



Health Care Opinion Leaders’ Views on Transparency and Pricing

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ABSTRACT: More than nine of 10 leaders in health care and health care policy believe it is important for the public to have information on clinical quality and prices, and such information is essential for improving U.S. health system performance, according to a Commonwealth Fund/*Modern Healthcare* Health Care Opinion Leaders Survey. Most leaders support moving toward salaried physician practice with appropriate rewards for quality and prudent use of resources. Survey respondents also support rewards for accountable care organizations through use of partial capitation and shared savings payments. Similarly, they support innovative mechanisms to foster price competition, including value-based benefit design, reference pricing for services, and tiered networks. Seventy-one percent of leaders believe it is important for all payers to use the same method of payment for rewarding quality and efficiency, and a majority support using all-payer payment rate setting or a single system of rate negotiation on behalf of all payers.

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OVERVIEW

Improving the U.S. health care system will require increasing the amount of publicly available data on clinical quality and prices. Such information could encourage physicians to perform better to meet benchmarks, allow public and private payers to become more prudent purchasers of care, and empower patients to select high-quality providers.¹ Provisions in the Patient Protection and Affordable Care Act (ACA) aim to increase the transparency and use of clinical information by developing measures that will allow individuals and insurers to more easily examine and compare health outcomes and appropriate use of resources. The law will also introduce incentives for providers to publicly report measures of quality and patient experience and will allow Medicare data to be pooled with information from other public and private payers to facilitate comparisons.²

In the latest Commonwealth Fund/*Modern Healthcare* Health Care Opinion Leaders Survey, leaders in health care and health policy were asked about their views on transparency and pricing in the U.S. health care system. More than nine of 10 respondents believe it is important for the public to have information on clinical quality and prices. Such information, opinion leaders agree, is essential in moving the U.S. health system toward high performance. Risk-adjusted capitation and shared savings for accountable care organizations (ACOs), along with other innovative payment methods that employ cost and quality information, will be effective methods for facilitating a more efficient health system, a majority of opinion leaders find.

Most respondents also support moving toward salaried physician practice, with appropriate rewards for quality and prudent use of resources. Payment mechanisms that use cost and quality information to foster price competition among providers and suppliers—such as value-based benefit design, reference pricing for services, and tiered networks—also enjoy substantial support. More than seven of 10 leaders feel it is important that all payers use the same basic method of payment for rewarding quality and efficiency. A majority favor either all-payer payment rate setting or a single system of payment negotiation on behalf of all payers. Less than 10 percent prefer the current system, in which public and private health insurers each engage independently with multiple health care providers to negotiate payment rates with hospitals and physicians.

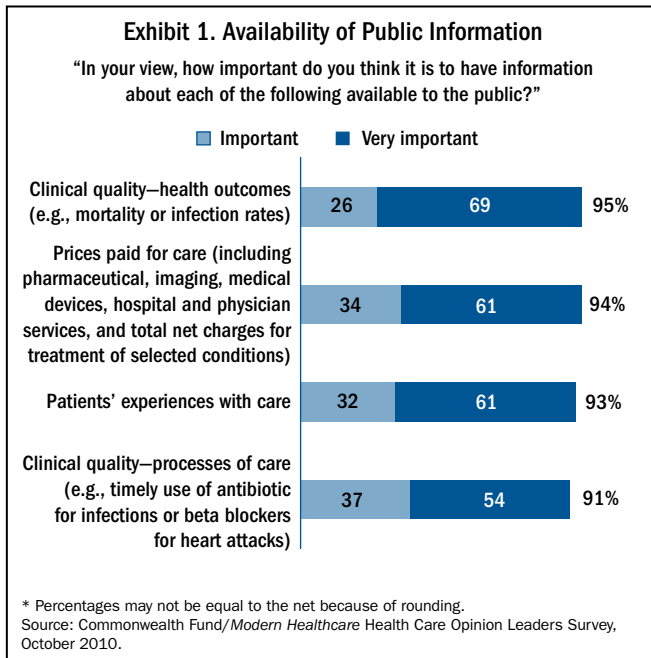
These views are in line with the recommendations of the Commonwealth Fund Commission on a High Performance Health System, which has a mission to promote better access, improved quality, and greater efficiency across the U.S. health care system.³ The Commission has concluded that generating more transparent information to guide and drive innovation among health care payers and providers has the potential to improve patient experiences and significantly reduce the cost of care in the United States.⁴ An analysis of the ACA demonstrates that the significant payment and delivery reform provisions included in the law utilize these strategies and place the nation on a path to a high performance health system that works for all Americans.⁵

