Price and Quality Transparency:
Tool Informing Health Care Decisions
Alliance for Health Reform
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ED HOWARD: It is a rowdy crowd when there is no audio amplification. Good morning. My name is Ed Howard. I am with the Alliance for Health Reform. I want to welcome you to this briefing. First, I want to thank you for making your way to this unusual venue, at least for the alliance, and at an unusual hour for us. It's a busy time in Washington we know, so here we are and we appreciate you making the effort to get here as well. As I said, I want to welcome you to this briefing on behalf of Senator Rockefeller and Senator Blunt in our board of directors, to this program to examine transparency in health care and in health insurance markets. Its prevalence, its importance and how to make it more common.

Now, in so many other aspects of our lives, we take market transparency for granted. We know a half gallon of milk meets certain quality standards, most of the time anyway, and we can see what the price is by looking at the shelf label; in health care, not so much. Judging the quality of health care delivered by any given hospital or physician practices, usually are really a complicated process, and even if you have the chance to shop around for a low price, it's almost impossible to find out what the price is. Hence, today's program. We are going to look at the tools needed to make cost and quality comparisons in health care and in health coverage and how much

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information is available for those comparisons. Now the Affordable Care Act has provisions that are intended to affect the flow of that information and we will take a look at some of those. Before we get into the logistics, I just wanted to say that a lot of you in the audience were thinking about the dramatic events of the past 12 hours or so and I just wanted to reiterate that our thoughts and prayers are with those both in West Texas, and especially today, in Boston where this drama is unfolding as we speak. Health is a multifaceted characteristic and we hope that those folks in New England get theirs restored, both physical and emotional and mental, as quickly as possible.

We are pleased to have as a partner in today's briefing, WellPoint Incorporated. They operate Blue Cross/Blue Shield plans in more than a dozen states. They cover 1 in 9 Americans and we are very happy to have them involved as a planner and participant in the program, and you will be hearing from Lewis Mattison in just a moment. A couple of other logistical items that you have probably heard before, if you have been one of these briefings. There are obviously a lot of important documents, useful documents, in your packet in front of you, including speaker bios that are more extensive and do them more justice then I will have time to do. The PowerPoint presentations are in there. There are a lot more pieces of

background information on our website and listed on the sheet of materials that are in your kits; allhealth.org, is where you find them, and that is also where you'll find next week, a webcast of today's briefing and somewhat later, once we get back, the transcripts of today's briefing. At the appropriate time, you have got a green card in there, one which you can ask a question. There are microphones that you can use to stand up and verbalize your question and there is a green evaluation card, I am sorry, blue evaluation form, that we would appreciate you filling out before you leave. A little tricky, there are extra questions were threw in on you. They are relatively brief and there are on the backside, so when you do us the favor of doing the evaluation, do both front and back. Okay, let's get to the program.

We have an incredibly knowledgeable group of folks today with a broad range of experience. We are going to keep them to relatively brief presentations, not because they don't have a lot to say, but because we want to get to the interaction among the panelists and to your questions.

So, let's get started. We are going to lead off with Sherry Glied. Sherry is a professor and chair at the Department of Health, Policy and Management at Columbia's Mailman School of Public Health. She has just finished a stint at the Assistant Secretary for Planning and Evaluation in the

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Department of Health and Human Services. She is one of America's most respected health economists, and we have asked her today to orient us to how transparency works or doesn't in health care pricing and quality and how it could be made to work a little better. Sherry, thank you very much for joining us.

SHERRY GLIED: There we go. Thank you everyone. I am going to talk a little bit from a 30,000 foot perspective about price and a little bit about quality transparency in health care and really ask the question about whether we can expect the same things from transparency in health care as we can from transparency in other sectors of the economy. So let me start off by noting why would we even care about price transparency, so I am from New York and we have a clothes retailer called Sims. They say an educated customer is an educated consumers are our best customer and that is kind of our thinking about how things ought to work in health care as well. If we have educated consumers shopping for prices, we should be able to get some really good outcomes. In what way though does that happen. It is important to think about what we are looking for in terms of price and quality transparency, because we sometimes mean very different things as we think about different approaches.

So one reason you might think that price transparency is really important is because it helps to reduce cost and we think about markets that are competitive with lots of buyers and sellers selling similar goods, people shopping in those markets and driving prices to marginal coSt. Basically, trying to find the least cost producer, putting their business there and essentially forcing all the other providers to lower their prices to match that low price, driving prices to the lowest feasible amount; what we call an economics marginal coSt.

A second reason is to improve the predictability that consumers face in the market, so people have higher cost sharing, some of them are self-insured. They face a lot of uncertainty and they need to make appropriate trade offs and to save the right amounts of money for health care, having some sense of prices is important to them too.

And third, prices are important because we know there is a lot of unnecessary utilization and our hope is that if people have some idea how much things cost, they won't necessarily use as much of it. I want to point out that these three ideas, while they all seem like they are symbiotic, really call for different measures of prices. If we are thinking about the first one where people are comparison shopping, the most important thing is the relative price. How much does this service cost here compared to the there? If you

are thinking about the second one where you are worried about predictability, you care about the actual price you are going to pay at the end of the day. And if you care about unnecessary utilization, you really care about the average price of this product, so we have some sense of whether to consume it or now, so different ideas of prices with these different logics.

I want to focus on five different issues that arise in thinking about prices and health care. The first question is price is to whom.

So, a lot of health care is purchased by public insurers. Price transparency is not really important to public insurers. They regulate the prices. The know exactly what they are paying. There is limited cost sharing. Price transparency is not that key there. There, we are really focusing on quality transparency issues. There is the self-pay market. Many of you have read the article by Steven Brill complaining about health care prices. He is mostly focused on this market. People who go into the market and by health care on their own. That's and important market, hopefully a shrinking one, but it is a very small part in general of the health care market.

The other big shock is the privately insured market, and that really we can think of transparency in two ways. One

is the price to the patient and the price to the patient depends on the insurance contract.

So, to give you an illustration, if you have an insurance contract with a $5,000.00 deductible and a $6,000.00 out-of-pocket maximum, that is a very high deductible policy, a health savings account kind of policy. You don't care whether you choose to purchase a provider who charges $10,000.00 for the product or $20,000.00 for the product. As far as you're concerned, both of those things cost you $6,000.00 at the end of the day because you max out.

So, a lot of what we care about when we think about insurer price transparency is the price to the consumer, net of whatever the insurance is paying and that's going to really differ between insurers. The second piece of price transparency from an insurer perspective is the price negotiations that insurers have with providers, so how much does WellPoint versus AETNA pay for something.

Now this kind of price negotiation turns out to be incredibly important. We know from the last time we went through something similar to this, which was in the late 1990's, that insurance companies negotiating with providers can achieve enormous price savings. But that kind of price negotiation doesn't necessarily benefit from transparency and transparency is not typical in that kind of market elsewhere,

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so Macy's does not know how much, I don't know, Wal*Mart pays for the same dress. We don't right when they buy it from the manufacturer. So price transparency at the, within the manufacturer provider relationship, is not normal and we shouldn't necessarily expect that it would benefit things here. Third, how do people shop.

