



**Empowering the Consumer as the Ultimate
Health Care Stakeholder
Anthem, Inc.
Alliance for Health Reform
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ED HOWARD: My name is Ed Howard and I want to welcome you on behalf of Senator Blunt, Senator Cardin, our board of directors to this program today on how best to empower consumers as they may more and harder healthcare coverage and care decisions. I suspect that you have heard the point even in these briefings made repeatedly, that consumers are being asked to do a lot more, to take a lot more active role in selecting their insurance plans and their providers and evaluating their care options. Well, today we are going to look at how well consumers are prepared to make those decisions, how literate are they, for example when it comes to things like deductibles and co-pays? What information did they have available and how hard is it to get that information? And can these empowered consumers, if we can empower them, drive the system toward lower costs and higher quality? Those are the other two of the triple aim. Now, we are pleased to have two partners in today's program -- Anthem, which among other parts of its business operates Blue Cross plans, providing coverage to more than 38 million Americans. And the National Consumers League, which is America's oldest consumer organization. Their mission is to protect and promote social and economic justice for consumers and workers. I should mention that with these same partners -- Anthem and the League, we will be exploring in September, a related topic that is the kinds of tools available to us when we become actually consumers of care, otherwise known as patients, and we think it will be a valuable bookend to the kind of discussion that we hope to have today.

A couple of logistical check-offs here before we get going with the substance. You will see that the WiFi credentials are on the screen, they are on the table in front of you in case you want to get on to the internet and one of the things you might do if you need that is to tweet comments and questions about the conversation. The hashtag #ConsumerHealth is the key to doing that. Now, in your packets, you can find a lot of information, including speaker biographies, more extensive than I'm going to have time to give our folks. There is a one page materials list that you will find useful, I believe, along with the Power Point presentations that the speakers are going to use. You can find all of that, by the way, also at our website, allhealth.org. There is going to be a video recording of this briefing available as early as Monday, followed by a transcript a couple of days later. Also, on allhealth.org. At the appropriate time, I have two colors for you to remember -- green question cards where you can use your pencil or pen to put a question on them and have them brought forward and we will try to get to as many of them as we can, and the blue evaluation form, which we hope you will take the time to fill out before you leave, because we want to get your feedback, particularly those of you on Congressional staffs, because we want to be responsive to the kinds of information and the kinds of speakers, the kinds of topics that you think are important in trying to get to your job.

So, let's get to our job, which is to present you with this program. We have a terrific lineup of panelists today and we are going to go through those presentations and then open it up for questions both among the panelists and from the moderator and you will have a chance to ask your questions as well. We are going to start with Rebecca Burkholder, who is the Vice President for Health Policy at the National Consumers League. Rebecca, we have asked to give us a sense of some of the challenges that are

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posed for consumers today in selecting a health plan in other aspects of the engagement process and what consumers think is important in making those healthcare decisions. Rebecca, thanks very much for being with us and for lending the expertise and experience of the league in trying to put this program together.

REBECCA BURKHOLDER: And thanks, Ed, for that introduction. The National Consumers League is really pleased to be here today and to be working in partnership with Anthem and the Alliance as we bring you this series of briefings focuses on the consumer.

So, today, as Ed saying, we are going to be talking about empowering and engaging the consumer, especially as they make choices about their healthcare coverage. So, the healthcare system today can often seem overwhelming and confusing for consumers and when it comes to selecting coverage, as this slide shows, consumers need to be doing a lot. They need to make sense of drug formularies, sort through co-pays and deductibles, calculate out of pocket costs, decipher a summary of benefits and ensure they have the convenience of their providers being in-network. This isn't even -- get to deciding on their treatments and care. So, we will be talking about these issues today, as well as in the next briefing in this series in September, which as Ed said, will really focus more specifically on those tools for consumers as they actually choose their healthcare treatments.

So first, let's look a little bit at the context in which consumers are making these choices. So where are consumers getting their coverage in today's health insurance market? As you can see in this chart, from Commonwealth, in 2014, over half received insurance from their employer, 19% from Medicaid, 4% individual or off the marketplace, 3% Medicare, 2% military, 2% from the marketplace or exchanges and in 2014, 12% uninsured.

So what are the choices that consumers have actually in the health insurance marketplace under the Affordable Care Act? So you can see from these slides, the number of issuers, or those companies or entities providing insurance has grown. There are 25% more issuers participating in the marketplace in 2015, compared to 2014 and in 2015, consumers can now choose from an average of over 40 health plans and that is up from 30 in 2014. So this really offers new opportunities for consumers to comparison shop and select the plan that best meets their needs.

I want to talk a little bit about the environment for decision making in healthcare for consumers and in recent years there has been some trends that have really impacted this environment for consumers. So, first, this huge growth in use and availability of healthcare information, and much of this is by the internet. So, our access to 24 hour a day, constantly involving information and misinformation about our healthcare options, is both overwhelming and can sometimes both present opportunities to improve our healthcare, but can also in some cases be hazardous as well. According to a recent Pew survey, 35% of U.S. adults say they have used the internet to try to figure out what medical condition they or another person may have -- what we call "online diagnosis".

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Two, there is a desire by consumers to be more in control of their healthcare. Patient engagement in healthcare has been termed the new blockbuster drug of the century. In fact, we know that patients more engaged in their healthcare have better health outcomes and some studies show lower cost as well. So, this consumer involvement and more active healthcare decision making, just goes to the care of how important it is to make sure that they have the tools and information they need. Third, a shift of cost to consumers to individuals in their healthcare costs and therefore, more consumer responsibility for informed choice regarding their health benefits and this is certainly true for high deductible plans or consumer driven health plans that allow consumers to design their own benefits more. So they are not just choosing a plan but levels of deductible, premium and choice within networks. So really being careful how they spend those health care dollars. Fourth, this increase in advertising noise. The average consumer in the United States is exposed to, as you all know, thousands of ads each day. Ads about over the counter drugs, ads about prescription medications and the consequence of too much advertising is really this clutter and it becomes harder to attract consumer attention, to hold their attention and consumers, all of us, also put up these defense mechanisms in that we just tune people out. We tune information out. And fifth, another trend is this declining level of trust in institutions including insurance companies and healthcare organizations, which really explains the skepticisms consumers may have when they get messages or information from certain entities. So, it emphasizes the importance of establishing really reliable and unbiased sources of information.

So all these trends point to the growing need for reliable information for consumers as they face more choices. And we know from studies that faced with too many choices, people tend to set their expectations really high and they put a lot of responsibility on themselves to make sure they are making the right choice.

So generally, what are consumers seeking when they are choosing a health plan? First of all, value, of course. They want the most coverage for premium they can afford, they want to make sure that the plan covers the care that their family needs, including their medications, taking into consideration their financial circumstances. They want quality information; they want information on the health plan and consumer enrollee satisfaction. Including what consumers report about experiences with the doctors and the healthcare providers and the network and the customer service. Consumers are also interested in quality information, specifically reported at the physician level. For example, for someone with diabetes, did the doctor perform regular blood sugar tests or cholesterol screening?

Then of course, cost information. Consumers want to know what their own out of pocket expenses for a service, given their insurance benefits including deductible, co-payment, other cost sharing, will actually be. Consumers want cost estimates for a complete surgical procedure such as a joint replacement and don't want to be surprised by added on costs later for an anesthesiologist.