The Health Care Opinion Leaders Survey

The Commonwealth Fund and *Modern Healthcare* recently commissioned Harris Interactive to solicit the perspectives of a diverse group of health care experts on transparency and pricing in the U.S. health care system. The 190 individuals who took part in the survey—the 23rd in a continuing series of surveys assessing the views of experts on key health policy issues—represent the fields of academia and research; health care delivery; business, insurance, and other health industries; and government, labor, and advocacy groups (see Methodology, [Appendix A](#)). Respondents were asked for their perspective on transparency and pricing between September 7, 2010, and October 6, 2010.

ABOUT THE HEALTH CARE OPINION LEADERS SURVEY

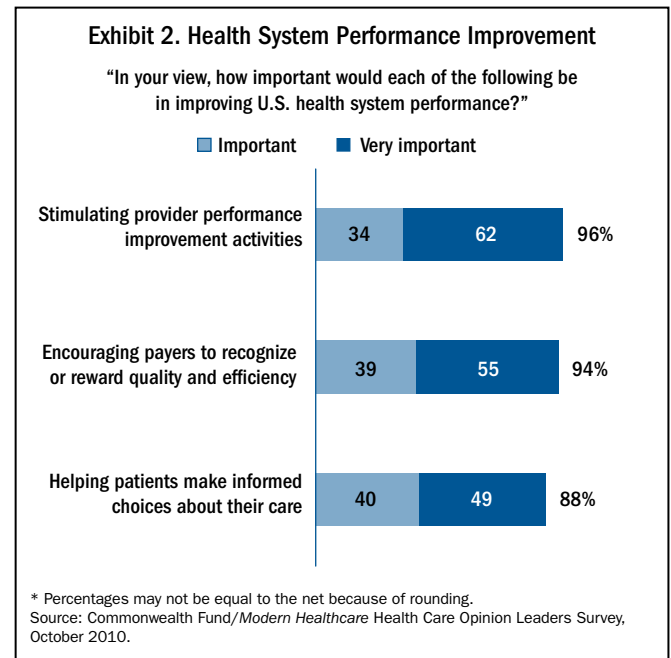
The Commonwealth Fund/*Modern Healthcare* Health Care Opinion Leaders Survey was conducted online within the United States by Harris Interactive, on behalf of The Commonwealth Fund, between September 7, 2010, and October 6, 2010, among 1,327 opinion leaders in health policy and innovators in health care delivery and finance. The final sample included 190 respondents from various industries, for a response rate of 14 percent. Data from this survey were not weighted. A full methodology is available in [Appendix A](#).



More than nine of 10 survey respondents think it is important for the public to have information on clinical quality, cost, and patient experiences.