So, a lot of people when they think about price transparency, they think of the stock exchange where there is real price transparency, everyone knows exactly what a stock costs, the products are identical, there is a very thick market, there are expert shoppers and people keep, and there is really very little price dispersion. But actually, if you look at the rest of the world, price dispersion is ubiquitous. Brill focused on health care prices, but if you looked on shopper.com at the price of a television, you would find that the price is not the rule and one price doesn't hold anywhere. We actually do not observe that people always pay the same price for everything. Why not? Well search costs really matter. Sometimes you just need a bottle of milk and you don't care whether this place is cheaper than the next one, sometimes you go on Best Buy and choose the Samsung TV there because that is where you went.

So, search costs matter, making it easier matters. Search costs are not only mechanical, there are also cognitive.

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They also have to do with people's use of time, and in terms of quality information, most people ask their friends. Most people don't read consumer reports. Now the good new is [laughter] I need to say this, right? [Interposing]

Now the good news is, and this is the good news for all of us, that while Lynn is doing a public service is, not everybody needs to be informed to make the market work. Even if only a small number of consumers actually shop on price and quality, that can actually drive providers to the best prices in quality and benefit everybody. So, we don't need everyone to do it and everyone doesn't do it in other markets either. I am particularly struck by this one. The price of a microeconomics textbook, you would think that there, the lock one price really would prevail, but it does not. [Laughter] Okay, services and bundles. Markets work best with identical unique products, but in health care, the treatment of a condition often requires a lot of different products followed by a lot of different providers and a lot of different prices. There has been some work on bundling products together, so people have a price for the entire unit of service, but that's complicated too. What is the price of an episode? How is that going to work out? And, again, one of the places markets don't work very well in terms of pricing right now, is iPhones, cell

phones, because the packages and the phones go together and that bundling causes problems all over the place.

Not unique to health care, pretty ubiquitous problem. Heterogeneity: Patients are different. If we create bundles, some patients are going to need simpler bundles than others. Now some of that is information that providers might know ahead of time, like you know that most people are going to need bundle X, but patients might not know it, so you go shopping, turns out that the Lasik surgery one is, market is one where this is actually turned out to be a problem, the advertise $299.00 per eye, but almost nobody has eyes that work for $299.99. So when you actually show up and you get your Lasik and you go for your Lasik surgery, they say oh well, $299.99 is nice, but you need $1,000.00 operation. So, is it predictable.

The second thing is if we work on bundles, providers may not want to deal with people who are really expensive so if you say well all Lasik surgery is $299.99, the providers will simply say we don't treat people who are really complicated. So you can wind up with selection around bundling as well. And, finally, there is also unpredictable heterogeneity, so people look like the only need the $300.00 surgery, and it turns out they need the $10,000.00 surgery, so, you can see there is a lot of variability even within those bundles. If you went in for a $300.00 surgery and it cost $10,000.00, who

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pays the difference? How do we figure out who bears that residual risk, and that is going to matter a lot to patients. Quality: Okay, you know well functioning market price actually is a marker of quality, so if restaurants work right, expensive restaurants have better food than cheap restaurants. That should be true in a well-functioning market. But, in a non-well-functioning market, people still think price is an indicator of quality. And in health care, and actually in many other markets, it turns out people actually perceive the quality to be better even after they have tried the good, if it came out a higher price.

So, if you give people wine to taste and you tell them that the wine cost $10.00, they think it is pretty lousy, and if you tell them that the wine costs $100.00, they all find all kinds of subtle notes or whatever in it, and this turns out to be true in skis, in beer, in Vodka, and televisions and most importantly, in prescription medications. You think your drug works better when it costs more per pill. It actually makes you feel better, there is a strong placebo affect. Okay. If that is true, you can imagine the kind of gaming that might go on. If you are a low-cost producer, you might actually raise your prices so people think that you are higher quality.

Okay, I've got to go faSt. What do we know to date. Well, we have actually had a fair amount of experience with

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quality information because efforts to disseminate quality information have been going on for some time. And, the evidence is pretty mixed about whether people use that information and how they use that information. Some people use it, a few people use it, a lot of individual people don't use it. On the other hand, it has turned out in the literature on quality information so far that providers use that information a lot, that providers do not like to be labeled as lousy and improve their practice or change what they do in response to that, even if consumers don't use the information so much in shopping. New Hampshire had an effort to try and put price information out, these are average prices at hospitals. Remember that average prices don't help you necessarily in shopping because you don't know what your real price is going to be, but average prices in hospitals don't seem to have made a whole lot of difference. Tiered pricing which we have used for pharmaceuticals for some time, does affect choice, but is also affects whether people utilize the service at all.

So, again, it is a mixed bag. Is it just causing people to comparison shop, or is it actually causing them to leave the market. Now, we went through a little bit of this exercise back in the managed care revolution in the late 1990's, where we tried to give people information about the price and quality of competing health insurance plans. What we

learned from that experience is that people are very responsive in that context to prices and less responsive to quality. We've had much less experience in having people shop for price and quality on medical services themselves, so we know a little bit more about what they do when the shop for insurance plans then when they shop for individual services.

We also do know though from experience at the VA, a recent study at Hopkins, that giving doctors and hospitals information about price and quality can change the decisions that those providers make, so price and quality can affect not so much the consumer, as the recommendation that the doctor or hospital might make about what treatment you need. So you might imagine giving doctors, for example, information about under your health plan, what will this prescription versus that prescription cost you. And, that might affect their prescribing behavior.

So, we need to think not only about prices, but also where we are going to give the prices to. Finally, like everything else in health care, price and quality transparency is not a no-brainer. It doesn't, it's not that it has no potential side-effects that we don't like. If we think about transparency of all prices, you can imagine that that might have a very negative impact on pair negotiations with providers. A provider who might have been willing to give a

discount to one pair, may say I can't give that discount because if everyone else sees that I am selling this to you for X, they're going to demand the same discount and I won't be able to do it.

So, we have something called price discrimination in health care. It's not always a good thing to make that go away in pair negotiations. We have some evidence that when you publicize providers' charges, they actually raise the charges to be similar to everyone else. So, we don't really know in that circumstance how they will behave. And, then there is the possibility that there is selection. If we say you have to price bundles, you might wind up with people saying okay, we price this bundle, but we won't sell this bundle to anybody but the healthiest person, because otherwise we are going to lose money on it.

So, these kinds of responses are potentially possible. There are insurer responses, so we have this very unusual experience in New York, where we were very concerned about the out-of-network pricing and how much insurance companies were reimbursing for out-of-network provision, so we did a big effort on price transparency in New York to get that information about out-of-network costs out, where upon the insurance companies said forget out-of-network costs, we are just reimbursing at Medicare rates, and everyone wound up

paying a lot more out-of-network, so people will respond to this information in a variety of different ways and you cannot control those responses, necessarily. Finally on the patient effect side, if people do continue to think that equate price and quality, you can imagine that this whole thing goes topsy-turvy, and you could actually wind up with some very perverse effects in that way.

So, in general, I would say this. The problems in price transparency and quality transparency are not unique to health care. It is not the case that we are all super shoppers in every other respect of our lives. People buy cars based on their next door neighbor's recommendation, and they don't shop that much even for high cost items. So, the shopping information does not sound like everyone is like a Wall Street trader as they engage in their everyday life. But problems tend to be worse in health care than everywhere else in the economy, no matter what the problem is and that's true with price and quality transparency as much as anything else. There are potential gains and costs of all of these actions and we should just proceed with caution and with very, very careful evaluation as we move forward.