So I want to take a little bit a look at the challenges that consumers face when picking health coverage, especially I want to focus on too literacy and transparency. So this slide

has some information from the 2006 National Center for Education Statistics Study. So, engaging patients in their own healthcare and healthcare decision really relies on health literacy and that is patient's ability to obtain, process, communicate and understand basic health information and services. So only 12%, about one out ten, U.S. adults had proficient health literacy according to this survey. So that means they are able to use a table that would calculate their costs for insurance during a calendar year. So, over a third of U.S. adults, 77 million people -- as you can see from the pie chart, are in the below basic or basic group and would have trouble figuring out some common healthcare tasks such as a prescription drug label or an immunization schedule. Also, according to this survey, adults over 65 had lower health literacy. Limited health literacy affects adults of all racial and ethnic groups, compared to privately insured adults -- both publicly insured and uninsured adults had lower health literacy skills and adults living below the poverty line, also have lower health literacy. So poor health literacy can be even more of a problematic for those entering the insurance market for the first time or have not had insurance for a while and that is the case for many people enrolling in the Affordable Care Act. According to a survey, 37% of enrollees did not know the amount of their deductible and for many people, their deductible will be really important to their budget and in some cases more important than the premium they will pay. If people don't understand their deductible and pick a plan based solely on the premium, they are going to be in for a big surprise when they start spending -- getting healthcare services and their deductible hits. Many enrollees also don't grasp the understanding of some basic health insurance terms. A study of people eligible to enroll, show that many -- 60% were not confident in some of these basic terms, as you can see listed on the slide. And this lack of confidence can really have an impact if people don't understand what it means to pick a provider out of network -- and they do pick a provider out of network. They can face some higher out of pocket fees.

And then lastly, people with lower incomes will less likely understand key elements of insurance. So really, people who need a coverage the most, may understand it the least. And then, secondly, another challenge is healthcare transparency, which I know Joel will be talking about a little bit more too. So, you know, we want to make sure that consumers have information up front about the health plans they choose. You know, I know when I pick a major house appliance, like a dishwasher, I'm going to be able to easily access information -- STAR ratings, consumer reviews -- lets make sure consumers have that for healthcare coverage as well. You know, we know that consumers now, in most cases, have the ability to browse anonymously on the marketplace plans, but we want to make sure that is the case for all plans. Drug formularies. We want to make sure there is clear information for consumers on which drugs are covered, especially those consumers with chronic conditions. We also want to make sure that consumers have reliable information on the providers that are in their health plans and that there is a direct link to that directory and that directory is up to date. Lastly, consumers need access to prices on common medical procedures as well.

So what does it come down to for consumers? In some cases, we can boil it down to three questions: What does the plan cover? Is the plan going to meet my health needs and the health needs of my family? How much does it cost? I need to consider the monthly

premium, but also the out of pocket cost. Is my doctor in my plan? Is the hospital down the street in my plan? Consumers want that for convenience.

So I think with that, I'm going to turn it over to my other panelists. Hopefully I have set the context for some of these issues that consumers are facing. Thank you.

ED HOWARD: Terrific, thanks very much, Rebecca. I should say, by the way, if you are watching on CSPAN and for those of you in the room, I will say they are not watching live on CSPAN, but it will be on the broadcast schedule later and on the website. If you are watching on CSPAN, you can find all of these slide presentations, all of the background materials on the Alliance website at allhealth.org. So try to make use of that if you would like to.

Now, we are going to turn to Natalie Schneider, she is the Vice President for Consumer Experience at Anthem and we have asked her to describe ways that Anthem and other insurance companies are trying to respond to the consumer needs that Rebecca was trying to sketch for us. Natalie, thanks so much for coming.

NATALIE SCHNEIDER: Thank you, thanks, Ed. So, as Rebecca alluded to, consumers are moving pretty swiftly into the center of this healthcare ecosystem and they are the ones driving the changes we have seen today and it's not an incremental change either. This is an industry defining pivot that is taking place and it's quite frankly causing health plan executives across the nation to issue this collective OMG, because rumor has it, health insurance has not been particularly user friendly in the past. But, there is a sense across Anthem and certainly across the sector, that things are different. That we are doing business differently and we are not taking the position that we are larger enough to sway the market, we are really, really listening and we are paying attention to what our consumers want and in order to understand sort of what's driving this level of urgency and determination that I would say is rather unprecedented, we really need to take a look at sort of the narrative and how that is unfolding right across the health ecosystem.

The first thing is, increasingly, more consumers are picking and comparing plans that didn't exist before, to the tune of 87 million customers by 2018. That will be the size of the retail market. And that is the lion's share of growth for many national plans. Secondly, as Rebecca mentioned, we are moving more towards narrow networks and these high deductible health plans, which means in the past, where the -- you know, the phone book was really the provider network, now you actively need engaged to figure out, is your doctor network? And actively compare prices. And thirdly -- and I don't want to exhaust these theme, we all know affordability continues to remain a persistent challenge. You know, \$22,000 for the average family of four, that's the price of in-state college tuition or a new vehicle. So they have got more skin in the game. Then we are seeing this tsunami of healthcare innovations from Samsung, Underarmour, Apple, you know, all these different companies targeted right at the consumer and in many instances, this is empowering the consumer to take more control of their health, by providing them better insights into their own pathologies. And lastly, the sort of unforgiving skyrocketing expectations that consumers like you and I have, when we engage with Uber, Amazon,

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all these companies that have 24/7 service, through channel of your choice and you know, really, really great personalization. So we know all of this is occurring. We also know that insurance companies today sort of don't meet a lot of these expectations.

If you look at our starting point, for those of you that are optimists, when fortunately not [unintelligible] in terms of MPS scores, it's actually third last, we are barely above cable companies, so we know what our starting point is. We also know this is unsustainable. You know, in a consumer choice market. So, as I mentioned before, we are really beginning to make changes and if you think about how health plans are responding and how they have [unintelligible] this problem historically -- historically it has been sort of the find and fix approach. And we have realized we have come across this inflection point way by, we need to go much faster and we need to go much father and we need to break away from this traditional mode of doing business. And we also know the way in which you create distinctive seamless, really easy consumer experiences, the type you see in hospitality or retail, is through the deliberate application of hundreds of decisions that are carefully orchestrated through the application of sort of the six disciplines, which are based in [unintelligible] strategy, consumer understanding, consumer design, measurement, governance, culture -- and if you look at consumer understanding as an example, we did something quite novel. We went out and we listened to consumers and we really, really listened to ten thousand Americans through focus groups and interviews to try to find out what makes them smile, what really ticks them off when it comes to health insurance and that allowed us to sort of coalesce around what are the things that matter the most? And we are measuring those through net promoter scores, through customer satisfaction and through member [unintelligible] and we are holding ourselves and our executives accountable. We also discovered that what consumers want the most - - and you will see some sort of symmetry in the remarks between Rebecca and I, is confidence, clarity and ease. They want confidence that they will be covered when something bad happens. That is, after all, why you buy insurance. They want clarity in that they need to know what they bought and what it will cost them and today, quite frankly, that is not the case. And, they want ease. And by ease they mean, minimal interaction with their health plan. In fact they don't want a relationship with their health plan. It should work somewhat like a utility, you know, think about your water and lights. It should work seamlessly in the background without much mindshare or sort of administrative overhead. Except when an issue arises and then they need high levels of engagements, high levels of personalizations and they need competent responses. And while these can't be reduced to broad generalizations, the interesting thing was, through all of this research, is they are actually more similar across statements, across Medicare and Medicaid, group and individual, then they are different. And this a very satisfying answer, because it means you are sort of solving for the same things. And we also found that when we interrogated the data, not everything matters. In fact, you get to diminishing returns pretty quickly. And that there was seven critical moments that matter the most to our customers. It is when you are selecting a plan -- we found that by and large, consumers want the decision about a health plan to be over and done with. It is equated to filing your taxes, getting the middle seat on an airplane, you know, getting a tooth extraction -- they just want it over and done with and you know, between these critical decision points, they want to be separated from the gravity and responsibility of making

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their choice. But today there are complex variables -- it takes too long, it's really frustrating and it's a high anxiety event.