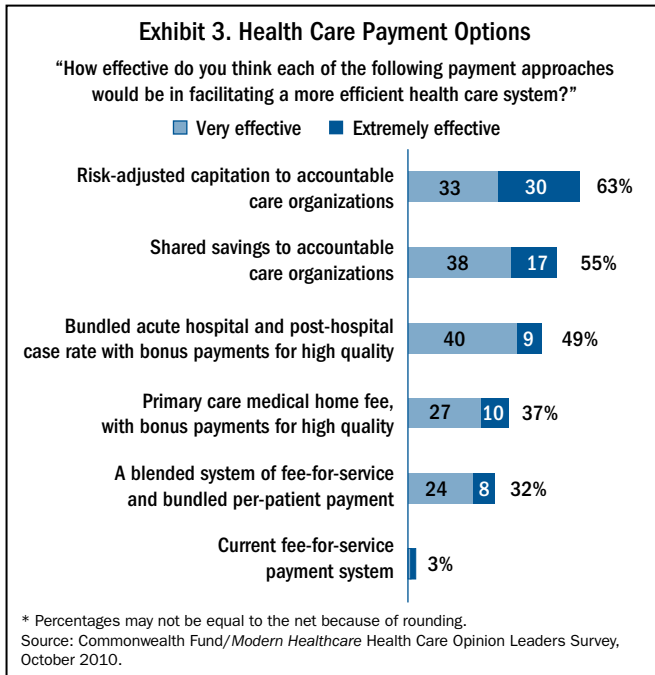
More than nine of 10 health care opinion leaders believe it is important or very important that information on clinical quality, prices paid for care, and patient experience with care be available to the public (Exhibit 1). Clinical information on outcomes (e.g., mortality and infection rates) and processes (e.g., timely use of antibiotics for infections or beta blockers for heart attacks) were both deemed important by an overwhelming majority of respondents.

This is consistent with a Commonwealth Fund survey that found that nearly nine of 10 adults feel it is important to have information on the cost and quality of care provided by different doctors and hospitals.⁶ However, a 2006 survey by the Employee Benefit Research Institute and The Commonwealth Fund found that fewer than half of insured respondents reported receiving such data.⁷



Opinion leaders believe using information to stimulate provider performance improvement, encourage payers to recognize or reward quality and efficiency, and help patients make informed choices is important.

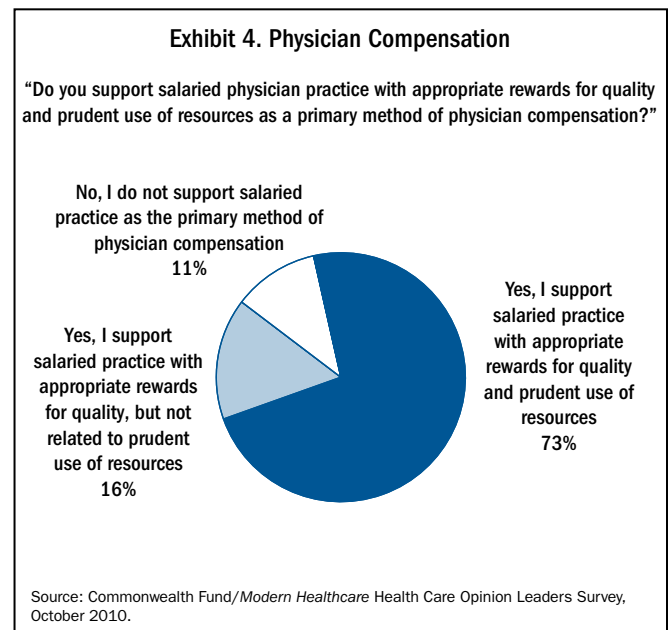
Opinion leaders were asked to rate the importance of using clinical quality and efficiency information in different ways. A large majority of respondents feel that using information to stimulate provider performance improvement activities (96%), encourage payers to recognize or reward quality and efficiency (94%), and help patients make informed choices about their care (88%) are either important or very important strategies for moving the U.S. health system toward high performance (Exhibit 2).



A majority of health care opinion leaders feels that risk-adjusted capitation and shared savings for accountable care organizations are effective strategies for facilitating a more efficient health care system.

The ACA includes numerous payment and delivery system reform provisions designed to realign incentives and encourage providers to deliver high-quality, patient-centered care. One provision creates a program in Medicare that provides the opportunity for ACOs to receive a share of the savings they generate after formally assuming responsibility for the cost and quality of health care given to a defined group of patients. This provision also calls for the new Center for Medicare and Medicaid Innovation to develop alternative payment methods for ACOs.