ED HOWARD: Alright, terrific, Sherry. Thank you so much for getting off to a great start. We are going to turn next to Jordan Rau. He is a senior reporter at Kaiser Health

News. Now tell me if I get this right, Jordan. Kaiser Health News is a project of the Kaiser Family Foundation, but independent at editorially from the foundation, and has no connection to Kaiser Permanente. Okay [laughter], apart from all of that, Jordan also knows more about HHS's Hospital compare website that almost anybody else in the country, so we are very pleased to have him with us. He is here to describe the challenges of using the comparison data that does exiSt. Jordan, thanks very much for being here.

Jordan Rau: Thanks for having me. So, I am going to talk also from a 300,000 foot level on quality and where we are in actually evaluating quality and just working off the most basic question of how good is your hospital. Now for the last 3 or 4 years since the Affordable Care Act was passed, there has been a huge explosion of number of quality measures that are now publicly available. There is over a hundred on hospital compare and you can see the list here. You have outcomes, measures like readmissions, rates, mortality rates.

We just started getting time spent in emergency room before being seen by a professional. If you go in there, it's very long, I suggest you stay away from the emergency room. Surgery patients getting anti-blood clot treatments; infections, there is a starting for a lot of infection data, how frequently patients do get a hospital-acquired condition;

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noise level in rooms; premature use of CT scans and MRIs which are the indications of overuse. This stuff is all out there. It is very difficult to use most of the literature and research so far has been—This is what is looks like. You can search two ways. You can search by your hospital, I picked Georgetown. They are always fun to pick on, and you can look on how Georgetown compares with the, your state or, in this case, the district, or the national average. You can also pick up to three hospitals and compare them. So, and you can look at those. Now, if you are scanning up and down and you spend a lot of time on this site, I consider it at lot like if you go on Amazon and if you are comparison shopping, the worst thing that you can possibly do is look at the consumer remarks, because they have the 5 stars and everything has some negative 1-star ratings and you would buy nothing if you read all of those, because they roast anything. If penicillin was sold right now on Amazon, no one would buy it because people would be complaining about how bad it tastes and how the marketing fell apart and no one took it back.

So, anyway, this information has not been useful, has been most useful or hospitals. Actually when they see their scores up, they get horrified and they start doing something about it immediately, even if people are not necessarily looking at it. They are also being factored into

reimbursements both by private payers, like WellPoint, as well as by Medicare as part of the new value-based purchasing program and the readmissions penalty program, so these are used for those as well a lot of the new efforts to pay providers in a way other than just in the terms of the fee-for-service and the amount of volume, ACOs, if you have heard of those, bundle payments all use these as well. Because, if you start paying people less, as some of these hope to do, if you can't monitor the quality, you have no idea if they are going to be stinting on it. But, there are a few procedures specific measures of the type of elective surgeries that you would actually go an shop around for on hospital compare, like if you wanted a new knee or a new toe or something, not that toe surgery is very common these days. You can also drive yourself crazy on this and I think a couple of unfair examples, but you'll get the idea. We compared Georgetown University and Sibley and you'll see that patients who said that nurses communicated well always, more of them said that for Georgetown. The patients who said that their doctors communicated well, more of them said it for Sibley, so you've got to decide, do I want to have a good conversation with my doctor or my nurse? [laughter]. Surgery patients, whose antibiotics were started at the right time, Georgetown did a better job of it than Sibley did. Surgery patients whose antibiotics were stopped at the right

time, Sibley did it right, a better job. So you have to decide more antibiotics or less antibiotics [laughter].

Now, on some of these, if you notice back on the last slide, and I am not going to risk my technical problems by actually trying to go backwards, but a lot of the differences are very small, 2-percent, 4-percent, and, as a consumer, it's almost impossible to evaluate this. Now on the outcomes measures, which are really the gold standard. How did a patient actually fair? The government and all private insurers to risk adjusts, so they take into account the age of the patient, how sick the patient was, the sex of the patient, a lot of factors, the comorbidities, what other conditions they had. When you do that, a lot of times to be careful and to make sure statistically that you are being fair to the institution, everyone comes out at as average and this is pretty much your basic question, which is mortality, did I die when I was in the hospital or 30 days after. This is heart failure mortality, 1 of 3 mortality measures on hospital compare, and as you can see, they rate almost all of the hospitals, 92-percent are average.

So, if you are trying to find out the simple question, you are going to find there is no way to really distinguish between your hospitals. Fortunately, there has been a flourishing market place of private companies and outfits that

are now taking all of these disparate elements and bundling them up into what are called composite measures, so just a simple way for a consumer to understand these things, and you are probably familiar with *U.S. News* has the best hospital rankings, both in specific departments like cardiology as well as overall, they have the honor roll that Truven Health Analytics has these things out of joint commission, which is a crediting agency, has top performers. *Consumer Reports* and *Leapfrog* have both gone into the safety scoring business. *Consumer Reports* uses scale 1 to 100. *Leapfrog* uses the report care. So that sounds great, right? However, they're all reaching totally different conclusions. Why is that? Well, different measures are included. *Consumer Reports* uses readmissions rates, *Leapfrog* doesn't; even though they are both reporting to measure the same thing, which is safety. *U.S. News* surveys the opinions of specialists and most of the other ones don't, so there is a lot of controversy about that. Even when they do use the same measures, they weigh them differently. The joint commission only uses what are called process measures, which is did you get a recommended type of clinical care on time or not, where as other groups just use a little bit. And, they have different time frames and because a lot of the sample sizes are small and because obviously some hospitals are getting better and some hospitals are getting

worse, if you are measuring at a different time, you come to a different result. Nonetheless, hospitals love these ratings because they are for advertising.

This is St. Mary of Mercy Hospital up in Livonia, Michigan, and it was very proud that it was one of the nations top hospitals, so they put a big banner on it, that was in 2007 to 2009; however, they dropped off that particular list so they is what the look like now [laughter]. So, anyway, so how is St. Mercy's, a good hospital or bad hospital, a pretty simple question, right? Not so much if you do your research. *Health Grade* says that it is one of the 50 best hospitals, *Leapfrog* gives it an A, its top grade for safety score, but *Consumer Reports* gives it a 47 out of 100, which his average, and it doesn't make the other 3 less.

So if you are a consumer doing your due diligence, you have no idea really of that. Now, what these quality metrics have been useful for is in marketing and because any hospital does well, will use it and you actually pay a fee, that is actually the financial incentive for a lot of these companies. So, you get in the market place, almost everyone is best, or rather a third. We counted up and we were pretty conservative in our counting. We found that 1,600 hospitals in 2012 were the best in one of these things, and we didn't even include *Consumer Reports*, because they are the only one that doesn't

allow the hospital to use it in marketing, but the other ones will charge as much as $50,000.00 or $100,000.00 for specific, you know so that you can take that U.S. best news badge and put it out there on your advertising. So, basically, and as you can see we picked out a couple of the worst markets in Fort Lauderdale, 21 out of 24 hospitals were the best and in Baltimore, 19 out of 22 hospitals were the best. So, it really has just created a chaotic, confusing market place for people and for consumers and that is all that I have and I am actually under my time, so I will, I don't know, give it to somebody else.