So, as it should be, making plan selection highly intuitive and easy is one of our biggest priorities going into the next few years. Once they have selected a plan, like other purchases, they want to feel valued, they want to feel secure and they want to know what they bought and today it's frustrating. You could sort of -- inundated with all of this paperwork that is really complex, really frustrating, you know, and let's be honest, how many of us have opened up a letter from a health plan recently and responded with, wow! That was incredibly helpful and very, very easy! I'm glad I read that! For the most part, it's really, really complex. As Rebecca said, even the terminology that is being used -- so we are taking as an example, the 40 most confusing terms that are used in healthcare and insurance and we are recoding our digital and our print assets, just to make it simple for people to understand. They don't know what a provider is, by the way. So they are sort of streamlining sort of the on boarding process. Then in terms of, what's it gonna cost me, we also know that costs are frequently unpredictable and unmanageable and when consumers are asked about the most frustrating part of treatment, they say it's dealing with cost, which is why 70% of them are demanding hospital prices to be posted online. So as it should be, transparency cost and quality transparency, which Joel will expand on, is going to become one of the most critical consumer capabilities to empower them, especially as we move to those narrow networks and high deductible health plans.

When they are faced with a medical decision, typically they have got a chronic condition and they need help staying well, they want to deal with someone that has empathy, but the nuance here is they don't want a health plan to intersect that relationship with their provider. So, this is an area where we are treading carefully and we are trying to figure out, how do we diminish the hassle factor for both providers and for consumers in a way that we are not trying to own that relationship, but we are trying to facilitate that mechanism and keep them well. And when they need urgent care or the unplanned needs, this always happens at 3:00 in the morning, have you noticed that? This is that moment when anxiety skyrockets because they are typically not using their regular PCP. And we are using our innovation lab, in fact, in Atlanta and I know this is an area that a lot of people are focused on, to figure out how do we help them quickly understand what is care and what isn't? What is the most appropriate side of care -- it can't always default to ER. And they need help navigating to a specific side of care and we are also focusing very heavily on quality as Rebecca mentioned, to make sure that our provider directories, etcetera, are correct, so we are not having incidences of people going to providers that are out of network. When you pick up your prescription -- this isn't necessarily a high anxiety event, but when you think about Medicare and [unintelligible], this is a really high frequency event, so we are trying to figure out for something that happens so frequently, how do we streamline it and make it as simple and hassle free as possible?

And lastly, the moment my insurance company says, no -- for any of you in the room that have experienced a claim denial -- it is a highly abrasive event. So we are working more upstream and trying to figure out, what interactions can we have with the consumer to prevent that from happening or if it does need to occur, how can we be as empathetic as

possible? So we believe, as health plans become more systematic and more professional about their approach to consumer experience, they are going to break away from this competitive convergence that exists today. And Anthem in particular, you know, we think the only way, given the complexities of modern healthcare, to treat our 36 million Medicare/Medicaid individual and group customers, is to deliver exceptionally well against the basics; against what you see on the screen today and a very anticipatory manner with ultimate simplicity and elegance. Thanks Ed.

ED HOWARD: Thanks very much, Natalie. If I can, let me just take you back to the five reasons slide, if you would. The very first one, the 87 million people you described as being likely to be in consumer choice segments. Is that basically high deductible plans and consumer directed plans that constitute that population?

NATALIE SCHNEIDER: That is primarily made up of private and public exchanges, but also Medicaid and what we are talking about here is, in the past, you know, employers really made those decisions on behalf of a lot of consumers. So, it's all instances in which the consumers are actively reviewing and selecting their plan choices. And you think about how the calculus -- membership calculus changes in that situation. You know, when an employer is making a plan, if 60% of the employees are satisfied, 100% will renew, because the employer is making the decision. In the case of a retail market, if sort of two thirds are satisfied, two thirds will renew with the health plan and the rest will buy from somebody else, which is why this has really got the attention of health plans.

ED HOWARD: Thanks very much for clarification. Next, we are going to turn to JoAnn Volk, who is the Senior Research Fellow at Georgetown's Center on Health Insurance Reforms. We have asked JoAnn to relate some of the policy issues that are raised by the challenges that both Natalie and Rebecca have been talking about, that face consumers as they choose and insurance plan and try to use that coverage -- JoAnn, good to have you back.

JOANN VOLK: Nice to be here, thank you. I'm going to talk about those policy options that come out of the Affordable Care Act. First, a tool that is available to everyone with private insurance and secondly, some tools that are available in the marketplace for plans chosen from that. I'm going to start with a quiz though. By a show of hands, how many people in this room have seen a form like this. That's encouraging. This is the federal employee health benefit plan, summary of benefits and coverage for one of the options for federal employees. I'm going to be talking a bit about this form. This is the first page of an eight page standard form.

The summary of benefits and coverage, which I will here after call SBC, because that is a mouthful, applies to all commercial or -- sorry -- private insurance plans. So, whether you are buying as an individual in the marketplace or outside on your own or buying through your employer, you will have a summary of benefits and coverage available to you. The goal of creating this under the Affordable Care Act was so that consumers would have a way to make apples to apples comparisons of their health plan options when they were

shopping. Certainly we have a history of health plans providing summaries of their benefits, but -- and some were quite good, but they vary depending on the carrier and what they chose to cover and how they might convey the information. So, if you simply wanted to do an apples to apples comparison of your plan choices, which may be greater in the marketplace than through an employer, you would have to decipher a number of different forms, until the SBC came along. Now, you have sort of top line information, you can look across the plans and see what your deductible is, your maximum out of pocket and other rules that are important to you when choosing a place. It must be provided upon application for coverage, once you enroll. When the benefits or cost change is enough that it would prompt a change in the content of the SBC and then upon request. I will say one shortcoming of this requirement for when to provide it, is that third one, when the benefits change enough to change the content of the SBC, because there are a lot of different ways your plans may change over the course of the year when you are locked in during the plan year, that wouldn't necessarily change the content of the SBC and you wouldn't necessarily get a heads up from your plan that something has changed.

The first page, as you might have remembered, seeing that example, is a bunch of top line information that is probably most useful when you are choosing a plan, what the deductible is, how it applies, what the maximum out of pocket limit is, whether or not you need a referral to see a specialist, which might be important for some folks to know that for example, they can get to their dermatologist or podiatrist without having to make a stopover at their primary care doc. And then, beginning on page two are a bunch of things called common medical events, that will tell you what your cost sharing will be for various things you might pursue over the course of the year. So a hospitalization, a doc visit, lab tests, it will tell you about your provider network, what your costs would be depending on the tier, what your costs would be for your drugs, depending on the formulary tier. There are also coverage examples at the back, which there are two now. One is for having a baby and the other is for person with diabetes. These are only intended to be illustrative, because any individual's cost will actually vary depending on the specific services they use, but again, it's supposed to be sort of a high level way to compare plans and say, if you are a person with diabetes, to know roughly what your costs might be under one plan versus another. The summary of benefits and coverage must also include a statement on minimum value and minimum essential coverage. These are two important ACA created terms or concepts. The minimum value is something that all plans -- the minimum value that all plans have to meet and we will tell you whether or not your employer plan meets one of the tests for getting premium tax credits on the exchange. The other is minimum essential coverage, which is the term that is applied to coverage that you must have to meet the individual mandate.

Finally, I wanted to share with folks that there are changes currently being discussed for the template that would take effect in 2017. The Fed previewed a proposed set of changes to the template, the NAIC, the National Association of Insurance Commissioners is currently debating what some of those changes might be to make recommendations to the Feds and I will talk a little bit more about some of the changes that they are considering there. I will say, for example, that we have learned in some of our technical assistance

work at Georgetown with navigators in some states, on helping consumers enroll in marketplace coverage, that the deductible was a really tough idea to get their arms around. What services they might get prior to the deductible, how the deductible was applied -- has anyone ever heard of an aggregate versus an embedded or non-aggregate deductible? Yeah, you have? Okay. So, it matters. It tells you how you accrue your expenses toward your deductible if you are in a family or an individual policy. And that may be important for some families, for example, if you have one high cost individual, you want to know that they are going to get to their individual deductible before everyone spends enough to hit the family cap. They are also looking at changes to better define preventative services.

