Financial transparency is on the rise due to consumer and regulatory demand. Access to quality of care data, coupled with an emphasis on consumer accountability, will make it essential for providers to demonstrate their value. Patients enrolled in high-deductible plans are already beginning to demand transparency as they decide how to spend their health care dollars. And quality is becoming an increasingly important differentiator. Beginning in 2015, every physician participating in Medicare will be subject to a value-based modifier (VBM), with results impacting 2017 reimbursement. Penalties tied to the Physician Quality Reporting System (PQRS) are also increasing.

Online tools are emerging that will empower consumers to make informed decisions. The Centers for Medicare and Medicaid Services (CMS) Hospital Compare website allows consumers to review hospital performance measures. The CMS Physician Compare website includes information about insurance and hospital affiliations, among other things, as well as performance data reported through PQRS. CMS explicitly states that the goals of both sites are to help patients make more informed decisions and encourage providers to improve quality. Private companies are also moving to meet consumer demand for quality and cost information.

High-deductible health plans (HDHPs) are on the rise among the newly insured. Up to 80 percent of the Healthcare.gov plans had high deductibles, and only 5 percent of the plans had no deductible. Enrollment in HDHPs has more than doubled since 2009 and more than a quarter of employers now offer HDHPs, and those consumers want financial clarity. Organizations that are transparent in their pricing can help patients better understand their treatment options and costs and be more active participants in their care.

Wide variations in cost and quality confuse consumers. An appendectomy can cost anywhere from $1,529 to $186,990, and a hip replacement can run anywhere between $11,100 and $125,798. Spending more, however, doesn’t guarantee better care. Without demonstrated value, many patients in HDHPs may simply delay or forego more expensive care, leading to more expensive complications later on.

CMS incentivizing value-based care
The Centers for Medicare and Medicaid Services has started implementing value-based payment modifier rules that reward providers who give high-quality, efficient care and adjusts reimbursements downward for providers who underperform.

- **The modifier** will be applied beginning in 2017, but will be based on care data collected in 2015.
- **The downward adjustment** for providers failing to meet the reporting requirements and those who classify as low quality/average cost or average quality/high cost will increase from 2 percent to 4 percent in 2017.
- **The upward adjustment** for providers classified as high quality/low cost will increase from 2 percent to 4 percent.
- **Solo practitioners** or groups of fewer than 10 physicians will not be subject to penalties until 2018 at the earliest. They can receive upward adjustments if they qualify.

Financial transparency becoming health care’s new normal
Increasing enrollment in high-deductible plans and a shift to value-based care will push providers to compete based on quality and more clearly communicate costs.
Quality is becoming a more important competitive advantage

In years past, reputations were made by word of mouth and longevity. In the new health care economy, reputations will be made by outcomes. Well-known health systems, such as Cleveland Clinic and Dartmouth-Hitchcock Medical Center, are beginning to make quality data easily available to consumers. Health insurers are also making moves toward transparency. For example, Aetna, Assurance Health, Humana and UnitedHealthcare all contributed data to a new website, Guroo.com, that helps consumers make informed cost decisions. Another insurer, Blue Cross Blue Shield of North Carolina, has posted reimbursement rates by procedure and provider. United Health Care and other commercial insurers are also beginning to integrate quality and cost ratings into network provider search engines leveraged by consumers under their health plans.

### TAKEAWAYS

1. **Organize around your patients**. Focus on clarity for cost, especially when it comes to their out-of-pocket expenses. Doing so can improve consumer loyalty.

2. **Emphasize the value of routine visits** along with preventive care for patients that are often fully covered by their health plan under an HDHP. Helping consumers keep their care affordable will contribute to your organization’s sustainability within a value-based system.

3. **Be strategic about opening your organizational reporting** on quality and cost to private companies, insurers and employers—not just to Medicare. This will allow your organization to compete on value instead of simply focusing on price.

4. **Leverage organizational resources and IT solutions** to collect and analyze data. Collaborate across the organization to improve the inputs by increasing attention to data governance and formalizing a strategy around making it actionable for your organization.

### Quality is becoming a more important competitive advantage

The new health care economy, focused on outcomes, makes it imperative that organizations determine the true cost of care. To do so, they must collect, analyze and leverage data from throughout their system and from all of their physicians. Providers such as UPMC and University of Utah Health Care are making strides in this area. UPMC has developed what they call an "activity-based costing system," helping them correlate the relationship between cost and outcomes. The University of Utah’s "value-driven outcomes" system helps the organization "find greater quality, not just eliminate costs."

### Enrollment in High-Deductible Health Plans Is Growing

The Kaiser Family Foundation (KFF) found that 20 percent of those insured by employer-sponsored plans in 2013 chose HDHPs. That number has increased from 8 percent in 2009.

### HDHPs

The larger the employer, the higher the likelihood that it will offer HDHPs. In KFF’s analysis, 45 percent of employers with 1,000 or more employees offered HDHPs, compared to 27 percent for employers with fewer than 200 employees.

### BDHPPs

Nearly 13 percent of Americans spend at least 10 percent of their income on out-of-pocket health care expenses, and nearly 50 percent of middle-income earners consider their deductibles "difficult or impossible to afford."