Fifty-five percent of opinion leaders feel that providing ACOs with shared savings payments (e.g., bonuses for increased efficiency, subject to required performance on quality measures) will be a very or extremely effective strategy, and 63 percent believe that providing a risk-adjusted capitation payment arrangement to ACOs will be very or extremely effective (Exhibit 3). Only 3 percent of survey respondents feel the current fee-for-service payment system is an effective method for facilitating efficiency.

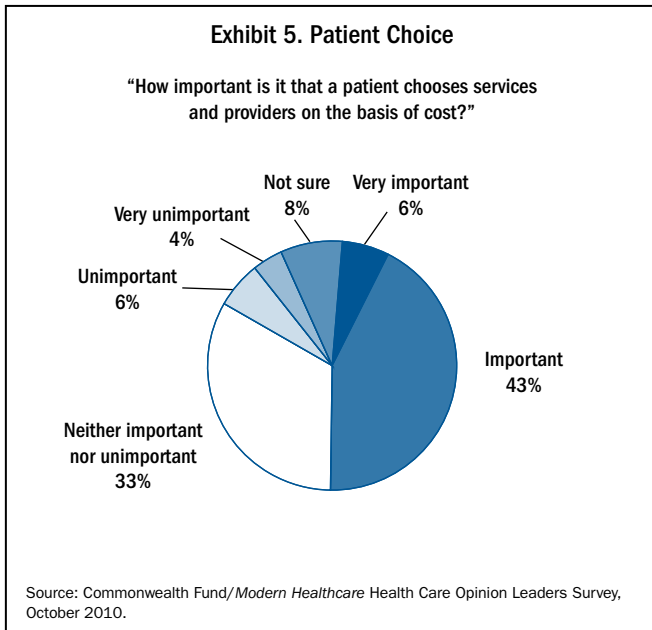


Leaders overwhelmingly support a move toward salaried physician practice with appropriate rewards for quality and prudent use of resources.

Health care opinion leaders were asked to indicate their support for salaried physician practice as the primary method of physician compensation. Nine of 10 respondents (89%) support using such an approach, with appropriate rewards for quality; 73 percent support basing rewards for salaried physicians on both quality and prudent use of resources (Exhibit 4). Support for such payment methods is high among all respondent categories—81 percent of those in health care delivery, respondents least likely to support the change, support using salaried practice as the primary method of physician compensation (Table 4).

Forty-nine percent of survey respondents feel it is important that patients choose services and providers on the basis of cost.

Increasing the amount of publicly available information on cost may empower patients to choose providers that use resources efficiently. About half of health care opinion leaders (49%) feel it is important or very important that patients choose services and providers on the basis of cost (Exhibit 5). Thirty-three percent of survey respondents are neutral, and