This is one area, I will pause for a moment on preventative services. This is a hugely popular benefit. This is the idea that for recommended preventative services, you should be able to get them free of charge. We learned in our discussions at the NAIC -- I am a consumer rep there and I have been participating in the discussions. Helping consumers know exactly what preventative services they may get cost free is a nearly impossible task. There is a list on healthcare.gov, but whether or not it is recommended for you, will matter. Whether or not you get charged an office visit co-pay in conjunction with that preventative services, whether or not your plan has to cover that list yet -- they have a year to adopt new recommendations -- for example, we found was very difficult. So this just highlights some of the challenges with the summary of benefits and coverage, trying to capture accurate and complete information.

I'm going to move now to the marketplace and some of the tools that are available there. First I want to talk about consumer assistance. Every exchange must operate a navigator program that is responsible for doing education and outreach and enrollment and eligibility. In state based marketplaces or federal partnership marketplaces, there were additional resources to provide additional consumer assistance in the form of in person assisters. So we certainly saw more consumer assistance funding and options in non-FFM states, because they had some funding opportunities there to do that. In fact, they outspent the FFMs. This is a critical piece, because there are some consumers that are just not going to be able to get there on their own. We did a report off of our experience providing technical assistance and for the families that qualified for financial help there, they can be incredibly complex lives and they are trying to fit within incredibly complex rules about availability of other coverage, whether it's Medicaid or employer coverage. They may have shared households that have a grandchild living in the household. They may have fluctuating wages, because they have three, you know, jobs that pay hourly wages and they cut back their hours during certain times of the year. So we found that for some consumers, they absolutely need to have this in-person assistance to help them understand what they are eligible for and choose a plan.

Certainly the literacy challenges that Rebecca talked about came up frequently for exchange shoppers, but so the navigators had to work with that. They also often had to deal with post enrollment questions, so once they help them enroll, they come back and say, now, how do I use these benefits? Going forward, there are funding constraints. There is a little bit more money for the FFM's this year, but the idea is that they are going

to try to leverage other resources including brokers and some of the online tools I will talk about next to help more consumers get there without the in-person assistance.

ED HOWARD: And JoAnn, just to clarify, FFM applies to --?

JOANNE VOLK: The Federally Facilitated Marketplaces.

ED HOWARD: As opposed to the state --?

JOANNE VOLK: A state based and then also those that run their own -- sort of the shared -- the partnership states that run some of the functions themselves. Quickly, on some of the policy tools that are going to be available in the marketplace. There are a number of things coming online that will make it easier for consumers. One is a new rule that all those SBCs that apply to people who get cost sharing reductions must reflect what their cost sharing would be. So those of you who don't know if you at a marketplace plan and you have income under 250% of poverty, you would qualify for an enhanced plan that fills in some of your cost sharing. Better than platinum for some, almost platinum for others and a little bit better than silver for some. In the past, it was not a requirement that your SBC actually had to show you what your cost would be with that additional help, you sort of had to imagine it, which made it complicated. They are going to roll out for this next enrollment an out of pocket cost calculator for consumers, similar, if you look at the materials in your packet, about the discussion about the FEHBP tools and sort of estimate your costs going forward. Not just the premium, the deductible, but what they might look like with your office visits as well.

There are going to be improvements to the provider directory and the formulary. For one, the provider directory now has to be updated monthly. In the past, we saw experiences where consumers did their due diligence to see if the provider of choice was covered by a plan, only to find out that the directory was out of date or inaccurate. They are going to also include information that is important for consumers like whether or not the doctor is taking new patients, their medical group that they might be a part of and institutional affiliation as well as contact information. The drug formulary must also be easily accessible from the website, be updated with each change to the formulary. So in fact, if there is a change in the formulary, that one drug is no longer covered, it shouldn't take effect until consumers can see it in the updated formulary online. In both cases, this information must be available in machine readable format, which is intended to help outside vendors convert it into other consumer tools they can use to search for a plan based on a particular provider for example.

And finally, I wanted to touch on one function of the marketplaces, which is in certifying marketplace plans to be qualified health plans or carriers to participate in the marketplace, there is one function, the certification includes the requirement that the exchange act in the interest to consumers, which is sort of this catch-all that can mean that they can do things beyond the minimums required by the federal law to make it easier for consumers. Georgetown did a report with Sara Dash and others, that looked at some of the tools that state based marketplaces -- I'm sorry -- requirements they placed

on plans to further standardize their benefits, so that you could look at a set of plans and know that they met certain requirements for cost sharing. I think you heard a lot about that from the California exchange with Peter Lee earlier, but its this notion of, a consumer for example might know that they get three doctor visits before meeting the deductible in a set of plans and further refine the plan so that it's easier to compare. And that's it.

ED HOWARD: Okay, great. Thanks very much, JoAnn. And by the way, we've heard a lot about literacy and the challenges to it and I want to call your attention to one of the pieces in your materials. I think it's way in the back on the left hand side, it's a Department of Labor produced glossary, which is about as simply put and clearly written as anything I have seen on this subject.

JOANN VOLK: That is a companion piece to the summary of benefits and coverage. It is required to be made available and in fact, within the SBC, there are a bunch of terms that will be underlined or in bold, which means you can find them in the glossary to know what they mean.

ED HOWARD: Terrific, thank you. Finally, we are going to hear from Joel White, who among other things is the President of the Council for Affordable Health Coverage and its Clear Choices campaign. Some of you remember Joel; I'm sure, from his two decades of service on the Hill including six years on the staff at The House Ways and Means Committee. Joel today is going talk to us about cost and quality transparency, including the ways to help consumers and employers make more informed healthcare choices. Joel?

JOEL WHITE: Thanks, Ed, and thanks for making me feel a little old today. I didn't think it had been that long. But thank you to the Alliance for putting on this briefing, we think it's absolutely critical at this point in healthcare that we have this dialogue around healthcare transparency and the information that is being presented to consumers as they make choices about not only their health plans but about their healthcare providers and their prescription drugs. So I'm going talk a little bit about what's going on in the marketplace right now and get into a few policy options, actually, to talk about presenting that better information.

So just real quick, Clear Choices is a multi stakeholder advocacy organization and that is why I'm talking about some of the policy options and these are some of our members. But why do we need transparency? Why do we need better information in healthcare right now? I think that unless you have been living under a rock, healthcare costs are increasing. Sorry for the news flash, but we are estimated to spend about 40 trillion dollars over the next decade alone and the total cost that a family is spending on that healthcare is increasing and its increasing at an alarming rate, we think. Eighteen percent of total family income was spent on healthcare in 2002. Today, that is about 35%. By 2030, it is going to be 60% of the typical family's income. What we are seeing on the ground right now in terms of the marketplaces, is next year we are looking at an average premium across 45 states of about 12%. That is on top of a 5.4% increase in 2015. So the costs are starting to stack on the premium side. Why is that important? Well, we know

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that people in 2014 and 2015 made a lot of their plan choice decisions based on the price and the price they were looking at was the premium. They weren't generally looking at the cost sharing. And the important thing with what we are seeing on the Affordable Care Act Exchanges is that the cost sharing is significant. In fact, it's much more than what we see in the employer market. And so what we are seeing is high plan cost sharing and deductibles. This year, the typical silver plan, which is where most consumers are signing up for an individual had a deductible of about \$2900, for a family it was about \$5800. That compares to about \$1400 on a typical employer plan. There is significant variation in both cost and quality of coverage for providers, that are included on those plans, and so the confusion that I think a lot of consumers make is, as they shop for a lower price plan, they are not necessarily looking at, is the provider included in the directory? Is the network a high quality, high value network? And the other mistake that we see in the research that consumers make is that they equate more expensive coverage with higher quality on the provider's side. And so, absent good quality information on providers, people can actually be choosing higher cost, lower quality providers. Because these costs are increasing being shifted onto consumers, they are running this risk of choosing this lower value health coverage.