ED HOWARD: Alright very good, thank you Jordan. I was saying to Sherry that a member of the Alliance board, Jim Talon, who is head of the think tank for New York City hospitals has pointed out that of the 25 best hospitals in the United States by various rankings, 50 of them are in New York City [laughter]. Well, for the only pristine rater we have representing *Consumer Reports*, Lynn Quincy, she is a senior health policy analyst for consumers union, which is part of *Consumer Reports* and, Lynn, as you might expect, is going to address the critical role of consumer knowledge and decision making in health care and health insurance. Lynn.

LYNN QUINCY: Good morning, I'm going to quickly rework my presentation to talk about Columbia University and Kaiser

Health News [laughter]. So, I missed the planning call for this panel, and then I got assigned, talk about all the transparency provisions in the Affordable Care Act and the status of them being implemented. So that is what happens when you miss the planning call [laughter].

The Affordable Care Act actually has, I haven't counted them, I am going to say at least 30 provisions that have some bearing on transparency, I clearly cannot talk about them or even their status. I will give you a little bit of an overview and then I'm just instead, going to do a deep dive on one and talk about bringing it home to the consumer. So, they have a number of provisions that affect transparency of health insurance plans, many may be familiar to you. The exchanges themselves are going to be a brand new, very transparent way of comparing your health insurance choices, so it's going to be exciting to see what there is to view on October 1 of this year. There is also information that is, kind of I grouped into treatments, having to do with better disclosures when physicians are self-referring, provisions called the Physicians Sunshine Act disclosing gifts and payments so you kind of know if they are subtly being influenced.

Not all transparency provisions are public facing. Another provision in the Affordable Care Act is that Medicare claims data is more readily available to researchers, so you

may not be able to see it unless you are a researcher, but that is, you know, good for us and there are all sorts of other stuff like calorie count requirements in certain restaurants and in vending machines, so there is lots and lots going on there and actually, if you need a research project, I do not think has been compiled all in one place. So instead of, I am going to ignore my actual assignment, and do a case study approach about getting it right from the consumer perspective. So one provision in the Affordable Care Act, is a new way, a standard way, of disclosing your health plan's coverage and benefits.

This is page 1 from the form and the full thing is in your packets, so I just wanted you to have a little sense of what it is. So, this is in the statute and the statute did some stuff that was really good from a transparency perspective and a consumer perspective.

First of all, it required that a diverse group of stock holders be used to develop this new form and, it required that it be culturally and linguistically appropriate, it is just to be understandable to the average plan in role E, and there is a little bit of a goal in there that they want consumers to be able to compare their insurance coverage and understand the terms or the exceptions, which is very important. There was a list of what was to be included and there was a provision for a

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periodic review and updating. I think that sounds good, don't you? Good, I'm glad we all agree. Whoever, I know there's probably only one of who how doesn't subscribe to *Consumer Reports*, unlike what I have been hearing, but see me afterwards.

Now, unfortunately though, the provisions of the statute did not meet Lynn Quincy's high standards. First of all, there was no provision for consumer testing and you are going to hear me say in the next five slides that if you do not consumer test your disclosures, you probably aren't getting them right. It also neglected to require the inclusion of premium information. When this was being developed by the National Association of Insurance Commissioners, there was a row for premium on the form, there isn't on the one in your packets, because it was a no-brainer. If you're going to compare plans, of course you want to know not only the benefits covered, but what it is going to cost you.

Then, they finally figured out the statute didn't include premium and there was some lobbying to get that taken off the form, and they were successful. There is no provision for monitoring to see if these statutory goals were received, so we were feeling this was poor so we actually said well we are going to go to some very generous foundations and we are going to do some testing of this form. So, we did some early

testing and then we did some more testing and then we did yet another round of testing and then the rules were written, it rolled out, and then we did some monitoring to see how well it did. Now, these are not things that Consumers Union and private foundations should be doing, these are things that should be in part impartial of entering a new disclosure, consumer-facing disclosure, into legislation.

So, when we did the testing, something unexpected happens so not only do you test to insure you are meeting your goals, but you're going to learn other stuff that is very important, and I want to do any even deeper dive into one thing we learned. This is one page from the summary benefits and coverage form. This is one of the requirements in the statute. In the statute, it was called a coverage fact label, now it is called a coverage example. And, as you can see, it shows what a plan would pay for a medical scenario. That may seem very straight forward, you know isn't that the general idea of health insurance.

Well, it turned out that this new thing was extremely powerful. These examples include three pieces of information that consumers have never seen before. First of all, they have no idea how much medical care costs. So, we did open-ended questions before we tested this particular feature and we would say how much does it cost to have a baby. Oh, $65,000.00,

people, or less, people have no idea and if you don't know how much medical care costs, you don't know how much coverage you need and you may feel that a policy that offers $20,000 of coverage per year is adequate, because $20,000 sounds like a lot. Not to people in this room, but to the everyday person on the street. So that's thing one.

Thing two, it shows what the planned paid for you because it applies the plans cautionary provisions, which are like Greek to consumers, to those medical charges. It applies the deductible, blah, blah, blah, and it gives you a bottom line. There is no consumer out there, including Lynn Quincy, who can get to that bottom line without help, so it is very hard to compare plans when you see one plane with a high deductible, but a low out-of-pocket max, the other plan has a low deductible, but a high out-of-pocket max; which is better, nobody knows. So, they can't do the relative shopping that Sherry described.

Here is the surprise. It is probably self-evident that doing the math with the consumer is a good thing. Here is the surprise. It shows the plan pays. Now that sounds like a residual, it sounds like it is not important, but think about it. In today's health insurance disclosures, you know, it's all about what you pay. You pay the premium, you pay the deductible, you pay the co-pay, blah, blah, blah, but the time

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you [inaudible 00:36:46] it's not a good deal for me. Then they, and would tell us when they were doing their fake shopping in our testing. Then they saw this and they said, oh, that plan is paying $94,000.00 for me, that is the first time they had seen that information. We don't talk about what they're getting for their premium dollars and it was very powerful and people said, you know what? That deductible that looks so high, that is chump change compared to the cost of the breast cancer scenario, I'll now buy this plan.

So, testing is extremely extremely valuable and should be part of every disclosure. Unfortunately, the breast cancer example, which was the most powerful because it was the most expensive, is not on your form, but we're hoping to get it in. HHS brought out two coverage examples, they are promising four more. You should all lobby them. So, let's take a step back from our case study. If you have a statutory goal with respect to transparency, you've got to approach this comprehensively. You've got to do all of the leg work that is involved with getting it right and you've got to put it right in statute and you've got to assign some dollars to it so that it happens, and that includes doing things like an environmental scan, not really done with a summary of benefits and coverage, it includes upfront development work. A lot of people now know the have got to do plain language review. You've got to get a

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writer to come in and rewrite things, so they are in plain language. That's fantastic, but it's not sufficient. There is a lot more that goes on with successfully communicating to consumers, like design work. No designer has ever touched that summary of benefits and coverage form and it could be made twice as impactable if they would just have a designer come in and tidy it all up. You have to pilot test these things. You've got to collect comprehensive feedback and refine over time. None of these things, typically these things do not happen and it is our loss. You have to be aware of everything you have to do right in order to have a successful communication.