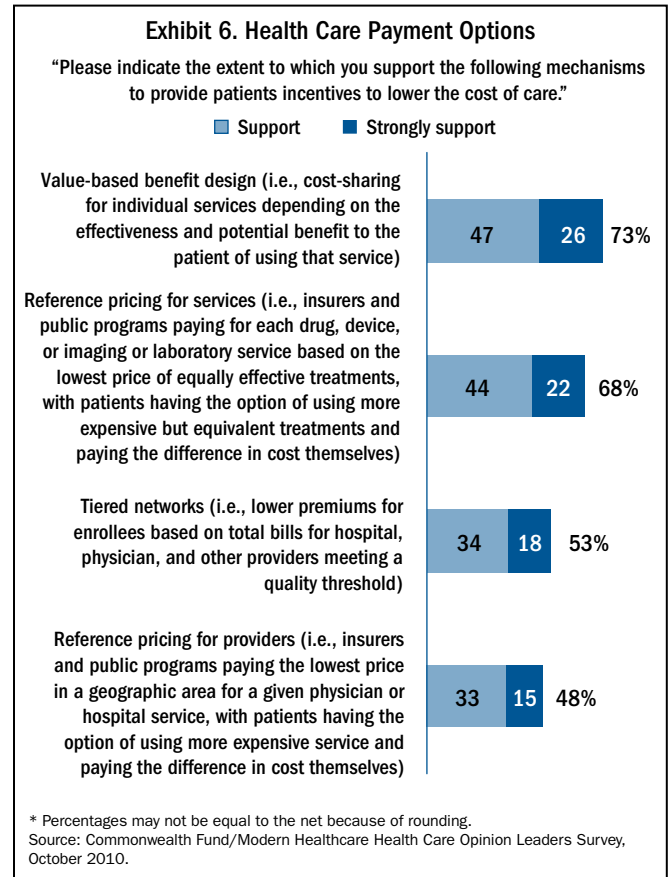


11 percent feel that patient use of cost information is either unimportant or very unimportant.

A majority of leaders support using value-based benefit design, reference pricing for services, and tiered networks.

Several provisions in the American Recovery and Reinvestment Act and ACA are designed to increase the amount of publicly available data on the relative effectiveness of clinical treatments, drugs, and services.⁸ Such comparative information has been used in other countries to improve the quality of patient outcomes and reduce the use of treatments with marginal or no value.⁹ Respondents were asked to indicate the degree to which they support or oppose several mechanisms that use information on cost and quality to foster competition among providers and suppliers.

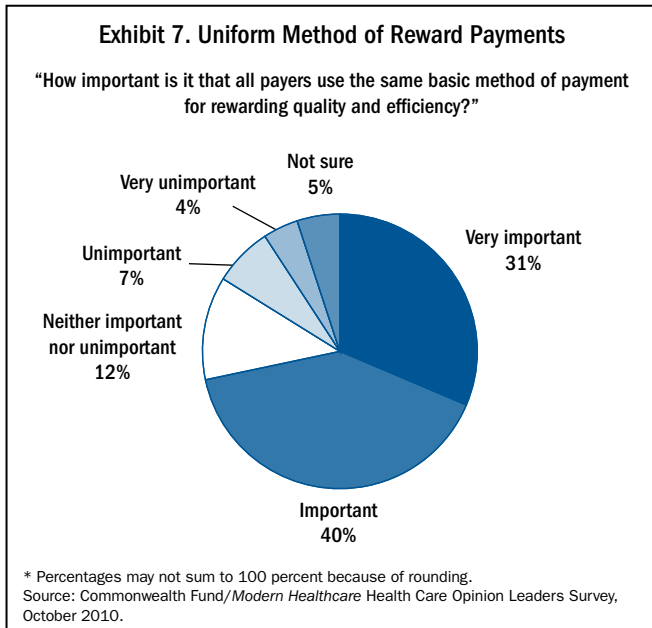
Seventy-three percent of leaders support or strongly support using value-based benefit design, a method in which cost-sharing for individual services varies based on the established effectiveness and potential benefit of the treatment or service (Figure 6). A strong majority (68%) also supports the use of reference pricing for services. In a reference pricing system, insurers and public programs pay for a drug, device, or service based on the lowest price of equally



effective treatments. Fifty-three percent of leaders support or strongly support using tiered networks, in which premiums for enrollees vary based on the level of spending by the hospitals, physicians, and other providers that they choose.