So just very quickly, the things that we are seeing in the marketplace, we know that consumers have more information on televisions then they do on their doctors. If you have ever been to a retail setting where you are looking at the price of a TV and you have whipped out your smartphone and gone onto Amazon to check the price, that is a real consumer experience with televisions. Just try this little test. The next time you are in your doctor's office, ask him for his email. You are more likely to get information on your television than you are to get your doctor's email, is the point. Prices within local markets vary significantly, and we see this from New York all the way down to San Diego and Sacramento to Washington DC. It is about a 700% difference in some local markets. What we see on the healthcare.gov website is that a lot of times the consumer experience is not user friendly, is very difficult to compare and select health plans off healthcare.gov and as was mentioned, there are some basic, rudimentary tools available on the state based exchanges and the federal exchanges for determining whether a provider is on that network, in that plan, or whether a particular drug is on a formulary at what tier and even to compare the common name versus the scientific name. Finally, I think what we see in the marketplace is, a lot of the data just isn't available to people, so this is leading to a lack of tools that are increasing healthcare costs and in fact, Donald Berwick, who used to run CMS, has said that this increase has cost anywhere between 84 billion to 174 billion dollars every year and while 90 billion is a pretty big range, that is still a lot of money even here in Washington DC.

So, in terms of our goals, I think what we have been able to divine through our stakeholder groups is that there are three core issues that we need to satisfy to make an effective system for consumer choices. The first is, we need better data. Basically, we need to measure the right things and we need to understand what consumer's value in order to empower them in making choices. And they can only make choices through better tools. And so these are improved health plan websites and improved things like out of pocket cost calculators. So, better tools will lead to better data and better tools will

lead to better markets and if we see better operating markets, we think that people will have additional choices that will help address some of the cost issues that we are seeing. So if I can kind of drill down into some of those issues there, the first on the better -- and more data, is that what we are seeing through HHS is really a lot of data dumping and it's being dumped out there with a lot of context and so people get confused, just by the data that CMS is releasing. I will give you a for example. Earlier this year, there was a release of physician claims data, the thought being that I could get online and search my provider and see how many claims he was responsible for, the cost of that provider. The media picked up on this and a lot of it was "gotcha journalism". So, my provider is the most costly provider, because they prescribe the most costly drugs, for example. That is not necessarily helpful to a consumer. I could turn that around and say, my provider does the most hip replacements and therefore is an expert at doing hip replacements. So we need to put this data into context, which means that HHS really needs a strategic framework for the information that it's releasing.

The second thing that we know consumers really value is this cost/quality equation. In other words, the value equation. Right now, we don't have really good measures of quality. So the information that could be presented on some of these health plan comparison websites, just simply isn't available. We are measuring the wrong things and things that consumers don't necessarily find helpful. For example, most of the measures used in federal programs right now are measures of under use. Did I perform the mammography on the preventive screen? Did I do some of those other preventive measures? It doesn't measure over use or misuse. Did I prescribe an antibiotic for example for a viral infection? Some of those types of quality measures are absolutely critical to consumers because they get at the core competency of a provider. Then finally, we know big data is kind of a catechism, but the more data that we have in the system, the better, more granularly insights we can make and right now, Congress passed an SGR law earlier this year, but right now we know that HHS is going to find it very difficult to double the amount of claims data in the system, because Medicaid and chip data is not standardized at the state level. We need to standardize that data and put it to use at the federal level so that consumers can use that information to make better choices.

Switching over to better tools, one of the things that we think is absolutely critical and we took a look across the CMS plan comparison websites and we also looked at healthcare.gov and we looked at a number of the state based exchanges. And we are going to be releasing a paper on best practices for plan comparisons this fall, which will include a number of consumer focus groups and what consumers actually value in making plan selections. And I think what we found was a little disturbing. A lot of the websites don't present accurate information and they don't present it in plain English. It's very hard to select a plan on a website where you are trying to make an honest comparison, if the information itself simply isn't accurate. And if there are loaded terms, jargon based terms that are being used -- you know, we have heard today that some people don't even understand a deductible. Well, we've got to get better at presenting this information in plain English. From our perspective though, the initial research that we have done, there are three primary things that I think consumers value. The first is the searchable, integrated provider directory and formulary, as has already been discussed, I

think, by all of our panelists here. It's absolutely critical to know whether or not your provider is in-network or not in-network. It is absolutely critical to know if your drug is covered by the formulary, on what tier and to know that information based on its plain English name, not its scientific name. Why is that important? Well, if your provider is not in the plan and you have to go out of network, which adds to your cost sharing. Not only that, it doesn't count against your annual limit. So it has a negative financial impact on the consumer.

The second thing is, there has to be a smart comparative display. I need to be able to match up my Anthem plan with my Aetna plan, with my Blue Shield of California plan. To make an apples to apples comparison across say, deductibles, cost sharing amounts, premiums and covered benefits, as well as the providers and the formularies. What we are not seeing in some of the exchange websites, certainly and on healthcare.gov, is those good, smart comparative tools that empower the consumers.

And then finally, something that came under a lot of criticism, but that consumers really value and makes a heck of a lot of sense, is we need to allow people to window shop. We need to allow them to compare those plans before they have to actually log in, get a user name or sign up for a plan and commit financially. Doing those three things, we think would vastly improve the consumer experience in the marketplace, would also vastly improve and continue to bring down the number of uninsured. Would be a better match for plans, better match for consumers that we think would ultimately lower healthcare costs. Thank you, Ed, for having me.

ED HOWARD: Great, thanks very much, Joel. We will now get a chance to get into an interchange. We have microphones that you can use to go to and ask questions in your very own voice or you can pull out that green card, write something on it and hold it up and somebody will bring it forward.

I want to get us started here actually with what Joel was talking about, in the way of the steps that could be taken, if the regulators and the people who run the marketplaces were to be able to do them or were required to do them. But I wonder whether the private sector is doing, in its segment, where it is controlling, whether in dealing with employers or in private exchanges, are they moving in this direction any faster than the government seems to be doing? Joel?

JOEL WHITE: The simple answer is yes. What we are seeing is a lot of innovation at the plan level. I think when we -- what we saw in '14 and '15 was a lot of competition, like I said, on the price. A lot of the plans and Natalie can probably speak to this better than I can, a lot of what they are seeing now is they need to have that service component, the customer service component where they are attracting people and they are saying, look, we've got to get a better fit here, because it's not just the consumer who, if they sign up for the wrong plan, the provider is not in the network or the drug is not on the formulary, that doesn't just impact the consumer, it affects the plan as well, because the plan then has to deal with an acceptations process and appeals process and really not having a good fit for that individual. So having this information, I think, actually better matches up

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consumers to the right plan and what we are seeing is some acceleration of the innovation around the plan tools that are available in the marketplace, but not yet on the exchanges.

ED HOWARD: Rebecca, do you want to comment on that? Or Natalie? Or both?

REBECCA BURKHOLDER: No, I would agree. It's to everyone's benefit that the consumer is able to pick the plan that best fits their need. I mean, I think the challenge -- and Natalie could talk about this some more, is how do you do that and so that all consumers can really have that information and match it up accordingly. You know, without really being able to predict the future too. We have been talking here about how consumers choose their health coverage, but we need to always remember, that's just one small step in their healthcare experience. As you said, they want to pick their health insurance and be done with it. But how do we make that experience the most productive that it can be?

NATALIE SCHNEIDER: You know, we have found that by and large, consumers have absolutely no idea what they have purchased and we have verbatims from the focus groups and interviews that in some instances people are using eoney, meoney, miney, moe, because of the way we named products and because there is a two dollar difference in sort of, the different products. And we know that affordability is still kind and a lot of people are buying on price, but without fully comprehending what the implications are with respect to co-pays, deductibles and all of those types of things. So, that remains the most significant challenge to overcome.

JOANNE VOLK: One of the things I wanted to -- your question about what employers might have been doing. I know one of your members is Pacific Business Group on Health. They have had a tool for a while that allows consumers to sort of estimate their out of pocket costs. We use it at Georgetown. It, like the one for the federal employees and like the one being contemplated by the feds, still requires consumers to sort of place themselves as a low, medium or high healthcare utilizer and it's a very rough estimate and it's difficult to, again, predict the future. So even if you have a planned event, like, you know you want to get pregnant later in the year, if it turns out to be a complicated pregnancy, that's going to cost you more than you anticipated. Even if you are a person with a chronic condition like diabetes and you generally know how many doc visits you are going to need or what drugs you are going to take on a regular basis, you don't know what else is coming down the pike. So, I don't want to oversell these tools. I mean, they are useful as a way to sort of ballpark things and help consumers shop and compare, but its still a very rough estimate because healthcare by its nature is just sort of an unknown in the year ahead.