First of all, the consumer has to be aware of the information. I suspect that one of the reasons people don't use quality information is they have no idea it is out there. It has to be easy for them to find it when they need it, not when you want to educate them in a stand alone setting, but when they are about to go and choose a hospital. It has to be understandable and you can't say, I think this is understandable, but you've got to demonstrate that it is understandable using testing. It has to be relevant to them, the design has to support the goals of communication. Don't make it look untrustworthy if you want them to trust the information. And, I already said this, there has to be

feedback mechanisms so you know whether or not you succeeded. So, thank you very much. I am going to turn it back over to Ed.

ED HOWARD: Thanks very much Lynn. Lewis Mattison is not Paul Martino, but plays him on panels from time-to-time. Yesterday in Chicago, Mr. Martino was on his way to O'Hare to catch his flight to Washington and as his assistant told me, the freeway buckled [laughter] flooding, sink holes, it swallowed cars and Mr. Martino is still in Chicago, but we are very fortunate to have all of the way from Cleveland Park, as opposed to Cleveland [laughter], Lewis Mattison. He is the staff vice president for WellPoint's strategy and innovation activity. Prior to that, he spent a good amount of time as a senior advisor to the national coordinator for health IT within HHS where he was helping to get that office established. When you look over his resume, he, himself, summarized it pretty well before we started. He said I think about new stuff. So he is in charge of new stuff thinking for WellPoint which makes him pretty important, and we have asked him to focus today as we had planned on what WellPoint is doing to help its policy holders make the kind of intelligent decisions that Lynn Quincy and *Consumer Reports* would have for everybody if they only subscribed [laughter]. So Lewis, thank you so much for being

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part of this, for jumping in at the last minute and we are very appreciative and looking forward to your remarks.

LEWIS MATTISON: Great, thank you. Great, thanks for that. First, I am a subscriber to *Consumer Reports* [laughter] and ironically it is one of those things that I actually use probably twice a year and it may not seem like much, but it is, because I use it when I really need, when I really need another opinion, because I can't figure something out. [Interposing] Wow I'm at zero anyway so [laughter] on the clock. You know, but there are decisions that we make and we don't do them that often and so I'm going to come back up to 300,000 feet, but starting here. All of this stuff starts with us and the decisions we try to make when he haven't done them before and so, you know, if you buy a car every year, get a lease very year, and I know people that do that, I wish I could, but they know how to buy a car. They know how to kick the tires. They know how to look at everything. But, I buy a car every 12 years. I am on my second car that I have actually bought. It doesn't mean I'm young, it's just I really hold onto cars [laughter] and it is really nerve racking to go through it and going to Edmunds.com, you go to all of these places and they you still get in there and you are in a sweat.

When I bought a power washer, I went to *Consumer Reports* and my PC, I didn't get a map, but, that shows my age

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again, my PC and my TV and pick a few other things. They're very diverse things and they are very very periodic purchases and you're going to be stuck with them for a while. So, health care is the same thing. You know, in strategy, we, and innervation, we look at things at 30,000 feet. We understand as much as we can around what is happening in the environment with the industry. We look at competitive moves. We look at what the voice of the customer and consumers are. Those customers and consumers are actually not just consumers like us, that aggregate up to over 300,000,000 people, but it is also the providers we partner with, it is the pharmaceutical companies and it is just a very complicated thing. However, as I go through all of this, you look at all of these macro things, use words like readmissions and then you try to bring it back down to yourself, and the decisions that each of us may have to make or may not have to make, so look at the readmission rates. I was studying readmissions. I could tell you who was bad, who was not, what the penalties were going to be from CMS. That whole business plan set up for a venture that we are going to invest in.

In the middle of that, we are commissioning a study with some providers to understand what some of the different things were where we are understanding everything at 10,000 feet and I had just finished a procedure where, by the way, I

had actually gone through all of these things, had part of my colon removed, I'm 100-percent healthy, healthier than I ever was, but in the middle of that whole traumatic thing, I am trying to find the right provider, he is in my network, etc. I got through it. I made a perfect pick. I was inside my network and the two weeks later, I am checking in my work, I'm checking out a project score and we are looking at readmissions, I am getting ready to say to the CFO, here's the next level we want to get to on our readmission project, you know, suddenly, I was a readmit [laughter] and all of a sudden, you know you take all of these trends and it makes a lot more difference when it is you, you know, the one I wouldn't be able to appreciate and talk about is the mortality rate, by the way [laughter].

But my whole point of that is to say that this is a really complicated thing and the more that we can, you know, as we are trying to do this as policy makers as, you know, business leaders, as those who can make inflections here, just try to go through some of the calisthenics and understand what it is like to actually make these choices. I hopped online last night and just started banging around on some of our tools, because, you know, I had all the talking points, I know what we do, but then I realized, I actually didn't even use all of them, I used some of them by the way, I didn't use all of

them when I went through my circumstance. Why? Because you're so scared, you forget to step back and think about all the things that are available.

So now let me just run through some of the things that we have, I won't tell you which one I didn't use and I won't tell you which ones I did use, but I'll tell you that if I had a little bit more composure, I would have used all of these, right. So let me just start flipping through. So what do we mean by transparency, right? There are things related to coverage cost, quality, and patient satisfaction. So at the end of the day, are you covered. You wrestle with it, you try to figure out, is this specific procedure covered? Will this doctor actually take my insurance?

Alright, that is exactly the question I wrestled with, and you bring it from 300,000,000 people you are trying to solve for. We work with 1 out of 9 of those, so I won't do the math, but it is a lot, but then you have to do it for yourself, right? It really matters. You get into the cost of it, which is what is going to be your out-of-pocket. It is mind-boggling how hard it is to figure it out and when someone tells you to post what the charges are, that is irrelevant. The only person who pays full charges, are the people who don't have insurance, and, by the way, they don't pay full charges, and the ones who do, it's a lot of money.

So, what WellPoint has done, what Anthem has done, is we actually, we put the costs. We really try to make it what it's going to cost from you. It is behind a secure log-in, so it doesn't go to everyone else, but it is just important to really try to begin to understand what it is going to cost to you, and it is still hard. The quality piece— as a doctor said to me, when I was going through these decisions, don't make the decision on the economics alone. Never make the decision only with the economics.

So you bring all of that to bear and then at the end of the day, the patient's satisfaction piece is going to be the most important, what do other patients think. And, this is the part, this is really the most important thing to me about how to think about this from a macro perspective and a micro, and that is all of these tools are available. We should all use them just like we use *Consumer Reports*. We use CNET, we use Edmund's for all of these different purchases, but at the end o the day, for the really big ones, it really matters to go out and ask other people what they have gone through. When it comes to navigating the post-acute, and what does post-acute mean? I sound like I'm not a patient any more. What happens after the surgery and some of these things are really complicated and if you are able to talk to someone who has gone through it, you actually become a much more informed consumer.

The transparency goes way past the discharge from the hospital, and the more we can share our experiences—you know there is a colleague of mine, she actually had the same exact operation that I did. I tried to help her pick a doctor. I helped her pick my doctor, except the only reason she decided not to, was it was 45 minutes from her house. We talked about the experience and I said, you know, I forget which one of you all said it, but it is the mental part of the choice as well and if your husband is going to need to be there every day, more than twice a day, 40 minutes is too far. So, she picked someone else. But we came to that decision based on quality, cost, convenience and other factors. I am not trying to go down into a data point of one, but strategy always comes down to what does it really mean?

