in the short term, it seems unlikely that many health care consumers will use 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 agree 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 the government provided Medicare with the 14 that generated losses, two groups had high enough losses that they 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 multispecialty 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 transparent 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 efforts, in May 2013 CMS took the unprecedented step of releasing hospital billing data for the 100 most frequently performed procedures. CMS 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 "charge master," 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.