NATALIE SCHNEIDER: But for those planned events and Joel spoke about this, just the huge variation in price with no discernable difference in quality. And we know for example that NIC MRIs will range in price from \$2,030 to about a 10th that amount. So, while there is a lot of unpredictability in the cost, there are certain instances where we can really come very far along in terms of helping people estimate costs and sort of partake in the favorable economics of smart decision making.

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REBECCA BURKHOLDER: Can I just add one more thing? And that's just about this whole issue, when we talk about the tools for consumers, of choice architecture design. So it's really how we present this information to consumers and there has been some studies that consumers will go with the default. So really have to think about how we are presenting the cost information if it's just based on premiums. So, careful thought needs to be put into that.

ED HOWARD: Very good, thank you. We have a lot of folks lined up. We would ask you to be as brief as you can in stating your question and before you do that, identify yourself and your affiliation if you have one.

STEPHEN SPITZ: Hi, my name is Stephen Spitz. I have two related questions on costs. One, I had an experience in a hospital where they said that I needed a certain common procedure and I asked what the price was. I gave them my insurance information and they came back and they said, "We don't know." I would like to know how common that is and what is being done to try to let folks actually know what something costs. I might add I had at the time a high deductible, so it was an important question about my out of pocket costs. The second question is Medicare part D, when I noted in the biography to Mr. White, was involved with, in 2003 has a provision prohibiting the government from negotiating prices with the drug companies. And my question is, why is that still in the law?

ED HOWARD: Why don't you start and --?

JOEL WHITE: I will do the first one and the second one real quick. The first one was, why can't they tell me what the price is. Like I said, forget about the email, ask them what a price is and it's like getting trade secrets out of Cuba, right? It's next to impossible. What we are seeing is that what the price is and what do I owe is two different questions, right? So if I have coverage, I think a lot of the plans are really good at estimating your costs, but sometimes not always. For Medicare, the vast majority of people have third party coverage and so it varies what you owe. But there is a bill moving through the house, it's actually part of Cures, so I guess it's in the Senate now, that said, for Medicare, you have to provide consumers a max out of pocket across the hospital outpatient department setting and the ambulatory surgery center setting. And so, we need to -- that's a kind of a blunt tool. What we need to get to and what is going to be really exciting is, as more data comes into the system, we are going to be able to parse this and cut it and slice it so that I can tell you, if you are on Medicare, this is exactly what you are going to owe for this procedure at this facility. If you are insured in the commercial market, this is what you are going to owe. If you are uninsured, this is what you are going to owe. Because what we see is that the price you pay is going to depend on what kind of coverage you do or don't have -- is kind of the first question. The second question is, the HHS is prohibited under part D from negotiating drug prices, the private sector is not. And the private sector plans, PBMs and managed care health insurers aggressively negotiate discounts in part D and I can't remember what the latest figure is, but it's somewhere around 20-25% discounts off prescription drugs for seniors. The interesting

thing, when we enacted that law, we talked to CBO about that specific provision. HHS getting in the middle of these private sector negotiations to get drug discounts, versus letting the folks who do this on a daily basis negotiate the discount. The private sector. And they said, if you had that provision in there, it probably messed with the negotiations, but you definitely wouldn't save any money. And if you repealed that provision in law today, what CBO will tell you is, it will not save a single dime. The reason is, those PBMs and those health plans are already negotiating the discounts and they are already being passed on to consumers. That's one of the reasons we did it.

ED HOWARD: Joel, going back to the first part of that question. Someone sent forward a question on a card -- a suggestion, actually, after a long description of a situation to which it would apply. Is it possible for providers to get access to health plan cost calculators so that they are able to inform consumers about their expected out of pocket costs before the services are rendered? Is that a practical possibility? Natalie or Joel? Anybody else on the panel?

NATALIE SCHNEIDER: I wouldn't say its common place today. It's definitely something that we are exploring, is in fact that whole in office doctor's visit and you know, I remarked early on about how we don't want to intersect that relationship, but certainly how do we make more shared decision making tools available at the point of service, so that when you are taking out your pad to write a script or you are comparing different treatment options, that you have transparency into that today. So, I wouldn't say its commonplace, I would certainly say that is where the market would like to move.

JOANN VOLK: One caveat though. From the consumer's perspective, some of this matters too on how the claim is submitted. So we saw this in the discussion around preventative services when I talked about the confusion there about what you may be able to access as a consumer without cautionary. Part of it is how it's submitted by the provider and part of it is how the claim is paid by the carrier. And depending on how all that flows, may in part dictate whether or not you have a co-pay for that service that might have expected none for. And I think that comes regularly, that that is another sort of unknown in the pathway from the care that you receive to the bill that you get.

ED HOWARD: Yes, go right ahead.

CAROLINE POPLIN: I'm Dr. Caroline Poplin, I'm a primary care physician. Just to answer the gentleman's question about price, price is proprietary information. Every insurance company negotiates a different price with every provider or with every large provider, hospital. So the price is different depending on not just what your plan is, but who your insurance is and the insurance companies don't want other insurance companies to know what kind of a deal they got from a big hospital. So, that won't go away. My question is unrelated to that. I have two. A quick one for Rebecca -- you said that surveys show that health insurance providers are less trusted and I was wondering where that information is? Where you got it from? The source?

REBECCA BURKHOLDER: I can share that with you. I think it was -- it was from numerous sources, but I'm happy to share that with you, I think it was on my slide, that it's noted. You know, that has been declining over decades and still some of the most trusted providers are the healthcare professionals themselves, but we have seen this gradual decline with health plans.

ED HOWARD: And Natalie, one of your slides makes the same point, right? That insurers are pretty far down there. Maybe if you had that source, you could provide it as well?

NATALIE SCHNEIDER: Sure, I didn't have the plenty of publicly available sources, I think it's sort of skepticism with institutions in general, but our sector, you know has come under criticism with respect to trust issues, I think because there is so much opaqueness around sort of cost and how that whole sector works.

ED HOWARD: And you had another question, Caroline?

CAROLINE POPLIN: Yeah, a real question. Something that hasn't been mentioned at all -- you assume that people know what they want or they will recognize it when they see it at least and behavioral economics has shown that in fact, with regard to health, people have really no idea about what they need, except for chronically ill people who know what their conditions are, know what medications they are taking, know what they need, better than a healthy person. For example, it said that women are much more afraid of breast cancer than they are of cardiovascular disease. But cardiovascular disease is a much bigger and more likely threat than breast cancer. So if they don't know what they need, how can they choose it?

REBECCA BURKHOLDER: I would say that is the question we are trying to answer. And so, again, everybody is going to have their different take on what they think they might need or what they're most worried about. So that is why information needs to be presented in various ways, so that consumers can look at the different -- whether it's preventative care, whether it's maternity care, whether it's joint replacement, but you are right, they don't know what they don't know.

CAROLINE POPLIN: That's right and the sensible to do then, would be to give a comprehensive plan for everybody, like apparently they do with the California exchange. That was, I think, what the gentleman said last week or the week before. That the plans on the exchange were standardized.

JOANN VOLK: Well, standardized to the degree that you can know that with a certain set of them, you can get a bunch of services without having to meet your deductible first. So that's -- particularly useful -- I mean, you still have the actuarial value, you still have this middle level -- general level of generosity, and they come with big deductibles, as Joel was saying. So the silver level plan is at 70%, AV is far lower than the typical employer plan, which is closer to like, 80-85% or higher AV, so that means you have higher out of pocket costs, but I believe in California, they have said there is a certain set

of services you can get without having to meet your deductible and for a relatively healthy person, that can be really important, who otherwise wouldn't necessarily see the value of their health insurance, if they didn't know that they could get three primary care doc visits and a set of generic drugs without having to meet a \$2,000 deductible, for example.