Let me focus through on a few things that we at Anthem have done. We try to make these charges and costs known to everybody, so that you can have a dialogue with your provider. You know, we have 40-percent of shoppable services that you can start to get a sense of what these are going to coSt. You can have the dialogue, so that if it doesn't make sense to you on the website, have the conversation. Some providers actually don't mind engaging. There are others, I have one doctor that I actually still go to, who told me that I am the only person that asks about how much these things cost, how much is going

to be out-of-pocket, and I am the only patient, besides my wife, who actually sends, who actually has our labs done around the corner at the place that is covered. That was a $600.00 lesson, by the way. But I had the discussion with my doctor and it is embarrassing, but it is eminently practical now that we have gone through it, it all makes a bunch of sense.

So, the dialogues are not just with other patients like you, it is with the providers. All of use have to engage there. But, Anthem's plan is to take these tools and make more shoppable categories, more shoppable treatments available so that we can ask the questions. I am going to flip through this one. So one of the things, that really ask this transparency discussion is trying to bring all of these factors together, so one is what are the right treatments that are needed? Who is the right provider that you can go to? And, how does the consumer really understand that. This is a critical sequence where all of it comes together in an industry, yes it is an industry, it's a sector. It all bubbles up to, you know, a large percentage for our GDP, but this is a sector where the lines are blurring and so the clinical review, which is prior authorizations, is trying to decide if this is right. It is no longer just a discussion between the provider and the insurance company and then pick another utilization review group. You know, picking a network is no longer just a provider and an

insurance company trying to figure things out and then contract and then hoping the member on the back end actually gets something good and there is this big surprise in reading in EOB, explanation of benefits. We have put in place something with one of our programs called AIM, American Imaging Management, and its radiology benefit management services. What does that mean? Well, it is to make sure that you guys, everybody, gets the right radiology benefits at the right time.

So we've incorporated best practices from the clinical literature around what's going to be right and what's not. It includes things to try to make sure that our patients, our members, don't get too much radiation, because over time, it' bad. Right, if a doctor wants to order another test, let's just step back and say is this really right and necessary at this time? Then, we try to help the doctors who are ordering these things, understand the cost of some of the cost and quality associated with the services that these can be referred to and then, depending on those two things, we, at AIM, American Imaging Management, will reach out to the member or be available for the member to in fact have a discussion with someone and try to figure out where can they go.

So, imagine if we have a reference-based price and 1,000 bucks is what it costs for an MRI, you can go down to 575 or you can up to 2030, but this give a chance for all of us,

who are pooling our financing of our cumulative costs into the same area and it makes sense for us to recognize we are all in this together. Go where the quality is good and we can go where the prices are reasonable.

So, I am going to flip to this one really quickly. I am out of time. There is a slide in here that shows a basket of—a range of—I'll just tell you, there is a range of prices that can show up for MRIs, from 300 to 3,000, that is a wide gap. And it is not like a glass of wine that goes from 10 to $100.00. I can't tell the difference in a glass of wine and I can't tell the difference on an MRI and then, I am going to flip through here to the final thing I'll leave you with as I am over time and that is, actually I'm going to do two points. The final point here on this part here with the tools that we bring is you can look, we can look at what the high quality providers are based on a number of quality factors.

We can also bring cost and efficiency into the equation and you will see here that for spine surgery, there is a difference of about 17-percent; for knee and hip replacements, it's about 19-percent. I mean these are big numbers. These are big numbers on big numbers and so if we all engage in the debate together, the discussion together, we can all get this down.

So, as I try to leave with a couple of points on top of that. The tools are there, but all of this happens as we change our culture. I have heard several providers and several insurers and several private equity and venture capital groups that fund all of this stuff, and then a lot of other niche vendors that are trying to come up with the right solutions to help all of this stuff happen and everybody latched during this during discussion onto the notion of culture and how we all come about it together, and the lines are absolutely blurring.

So I sort of see a real convergence around the patient where the providers and the payers have to collaborate and we are collaborating, but it is not just the payers and the providers collaborating, it is a discussion that it is a discussion that is enabled by some of the data, some of the tools that we can all provide and if we talk to our doctors, we are going to find that some doctors want to help us figure this out. As we get further down the road, I would like to see our doctors saying if you go with Anthem, you are just always going to know and you get to stay with me. That is the ultimate where were it is all collaborating together, but the buzz word is payer-provider collaboration and we are seeing the lines blur. We are trying to finance the right things, even in an outmoded reimbursement system that is evolving, but if we know what we are trying to do around the patient, we can enable that

dialogue and everybody has got the tools to ask the right questions, just like going in with your Edmund's number to the car dealer. Oh by the way, it's just as nerve racking when you start to bring that number up, it's always nerve racking, but it is the dialogue that happens on these tools.

ED HOWARD: Thank you very much Lewis. We are at the stage of the program where you get a chance to enter into the conversation. As I mentioned, there are green cards in your package that you can use on which to write questions and there are microphones which you use and if you hold those green cards up, someone will bring them forward. The microphones are at either side and if you come to the microphone, we would appreciate it if you would identify yourself and keep your questions as brief as you can.

Let me start, if I can, with something that Lewis was mentioning and actually Sherry talked about bundles and pricing of mechanisms that are evolving. How does all of this demand for better price information and for that matter, better quality and more quality information sit with the often expressed need to get away from fee-for-service pricing which is exactly what we have been talking about. Can't we just get on with it and go to the new systems?

SHERRY GLIED: I would say some of the insurers that are moving forward with price transparency efforts are trying

to combine that with bundle payment approach, so if you can bundle the payment for the—, you can create a bundle that is plausible, it is easier for people to compete, to compare prices around the bundle. Of course, it's really important to know whether that bundle price is an average bundle price or that is the actual bundle price you will face no matter what happens to you, even if things go wrong. So is it an ex-anti-promise or it is just an average sort of expectation, and those are going to work very different ways in the market.

ED HOWARD: Lewis, you want to add to that?

LEWIS MATTISON: So how we get there, it's going to take longer than, it's going to take a long time and, you know, we can take these steps, step-by-step, we can put some bundles in and try to make them work. We find the right providers who are going to collaborate with us, how they debate around it, but the predominant reimbursement system is still this evolving fee-for-service, and what is difficult is we are all still on that Titanic. We've got a really small rudder and we are just trying to add more length to the rudder, so we can turn the ship. And, one of the things that we are seeing is that a lot of people are scared about how we try to step into this new world of reimbursement that allows these types of things, but if you shift overnight, people are going to lose money. The last time people tried to shift too quickly was when providers,

back in the mid-90s were jumping into capitation and a lot of them lost their shirts, and so what we are trying to do, is find a way of getting in quickly, but methodically, not too quickly and it is a matter of cadence. Cadence does not imply that we are going to go at a trot, but we just have to recognize that when some things go in too quickly, if you don't know how to price things, you are going to lose money on one side or the other, and then you have an issue with if a provider or an insurance company loses money or goes out of business, those costs are picked up elsewhere, so finding the right cadence here is critical.

ED HOWARD: Yes, Mike.

MIKE MILLER: Hi, Mike Miller, a health policy consultant and blogger and a terrific event, a great presentation by everybody. There was talk about the hospitals and specific kind of procedures, bundling, but I wonder if the panels can talk more about primary care and transparency price and quality. I know in Massachusetts, the state has created a system for tiering their primary care providers into, sort of the best and then average, or there is not a lot of information, and then less than average, and tied that to what the state employees have to pay in terms of copayments for seeing their primary care doctors. Could you talk more about, I don't know if any of the panel know about that or could talk

about similar things for helping people choose primary care providers which encompass a broader range of services than a specialist or the categories for hospitals. Thank you.