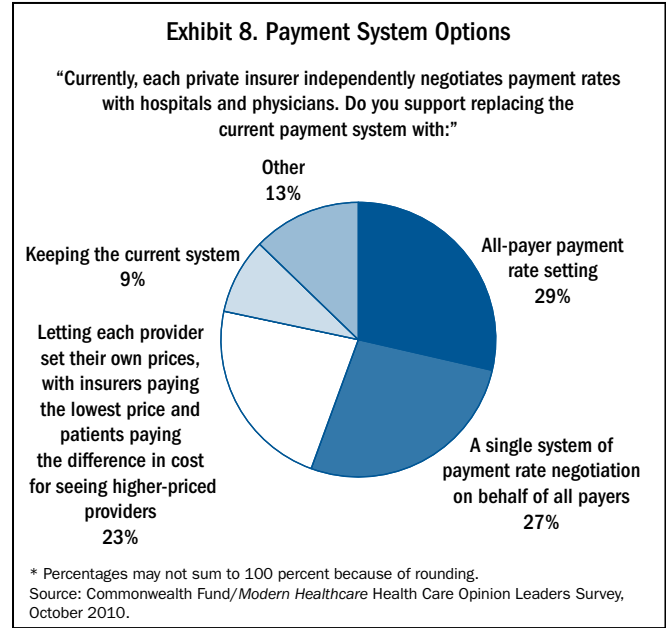
More than seven of 10 opinion leaders believe it is important that all payers use the same basic method of payment for rewarding quality and efficiency.

Inconsistency among the incentives offered by different payers can diminish their effects and create confusion about what behavior is desired.¹⁰ Using a uniform method of rewarding quality and efficiency across private insurers and public payers may be an effective way of improving patient outcomes, reducing wasteful administrative expenses, and lowering costs. More than seven of 10 (71%) opinion leaders feel it is important or very important for all payers to use the same basic method of rewarding providers (Exhibit 7). Eleven percent of respondents feel it is unimportant or very unimportant.



A majority of respondents support all-payer payment rate setting or a single system of payment rate negotiation.

Currently, public and private health insurers engage in a complex and continuous process of negotiations with multiple health care providers to establish reimbursement rates for services. This increases administrative expenses among payers and providers and leads to wide variation in prices.¹¹ Fifty-six percent of leaders support replacing the current system with either all-payer payment rate setting or a single system of payment rate negotiation on behalf of all payers (Figure 8). Twenty-three percent of respondents support letting each provider set its own prices; insurers would pay the lowest price and patients would pay the difference in cost for seeing higher-priced providers. Nine percent of leaders support keeping the current system.



THE PATH TO A HIGH PERFORMANCE HEALTH SYSTEM

Health care opinion leaders overwhelmingly agree it is important for the public to have information on clinical quality and prices, and that such information is essential to improving U.S. health system performance. Most opinion leaders support moving toward salaried physician practice with appropriate rewards for quality and prudent use of resources. Survey respondents also support the use of mechanisms that foster competition among providers and suppliers to increase the quality and lower the cost of care, including value-based benefit design, reference pricing for services, and tiered networks. Seventy-one percent of opinion leaders believe it is important to use the same basic method of payment for rewarding quality and efficiency, and a majority support using all-payer payment rate setting or a single system of payment rate negotiation on behalf of all payers.

Fortunately, many significant provisions designed to improve the transparency and use of quality and cost information are included in the Affordable Care Act. The new law provides for the development of measures that will allow individuals and insurers to more easily examine and compare health outcomes and appropriate use of resources. The law will also introduce incentives for providers to publicly report

measures of quality and patient experience and will allow Medicare data to be pooled with information from other public and private payers to facilitate comparisons.

Commonwealth Fund research and analyses have suggested that these reform provisions will empower patients to identify and receive care from high-quality providers, encourage physicians to meet

local and regional benchmarks, and allow public and private payers to become more prudent purchasers of care. Together with the significant payment and delivery system provisions included in the new law, efforts to improve transparency can help ensure that the U.S. health system adequately rewards high-quality providers while responding to the needs of all patients.