CAROLINE POPLIN: Okay, I thought it was much more standardized than that, not just preventative services, but -- Ed, were you there? Do you remember?

ED HOWARD: Two different questions.

JOANN VOLK: I think it was everything but like specialty drugs and -- like, high ticket, high cost things. There were a bunch of things that you -- primary care visits, prescription drugs.

ED HOWARD: The transcript from that briefing is on our website, by the way. I think we are here -- actually, this gentleman was in line first and then two people over here and then we will go back this way.

AUDIENCE MEMBER: Thank you very much, Bob Roehr, with BMJ. We have -- consumers are really drowning in choices and options there. One thing the system tried to do, was with preventative care, is at least limit the package and define it a little better. We heard today that they may not have done that good a job here. I guess my question is, primarily, is there any rule for simplifying and standardizing what insurers can offer and how they can offer it?

JOANNE VOLK: Well, the actuarial value is supposed to be a way to bucket plans in big terms. Like, the relative generosity by middle level. I touched on this, one of the requirements for all plans is that there has to be a meaningful difference in the marketplace, but that leaves a lot of wiggle room. So the kinds of things that they are doing in California or other state based marketplaces to limit the number of plans or products that any given carrier can offer or to standardize them so that some set covers the same things in the same way, is one attempt to do that and that is certainly within the authority of the marketplaces.

JOEL WHITE: My actual -- the reason I said, "wow" was, I would actually argue the other way. I think people like choices. I think when you think about someone with breast cancer, versus someone who has cardiovascular disease, versus someone who has cancer, they are going to value different things in different plans and one of the reasons I think we see -- well, I think the Affordable Care Act did a very good of saying, plans have to do X, Y and Z. I think a byproduct of that X, Y and Z has been limiting options for plans in order to offer lower prices and that is why we are seeing some of the higher cost sharing in the plans. So, I think that to the extent that plans can do a better job explaining the nuances and the difference in their coverage, that will be very important. But I think limiting choices is probably the opposite direction, at least that I would say we should go, because healthcare is so personalized, it's becoming increasingly personalized and as we

develop those cures and therapies for cancer, cardiovascular disease, some of those other things that are really going to benefit from precision medicine, you should probably go the opposite way on the choice side, not further constricted.

REBECCA BURKHOLDER: I would also agree with that, even though I talked about how some consumers can be overwhelmed with choice, we do like our choices and everybody is in a different situation and also, their threshold on risk really varies. So again, the solution is -- or the answer is -- how do you present those choices?

ED HOWARD: I mean, you were talking about the framework for choice and presumably there are standards for the optimal size of the choice universe for individual consumers. Is that fair?

REBECCA BURKHOLDER: Yeah, that is correct. Also, it's how -- I talked about how we present that information to consumers. What you present first is really important because consumers often -- even though we weren't allowed all that customization, there has been studies done that consumers don't always go in then and customize it. So how you present it, that default position, is really important. Whether it's just showing the premium, whether it's showing the deductible, whatever its showing, preventative services.

ED HOWARD: Okay, Natalie?

NATALIE SCHNEIDER: Not to pile on, but I think the [unintelligible] is perhaps a little more nuanced in that we talk about the paradox of choice and when you are overwhelmed with too many things where you can't distinguish between them, it actually adds to your frustration. So it's about sort of curation that set of highly relevant options where it's very clear what the difference and the tradeoffs are between them. So, you know, I think it's having choices, but you have got to know -- you've got to know what they are and they've got to be relevant to you.

KEN SHARMA: Hi, my name is Ken Sharma, I'm with Enroll Virginia and we predominantly help people who are below 400% of federal poverty level, so usually people who have very low health insurance literacy. So my question to the group is, why not work at insurance companies reducing complexity and reducing the jargon, instead of trying to educate these consumers on some of this jargon and trying to get the consumers to learn the program as opposed to changing the program?

NATALIE SCHNEIDER: You know, that's precisely what we are doing. We are actually going sort of artifact by artifact, letter by letter, screen by screen and really looking at it through the lens of the consumer, which is quite new, I will say, for our entire sector. You know we used to sell them to employers primarily, now we are selling to end customers. And one of the examples, as I mentioned early on, is taking the 40 most commonly misunderstood terms, things that probably everyone in this room is very familiar with and recoding those. But also kind of taking every single customer journey and literally storyboarding it out and making it easier and more simplified and this by the

way is stuff that banking, retail, hospitality, has already done. So we are a little behind as a sector, but that is very much the focus of the consumer centricity strategies that the large health plans have underway today.

REBECCA BURKHOLDER: Yeah and I would just say, we need to be really careful of that word -- “empowering” the consumer and not “blaming” the consumer, so you are absolutely right, that the information needs to be presented in that understandable way, that plain English way, so that consumers can understand. And I would add on to that, healthcare professionals really need to be a part of this too. There needs to be more education on how they can communicate clearly to patients and also need to be thinking about if information is available in other languages as well and when its translated into those other languages, that that is also understandable and accessible to people.

JOEL WHITE: I think some of this reflects kind of the bumpiness of the shift in strategies. I think one of the things the Affordable Care Act did was -- you know, for the industry, people are now looking at this direct to consumer type channel, whereas before, they were going to the employers or to the brokers and agents. And that’s a difference. And so there is some bumpiness in the marketplace and some turbulence, but I think probably what you are hearing is that a lot of the carriers recognize this, they are working on it and there is a lot of really smart marketing and other people in the system who are probably gonna get us back to something that is more plain English, accurate, reliable and that consumers can really understand and get their arms around.

JOANN VOLK: One more thing. I’m going to bring it back to the SBC. To the extent that this is out there more and more and consumers can really build experience with using this to choose plans and use their coverage, I think it becomes easier. It’s an education process that they are going to learn the terms and how to use their benefits. The glossary that Ed talked about, we heard that there is an info graphic on the last page that explains how deductible co-insurance and out-of-pocket limit works and we heard from some consumer testing, but that was enormously helpful to consumers to make those concepts understandable in a way that they haven’t been before.

LINDA BENNETT: Hi, Linda Bennett, I’m with AFSCME and I just want to pay back on a statement that Rebecca just made and Joel and others have said about plain English, but that the demographics now and in the future, are that there are more limited English proficient or non-English proficient speakers as consumers and stakeholders. So, beyond translating for the plans or the SBC and having good navigators explain, when they get that card and they go to a provider, I would like to ask Natalie, what is Anthem and the industry doing to make sure your in-network providers have access to the interpreter in person services they need, so that they have good communication and you have an empowered consumer and what are you doing to make sure that that’s a system. That there is a system of support. Are you monitoring the electronic records where they say, look, we know this person has limited English proficiency? They prefer their documents in something else? Are there providers providing them with an interpreter?

NATALIE SCHNEIDER: I just want to make sure I understand the question. So, are you saying, at the site of care, where we have limitations or constraints in terms of English speaking, what are the support capabilities to ensure that the physician is engaging with the patient?

LINDA BENNETT: In the language the patient prefers. That they have an interpreter. Part of this is -- the state of Washington, for its Medicaid program, they have a statewide interpreter program where every provider that is Medicaid covered can get on and say, "Next Wednesday, I need someone in Russian, to speak Russian at 10:00. I need someone in Mandarin at 11:00. I need someone in Spanish at 3:00."

NATALIE SCHNEIDER: I can't speak to what the health plan is doing specifically in that venue, in the side of care. I'm not sure if anyone else can speak to -- I think that hospital systems and providers probably have a response to that. I'm not entirely sure; sort of again, being careful about how does the health plan intersect at that relationship? I think we want to ensure -- which is where you are going -- if we reduce the hassle factor and we make it simple and easy. I'm not sure I'm well enough educated on what Anthem specifically does in those venues.