JORDAN RAU: I'll take the first crack at it. I am not that familiar with Massachusetts, except on the map. But breathing quality for doctors is really, really hard because, first of all, you've got a very small sample size, they don't see as many people as a hospital or a nursing home or whatever and then, also, you know how do you actually evaluate them. For primary care doctors, a lot of it is around very basic clinical care measures like did you give a regular eye exam to a diabetic patient? And so, there is some movement on that in various places and Lewis will probably know more about is going on in the private market, but the main thing is you run into the same problem that most people in terms of quality, if you are going to be fair to everyone, are going to be more or less average. They are going to be in the lump and you are going to catch the outliers, but it is very hard, you know, just like it is if you are picking a doctor to find what the criteria are that you can judge them on.

LEWIS MATTISON: Let me jump in. I don't want to dominate too much, but this is one that's very near and dear to me from a strategy perspective and I'm not sure, I'll have to check and see where we would stand on the tiering of primary

care, but I'll tell you where we are going, and that's the most important thing. As we think about accountable care and how we are going to bring quality, you know, to the populations, how we are going to keep costs in check, because we are all solving the same problem. This all happens with primary care. Accountable care is primary care.

So, if a delivery system or health system wants to become an ACO, the more that they can manage the population, manage the costs down, starting with the front end disease management, helping your chronic patients, better manage those conditions so they can avoid or mitigate what happens with their hospital visits. Every visit you can halt, is good for everyone, especially when the incentives are aligned for them.

So, we believe that if you can enable primary care, whether it's with the primary care physicians that you can help give them tools, the one and two doctor practices, to the large group practices, even multispecialty that has primary care, or even the integrated delivery systems that have invested in the acquisition or employment of primary care doctors, but if we spend all of our, if we spend a lot of effort there, we are going to solve a lot and we believe that if you reimburse primary care more, and also help the doctors with tools that; the word I'm hearing a lot about, at first, it sounded more like a buzz word, but it just makes a lot of sense to me, if we

can help them increase their capacity. What does that mean? Help them operate at the top of their license, help them bring in the other support whether it's our care managers that can actually have the dialogues with them in between the visits around their chronic condition, but if we can help increase capacity so that we are able to do more, then we are actually paying them more. I think that right there is one of the biggest strides that, again, use the analogy that adds more rudder to the ship that we are trying to steer.

ED HOWARD: Okay, yes.

BOB ROBE: It seems that we are drowning in information. There is so much, that we can't make sense of it and part of it is because, you know, everyone has sort of their own cottage industry of how they measure and evaluate and even terminology. How important is the need to standardize what we are looking at and how far would that go in trying to make sense of transparency in terms of quality and price?

ED HOWARD: Lynn?

LYNN QUINCY: Well I think if you look at the miles per gallon sticker on cars or the Energy Star ratings on appliances, the nutrition facts panel on food, I think that answers your question, that we absolutely need to standardize. There has to be a gold standard for how we measure these things.

ED HOWARD: Among those many provisions in the ACA are some reporting and standardizing provisions, correct?

LYNN QUINCY: Yes, I think. So there are some, and there is more to come, so the summary of benefits and coverage which I do think of as an evolving document, but it is the only standard way of conveying the coverage and benefits for a health plan right now. There's other, there's quality measures coming down the pike. There is also still going to be diversity. There's exchanges across the country who are going to report things in different ways. But I think you are on the right track.

SHERRY GLIED: However know that, although even though we have miles per gallon and Energy Star ratings, most people when they make decisions, that is one of the factors that they will consider and most rating agencies will consider that as well as a group of other factors. So we never are in a situation where there is just a single valued rating and that's never going to happen in health care either. We will never be able to say that on all criteria, this thing is best. We're always going to be a little bit.

ED HOWARD: Before we go on, there is a question on a card that actually follows onto that. The questioner asks what the prices on the summary of benefits are based on? Are they negotiated rates with insurers and providers? Are they going

to vary from plan to plan of the same market or are they average costs? Are they charges?

LYNN QUINCY: Astute question. In the ones consumers see today, because this form went into, was first used last fall, it is based on Medicare pricing. That was not the recommendation that came out of the National Association of Insurance Commissioners; it was supposed to be representative nationwide pricing. The idea though is that the price is always the same and that the only thing that is changing is the way the plan pays those prices, so that the bottom line you see can be compared across plans, but it is no meant to indicate exactly what you would pay. And, in our testing of the document, consumers completely got that. There was no confusion on that point.

ED HOWARD: Yes, go right ahead.

BOB LEIBENLUFT: Bob Leibenluft with the Healthcare Incentives Improvement Institute, HCI3. There are a number of states that have laws that mandate some sort of transparency, and I think as we've heard, they may not be going up to the right information. Are charges made actually more confusing to consumers, and, on the other hand, we see WellPoint doing something which actually might be very creative, going to where consumes could be getting useful information to make decisions. The question I have is should we let the market work and let

WellPoint and other health plans compete with each other and it should be in their interest to develop the best systems to get transparency that would drive costs down, improve quality or is there some obstacle or something that government should do to facilitate the process, either on a state legislative level or better legislation, I would be curious to hear what people have to say about that.

LYNN QUINCY: Well, I would, I think that we should build on the efforts of plans and other entities that are working on better transparency, things that are consumer facing, but I would like to see a uniform approach at the federal level. Just as an example, when their information is behind a login script for people who, for their members, I can never remember my password for these things. I cannot, there are so many accounts I cannot get into because I have no idea what the password is. I would really like this to be more accessible and uniform so that people can learn it once and for all, like the nutrition facts panel on food, and it's the same wherever you go.

ED HOWARD: And actually, Lewis, there is a question here that would indicate you might want to amplify a little bit what the mechanism is that you were talking about because the question is, how is WellPoint advertising their cost tool to consumers? Aren't there concerns that advertising rates may

impact contract clauses with providers for nondisclosure of negotiated rates, and presumably you don't advertise those—

LEWIS MATTISON: We don't advertise our rates, but we do advertise the tools to our consumers, right?

ED HOWARD: And you make them available only to your own subscribers?

LEWIS MATTISON: Yes, I went on last night just, you know, it is always good to understand, you have your strategies, and I have used some of these tools in the past, but I wanted to think about the ones I didn't use, and you have to go behind a password. So really it's for our members. I think over time, we are going to get to a place where you can see transparency across. It's probably part of the plan selection, but, you know, there are companies out there that are trying to aggregate some of these tools and, I'm trying to think one of the ones, it's a company called Vitals, and they're trying to aggregate all of the different transparency tools from all the different plans and so, some of this may happen in the private sector and if it doesn't then the government may want to try to step in, but we do make it available primarily to our members because it's how we help them make the choices with the providers that we set them up with.

ED HOWARD: Yes, go right ahead.