NOTES

- ¹ K. K. Shea, A. Shih, and K. Davis, *Health Care Opinion Leaders' Views on the Transparency of Health Care Quality and Price Information in the United States* (New York: The Commonwealth Fund, Nov. 2007).
- ² K. Davis, S. Guterman, S. R. Collins, K. Stremikis, S. Rustgi, and R. Nuzum, *Starting on the Path to a High Performance Health System: Analysis of the Payment and System Reform Provisions in the Patient Protection and Affordable Care Act of 2010* (New York: The Commonwealth Fund, Sept. 2010).
- ³ The Commonwealth Fund Commission on a High Performance Health System, *Keeping Both Eyes on the Prize: Expanding Coverage and Changing the Way We Pay for Care Are Essential to Make Health Reform Work for Families and Businesses* (New York: The Commonwealth Fund, Nov. 2009).
- ⁴ The Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (New York: The Commonwealth Fund, Feb. 2009).
- ⁵ Davis, Guterman, Collins et al., *Starting on the Path*, 2010.
- ⁶ S. K. H. How, A. Shih, J. Lau, and C. Schoen, *Public Views on U.S. Health System Organization: A Call for New Directions* (New York: The Commonwealth Fund, Aug. 2008).
- ⁷ P. Fronstin and S. R. Collins, *The 2nd Annual EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006: Early Experience With High-Deductible and Consumer-Driven Health Plans* (New York: The Commonwealth Fund, Dec. 2006).
- ⁸ Davis, Guterman, Collins et al., *Starting on the Path*, 2010.
- ⁹ G. R. Wilensky, "Developing a Center for Comparative Effectiveness Information," *Health Affairs* Web Exclusive, Nov. 7, 2006, w572–w585.
- ¹⁰ M. B. Rosenthal and R. G. Frank, "What Is the Empirical Basis for Paying for Quality in Health Care," *Medical Care Research and Review*, April 2006 63(2):135–57.
- ¹¹ U. E. Reinhardt, "The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy," *Health Affairs*, Jan./Feb. 2006 25(1):57–69.

APPENDIX A. METHODOLOGY

This survey was conducted online by Harris Interactive on behalf of The Commonwealth Fund among 190 opinion leaders in health policy and innovators in health care delivery and finance within the United States between September 7, 2010, and October 6, 2010. Harris Interactive sent out individual e-mail invitations to the entire panel containing a password-protected link and a total of five reminder e-mails were sent to those that had not responded. No weighting was applied to these results.

The initial sample for this survey was developed using a two-step process. The Commonwealth Fund and Harris Interactive jointly identified a number of experts across different professional sectors with a range of perspectives based on their affiliations and involvement in various organizations. Harris Interactive then conducted an online survey with these experts asking them to nominate others within and outside their own fields whom they consider to be leaders and innovators in health care. Based on the result of the survey and after careful review by Harris Interactive, The Commonwealth Fund, and a selected group of health care experts, the sample for this poll was created. The final list included 1,246 individuals.

In 2006, The Commonwealth Fund and Harris Interactive joined forces with *Modern Healthcare* to add new members to the panel. The Commonwealth Fund and Harris Interactive were able to gain access to *Modern Healthcare*'s database of readers. The Commonwealth Fund, Harris Interactive, and *Modern Healthcare* identified readers in the database that were considered to be opinion leaders and invited them to participate in the survey. This list included 1,467 people. At the end of 2006, The Commonwealth Fund and Harris Interactive removed those panelists who did not respond to any previous surveys. In 2007 recruitment for the panel continued with *Modern Healthcare* recruiting individuals through their Daily Dose newsletter. In addition, Harris Interactive continued to recruit leaders by asking current panelists to nominate other leaders. The final panel size for the Healthcare Transparency and Pricing survey included 1,327 leaders. With this survey we are using a new definition of the panel. One hundred ninety of these panelists completed the survey, for a 14.3 percent response rate.

With a pure probability sample of 190 adults one could say with a 95 percent probability that the overall results have a sampling error of ± 7.11 percentage points. However, that does not take other sources of error into account. This online survey is not based on a probability sample and therefore no theoretical sampling error can be calculated.

The data in this brief are descriptive in nature. It represents the opinions of the health care opinion leaders interviewed and is not projectable to the universe of health care opinion leaders.

ABOUT THE AUTHORS

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