of care measures are still very much in their infancy. To be meaningful, those measures would have to encompass the services of multiple providers and sites of service, as well as pharmaceutical, radiological, and laboratory costs, rather than just the cost of care provided by a single physician.
- Physicians often have a single retail "fee" for each service, but the amount they charge—and the amount they actually collect from the patient— is a function of a specific contract signed with a particular insurer.
- Some physicians practice in more than one setting or in the employment of more than one employer, so an individual physician may have a different set of fees for each setting and/or employer, meaning the physician may have multiple fees for the same service.
- Telling patients what a physician’s retail fees are for common procedures still does not let patients know what they will have to pay out-of-pocket— unless insurers also disclose how much they reimburse for a given service, including the patient’s co-pay or co-insurance for covered services, in advance.
- The fees physicians can charge and the amount they can collect from patients enrolled in Medicare, the country's single largest health care payer, are subject to strict price controls.
- Comparing prices could be misleading unless patients also have comparative data on the quality of care provided. However, we are still very much in the early stages of developing physician-specific, evidence-based quality measures that can be reported to the public.
- And finally, there is little evidence to date that patients are willing or able to consider the price of services when seeking medical care for themselves or family

members, particularly for non-elective, urgent or potentially life-threatening illnesses. To the extent that patients would consider price, experts are concerned that patients may forgo beneficial treatments.

For these reasons, price transparency is most useful for elective procedures where the patient has the time and ability to potentially choose among different providers. But even in such cases, price may still not be a good predictor for the total cost of care and any posting of the typical fees for elective procedures needs to state this clearly.

IV. Recommendations on Looking Beyond the Disclosure of Unit Pricing and Considering New Models

ACP is concerned that price data, alone, is a poor proxy for determining the total cost of care and informing consumers' choice of physician. As long as Medicare and other payers continue to pay physicians based on unit prices and volume of services, efforts to introduce price transparency will have only a limited impact on quality, cost, and consumer decision-making. We therefore recommend that the Administration look beyond the disclosure of unit pricing and consider better ways to help patients make informed choices.

New payment models proposed by ACP would provide consumers with a more meaningful picture of a physician's performance by reflecting quality, cost, and patient experience, while at the same time incentivizing physicians to organize their practices to produce better care at a lower cost. Providing consumers with more robust data on both cost and quality is the premise behind ACP's recently proposed Advanced Medical Home (AMH), a patient-centered, physician guided model of health care under which patients would select a physician based on service attributes—such as patient-centeredness, improved access, and coordinated care of a practice— as well as value attributes as demonstrated by publicly available reports on quality and cost. ACP believes this model would provide consumers with a much more comprehensive and complete assessment of a physician.

ACP also supports the concept of linking payments to physician performance on evidence-based measures. The College's position paper, "Linking Physician Payments to Quality Care," provides a framework for developing and implementing a Medicare pay-for-performance program that would recognize and support the value of care coordination and quality improvement by a patients' physician. Incentives would be based on effort, so that physicians who expend a disproportionately large amount of time and resources trying to improve quality—such as the effective management of patients with multiple chronic diseases— are recognized and rewarded accordingly. This is especially critical for the internist, whose ability to provide better care at lower costs through effective management of patients has been historically under-valued.

ACP's long-standing commitment to evidence-based medicine and continuous quality improvement is also evidenced by our active involvement in the Ambulatory Care Quality Alliance (AQA). The AQA, a national consortium of large employers, public and

private payers, and physician groups, aims to improve health care quality and promote transparency and uniformity by evaluating ways to most effectively and efficiently measure physician performance, aggregate data, and report on the results. The AQA recently endorsed principles on: reporting to consumer and purchasers; reporting to physicians and hospitals; data sharing and aggregation; and efficiency measures. It is also pilot testing quality reporting at the physician practice level.

More information on these topics can be found at:

- The Advanced Medical Home: http://www.acponline.org/hpp/adv_med.pdf
- Linking Physician Payments to Quality Care: http://www.acponline.org/hpp/link_pay.pdf
- The Ambulatory Care Quality Alliance: <http://www.ambulatoryqualityalliance.org/>

ACP welcomes the opportunity to meet with you or your staff to further discuss these topics.

Conclusion

Any model for price transparency must take into account the special circumstances involved in patients' medical decision-making and the peculiar way that health care is financed in the U.S. It is also critical that transparency models be created specifically for and by those who deliver and receive health care services, rather than being grafted onto medicine from another industry.

ACP is committed to working toward the goal of transparency in pricing and quality and appreciates the Administration seeking our input on how best to inform consumer decision-making in health care. We hope this discussion will encourage the Administration to look beyond unit pricing of physician services and to consider alternative models that would make the overall quality and efficiency of health care transparent to consumers.