ARIELLE ZINA: My name is Arielle Zina with the Smarter Healthcare Coalition. Earlier today, I think Rebecca raised that, given the increased cost sharing, consumers are responsible for making more informed decisions and providing information and providing clear information on cost and quality was raised as one of the solutions to facilitate those informed decisions. But I wanted to highlight that in April, the Kaiser Family Foundation study showed that only 6% of consumers actually looked at price information and only two to three percent actually use that information. So I was wondering, in light of that, particularly given that consumers indicated they don't actually want a real relationship with their health plan, who is really responsible for providing that information and informing consumers and then also, when that information is presented in a clear and understandable way, how do we ensure that consumers actually are using it, rather than assuming that they want that and if it's able, they will be accessing it?

REBECCA BURKHOLDER: So yeah, there is this issue about consumers saying they want quality and cost information, but also knowing that they are not always accessing it. But the thought behind that is that it's because it's still not presented in a way, usually, that is accessible to consumers and really answering the questions they have about cost and quality. So I think part of it again is just how we are presenting that information. As far as the high deductible plans, we do know that recently, I think, there was a survey by Families USA that 25% of families that had the high deductible plans were actually forgoing healthcare. Were not taking their medications as often as they needed to, were skipping follow up care. Were skipping preventative care. And I think some of that research showed that sometimes consumers were picking those plans because they couldn't afford the higher premiums that gave them a lower deductible. But some people may have actually not looked at the information as carefully as they should have, about that cost. I'm not sure if there is any way we can absolutely ensure consumers read and understand something, but we can do a lot better job of presenting the information.

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NATALIE SCHNEIDER: And I would say, it's where you are on that adoption curve. I would say we are probably still on the linear part and we haven't gotten to that knee of the adoption curve and when things become open table easy or Amazon easy, I think that is where you really see the kick up. So we know we've got traction, we know they still dare to call it a issues, etcetera, but it is certainly demand. It's just not sort of served up in a way that is incredibly convenient and incredibly digestible right now. But I think the intention is there, the strategies are there. The investments are being made and you know, the one thing that I think sort of reinforces this, is the amount of third parties and external investments in the solutions, vitals, cast light, and other third party groups that are making massive investments in this area of capabilities.

JOEL WHITE: One of the things that I think is absolutely critical is the information also has to be actionable. Like, it doesn't really do me a lot of good if you tell me the lowest cost provider in Des Moines. I don't live in Des Moines, right? And it's got to be in network, right? Or out of network, right? It's got to be an actionable type solution for the consumer in order for them to use it.

ED HOWARD: Okay, I'm not sure which of you was first. I will leave it to your sensibilities.

BOB GRISS: Thank you, Bob Griss with the Institute of Social Medicine and Community Health. When Ed introduced this topic, he said that the subject is, can an empowered consumer drive quality and costs in our healthcare system after the ACA. And I think we have heard lots of information about costs going up and people being overwhelmed with choice. What I learned so far is that empowering the consumer really means overwhelming them with choice, so you can blame them for the fact that they don't get what they need. But what I don't hear any discussion of, is the strategy on Capitol Hill to de-fund the Agency for Healthcare Policy and Research, which is designed to study healthcare quality and to translate good practice into systems that providers can be held accountable for. In other words, while we were focusing here, so much on consumer choice, the very function of government to improve the regulatory system or to even conduct research on what quality means, is being taken away from us. The House help committee, probably represented by people around the chairs in the audience here, has voted that as early as the beginning of 2016, to zero out the budget for the Agency for Healthcare Policy and Research. How can we take seriously a conversation about healthcare quality and choice, when we are undermining the very foundations of government's function in doing this?

ED HOWARD: Okay, there is the question, anyone want to respond to it? By the way, it's the Agency for Healthcare Quality and Research. Thanks to a former co-chair of the Alliance Board, Bill Frist.

JOEL WHITE: I love ARC, I think they do great work. I think the answer to this problem is going to be found in the private sector, it's not going to be found through ARC.

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REBECCA BURKHOLDER: Yeah, I think you are referring to ARC, the Agency for Healthcare Research and Quality. Yeah, and we do a lot of work with them and they have done an excellent job on producing plain language summaries for consumers and comparing various treatments, so our organization would hate to see that funding go away. We think they are instrumental in producing information for consumers and being able to compare treatments.

ED HOWARD: We have just a couple of minutes left. This will be the last question, as Karnack used to say and I would ask if you would multi task by starting to fill out the blue evaluation form, while you are listening to this insightful question.

JAMES CALDERWOOD: So my question goes to -- when I think about empowering healthcare stakeholders, I think a lot about the expansion of HSAs and other medical savings accounts. I was wondering, with your experience, have you seen people making the phones and finding out their drug is half the price at Wal-Mart than it is at CVS and have you found people are forgoing care or pursuing more efficient care based on those decisions?

ED HOWARD: I have a related question on a card. Would you like to identify yourself, sir?

JAMES CALDERWOOD: I'm James Calderwood with AVMED.

ED HOWARD: Okay, the card question says, 97% of insurance plans have price transparency tools, but only 2% of policy holders use the tools to shop for prices. What can insurers and Congress do to promote the use of price shopping? So we are shoppers or can we be made into shoppers in this healthcare field?

JOANN VOLK: I think you need to be clear that for a set of services, you are not in a position to price shop. Right? There are some things that are time sensitive, you are not going online to do your research. Its not like buying a refrigerator or a car that you can take your sweet time and do all the research you want. Even for those services where you might have time, and in incentive in the form of a high deductible, to do shopping, we have heard today that it is difficult to know the price. I would argue that price is just one factor that consumers might consider. The price of the service, the price that they pay out of pocket, but it's also convenience and preference for providers and other factors that come into play. I'm going to share my one little personal example of a person who tried to use price to make a treatment decision and it went very awry. For my daughter, I had to choose between 40% co-insurance on a \$17,000 drug or a \$70 shot and my carrier could not tell me what my co-pay would be if I went ahead and got this procedure, what my cost would be out of pocket. Again, it was based on how the provider was going to submit and how it got paid. So, even in the best of circumstances, when you make efforts to do a price comparison, among your factors that you are taking into consideration, it can be hard.

JOEL WHITE: I think we are getting there. We are getting better data, we are getting more powerful tools, a couple of private sector initiatives were put here. I have an HSA. I love HSAs. I worked on the law when it was first enacted. They do promote shopping and I think at our heart, we are all shoppers. We all make comparisons; we make judgments every day about a whole number of things. One of the areas I would highlight is we want and took a look on a lot of the state based exchanges and then healthcare.gov and unless HSA was mentioned in the title of the plan, you couldn't tell whether that plan was HSA qualified or not. So right now, under the tax code, however you feel about HSAs, there is a significant tax benefit to signing up for an HSA and it's associated high deductible health plan, but consumers aren't getting that information just by going to an exchange website. So one of the things that we think needs to change and this could be done regularly or through legislative action is, we ought to tell consumers that this plan is HSA qualified, this plan is an HMO, this plan is a PPO -- and that they may be eligible for some significant tax benefits if they go that route.

NATALIE SCHNEIDER: With respect to the portion of the question about transparency and how effective is that in modifying mindsets and shifting behaviors, is, you know, market dynamics dictate that when you do have more skin in the game, you do start making some of those tradeoffs. If [unintelligible] healthcare, which is highly personal, so what we have seen and there was a great article published in *Health Affairs*, that there -- when people are served up the right information and are put in a position to make those tradeoffs, then a significant portion of them sort of do make choices towards more affordable treatments at the same quality, but not to the same intensity you would find in other sectors like consumer packaged goods or something like that. So it is effective, but just a different level of intensity.

ED HOWARD: Alright, we have a lot of green cards here to which we were not able to get, for which I apologize. But I think that also reflects the level of engagement of our consumers of health policy information here. Thank you for spending a beautiful Friday afternoon inside a very cool hearing room, helping us grapple with one of the most multi faceted set of problems in health policy these days. Thanks to Anthem and the National Consumer League for helping us think through this topic and assemble a great panel. And speaking of said panel, help me thank this panel for some wonderful discussion. And we will come back to this topic in September. Thanks very much.