Appendix A

Definition of Terms Used in the Context of Health Care Pricing Transparency

- Retail price: refers to the amount charged for a service and is most relevant to self-pay patients (e.g., those who do not have health insurance or have a high-deductible health plan) and traditional indemnity insurance patients.
- Cost of care: refers to the total cost of services provided to a patient (price multiplied by volume and intensity of services). Cost of care can be accounted for at the level of an individual physician based on the costs for which the physician is directly responsible or can include the costs of care associated with all the care received by a patient for a specific episode of care.
- Total cost of care measures: refers to measures of the total cost of care attributable to a given provider for a defined episode of care (by diagnoses and duration of services provided).
- Allowable amount or maximum negotiated fee schedule amount (or other similar terms): refers to the amount that a health plan will reimburse for a particular service, which may have little or no relationship to the retail price charged by the provider.
- Out-of-pocket expenses: refers to the costs for which the patient is responsible; the amount of patient out-of-pocket expenses varies according to whether the patient has Medicare; is covered by a typical managed care or PPO plan; or is self-pay.

Appendix B

Private Sector Initiatives

Aetna: Recently became the first health insurer to make available online the actual negotiated rates it pays some of its physicians for their services. Aetna posts the actual discounted rates it pays doctors for about 25 of their most common office-based procedures, such as physicals, electrocardiograms, and vaccinations. Under an initial pilot program, members in the greater Cincinnati area can now look up the fees charged by 5,000 local physicians and specialists.

Cigna: Uses a three-star rating system to rank hospitals by their contracted rates for specific services. The insurer soon plans to replace the stars with actual price ranges. Cigna also recently launched a web-based tool that lets members comparison-shop for medications at 52,000 pharmacies nationwide. Enrollees can view the discounted price of drugs at various pharmacies as well as their share of the total cost based on the type of coverage they have.

Humana: Provides members with an online tool that lets members compare hospitals based on their average discounted price for an entire episode of care. The price quotes are derived from claims data Humana tracks by diagnosis. The prices reflect inpatient costs as well as physician fees, laboratory work and all other expenses related to a specific procedure. By entering their ZIP codes and the type of care sought, members can view estimated out-of-pocket costs at up to 10 local hospitals at a time.¹

Council for Affordable Quality Healthcare (CAQH): CAQH, which represents many of the nation's largest private health plans, has an initiative to establish a system that provides physicians with online access to patient eligibility and benefits information for CAQH participating health plans. The goal is to give physicians access to patient eligibility and benefits information before or at the time of service. Physicians would be able to send an on-line inquiry from a single point of entry, using an electronic system of their choice (similar to the real-time response from processing a credit card charge), to find out:

- Which health plan covers the patient;
- Whether the service rendered is a covered benefit, including co-payments, co-insurance levels, and base deductible levels;
- What amount the patient owes for the service; and
- What amount the health plan will pay for the authorized service.

ACP recommends that the Administration contact CAQH to determine if it is interested in exploring whether this initiative can be modified to provide payment information specific to a particular physician within a specific health plan.

¹ Benko L. Price Check! Modern Healthcare. November 14, 2005.

Appendix C

Common Services/Procedures Pricing Template

[X Internal Medicine Practice] believes that patients have the right to know what the charges for physician work might be before arriving at the office. We have posted the fees for our ten most common services/procedures below. Please note that it is often difficult to determine what must be done to find out what is wrong with you or how to take care of it until you arrive in the office. For that reason, we cannot say with certainty how much care you will need from us or from others, such as the lab or a pharmacy, and how much you will be charged in order to diagnose and treat your condition.

These charges are the established fees for the office and in most cases do not match the amount that the patient will pay. The amount paid by the patient will vary based on insurance coverage and the meeting of deductibles and copays. It is also important to remember that your primary goal in seeing a physician and our primary goal in treating patients is the maintenance and improvement of health and our practice is fully dedicated to this goal.

Service	Price	Medical Code*
Office Visit (New Patient)	\$xx - \$xxx	99201-99205
Office Visit (Established Patient)	\$xx - \$xxx	99211-99215
Hospital Admission	\$xxx - \$xxx	99221-99223
Hospital Visit	\$xx - \$xxx	99231-99223
Hospital Discharge	\$xx - \$xx	99238-99239
Nursing Home Visit	\$xx - \$xxx	99231-99233
Electrocardiogram (EKG)	\$xx	93000
Flu vaccine	\$xx - \$xx	90655-90658
Chest X-Ray	\$xx - \$xx	71010-71030
Removal of Lesions	\$xx - \$xxx	17000-17250

*These codes are needed for insurance companies to process bills.