DR. CAROLINE POPLIN: Hi, I'm Caroline Poplin. I'm a primary care physician. I wonder about this business of price transparency with hospitals. I mean hospitals now, as was shown in the Steve Brill article, they charge whatever the market will bear. If you are a strong insurance company, the price will be a little lower. If you are a small insurance company, the price will be a little higher. If you are uninsured, the price is the highest. And, I forget what he called it, it's the price the hospital, the [interposing], the charge master. They set it high enough so that they will make money whatever, whoever pays. When I get my, I buy, I take hydrochlorothiazide. It's an antihypertensive. It costs pennies and I pay, well what Blue Cross tells me they pay, is $34.00, that's for 90 pills, that is $.30 a pill. Hydrochlorothiazide is pennies a pill and that's what I pay, but what they are telling me they pay, is absurd. I know as a physician, that is ridiculous and if I get, you know, something like that, that tells me that, you know for $100.00 service, Blue Cross/Blue Shield is paying $2,000.00 and I only have to pay $25.00, that is not useful information, that's ridiculous.

ED HOWARD: Don't you agree? [laughter]

DR. CAROLINE POPLIN: What are they going to do about it?

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ED HOWARD: I just made that into a question. [laughter].

SHERRY GLIED: I think the problem is that those charge masters are not really used for anything except to charge uninsured patients. They are not used by Blue Cross either. The prices that you see on those bills, the totals make some sense in the sense that that is what Blue Cross pays to the hospital, but the breakouts, they are pretty arbitrary. These are, you know, the negotiations that Blue Cross, or whoever has with hospitals, are more global than how much am I paying for a pill and then, it's going to be divided up in some funky way. So it is not very meaningful.

DR. CAROLINE POPLIN: I understand that, but I think that the prices that we will see are not the prices that Blue Cross pays. I think they will be something off of which Blue Cross gets a "[inaudible]".

SHERRY GLIED: Well that is what you usually see. This is what the hospital charged, and we paid something or other. It's never right. So, we do have a problem, a particular problem for researchers that most of the numbers that float in this world are nonsense. [laughter].

DR. CAROLINE POPLIN: Exactly, I would agree with you.

LYNN QUINCY: I'm not an expert in this, but I believe for some categories of medical care in the Medicare world, they

do try to relate it back to what this actually costs, for what that' worth, but is it no every category. Drugs would not be one of them.

ED HOWARD: In your materials, by the way, there is a wonderful blog post reference by Hoover Reinhart in which he talks about the Steven Brill article and the Marilyn Serafini article that preceded it by a decade and also talks about how that stirred him to lobby for and see enacted a law in New Jersey that requires hospitals to charge no more to uninsured patients than a stated percentage over the Medicare rate. So, there is room for some government intervention at some stage and models for other states and perhaps the federal government to think about.

DR. CAROLINE POPLIN: And, maybe that's what they need because I think they just markup prices to mark them down.

ED HOWARD: Yes, go right ahead.

LISA SUMMERS: Hi, Lisa Summers, from Centering Healthcare Institute and my question is for Lynn, and I have to, Lynn, I'm a longterm subscriber [laughter] and I actually, very honestly, your coverage of health care in the last few years has been amazing for those of us who thought about it when we bought a washing machine. It has been great to see consumers understand the ACA through your coverage, so thank you. So my questions is a followup to your comment about

providers using cost and transparency data to a greater extent than consumers have to date and, as a provider, I know that we really struggle when we talk to patients about less costly options or particularly when you try to steer a patient against a costly, but not proven treatment and the example of maternity care is a great example where we spend a lot of money on things that have no evidence related to outcomes. So my question is in your testing, did you learn anything that helps us understand how we can address that issue that consumers often do in health care equate cost and quality and it's hard to steer them away from costly things that they don't need.

LYNN QUINCY: Which answer would you like? No, since you are a subscriber [laughter]. No, the truth is that the reports that I threw up on the screen before did not get into your question, because they were very focused on shopping for health plans. You raise an excellent point that I think that everybody in the room would agree with, that this is a very hard conversation to have with consumers because they're not in a position to rank relative treatments as to what's the best value, so they have to take short-cuts and using price is as cognitive short-cut that says well, more is better, you know I'm going to do that. But there is some effort to address that. I don't know if folks know about this choosing wisely campaign? Which is a campaign to just focus on a few, like

starting with three overused procedures, have trusted voices like a physician or *Consumer Reports* say, you know you should think twice about getting his particular procedure and I may or may not have brought some literature about it, but if you are not familiar with choosing wisely, that is a starting point for having new conversations with consumers.

KAREN DOMINO: Hi, I'm Karen Domino, Robert Wood Johnson Health Policy fellow, and I'm wondering if the panel could talk a little bit more about adverse risk selection, especially in how you make adjustments, particularly in some of the charge and cost data. I mean looking at it as an example for hip surgery. You know, there are a lot of patient comorbidities. I mean if you are taking a morbidly obese, 400-pound person with diabetes who's elderly, having a hip replacement, it is a very different thing than someone who is fit, thin, and has no comorbidities and I'm concerns in seeing those kind of data that people, hospitals with the lower cost amounts for these kind of procedures are actually cherry-picking their type of patients and I wonder if you could comment on that.

SHERRY GLIED: So, as you know, the literature on quality rating and pricing in health care is replete with evidence that we don't risk adjusting this perfectly and I think we have to be very, very careful about it. I don't think

we should give up on the effort because of selection concerns. There is a balance that we have to try to achieve. I think we have to go as far as we can in that risk adjustment and be very careful about cherry-picking and I think the other end as well, which is, you know, that there is some evidence, somewhat disturbing evidence out of places that do cardiac surgery ratings for example, that some of the most risky patients don't get treated because they don't want to have it affect their ratings. That might not be a bad thing and it might be a bad thing. I mean, the jury is still out. But this is definitely a problem. It is one that we should keep flagging all the time and we should just keep trying to get better because I don't think it is a reason to throw the whole enterprise out.

KAREN DOMINO: Any comment from the WellPoint person?

LEWIS MATTISON: I'll say it's just going to get harder as more people probably with higher risk condition come onboard, so is a lot of people who qualify for Medicare. If you think it is hard today, it is going to hard when many many million people who have not have insurance before start to get treatments that they have foregone. It's just going to get harder. I mean if you just look at some of the statistics around some of the Medicaid populations, they have more chronic conditions. And what does that imply? We are going to end up with more of these comorbidities. The whole risk selection and

risk rating, the equation is being thrown into a whole new light, all the way up to how people buy their insurance. So, I think there is just going to be a great juggling act and we have to scramble and we have to just try to just improve it very, very quickly.

ED HOWARD: And what about the general proposition that quality is very difficult to measure with or without risk adjustment. I mean we have, on the one hand we have Medicare advantage now being, plans being rated with a number of stars by CMS and how is that working out, and with a couple of references to the difficulty of getting to individual physician levels, but now physicians are joining hospital staffs and joining multispecialty practices, and, you know, where does WellPoint get its quality data on which to make its kind of recommendations and network connections. Putting consumes in control with good pricing and quality information presumes good quality information and how we do it. Lewis, do you want [interposing].

LEWIS MATTISON: Yes, so today we have a lot of information, we have a lot of claims data. We try to get a bit of data from the providers, but you know as we start to see more date sets coming in from the clinical side, I'm hopeful that soon we will be able to have more of a combination of the administrative sets which are longitudinal across providers and

the depth inside of each provider setting that lets us really get it what the quality measures are. It's looking a little bit up, but it is not that far out. So we have a group within WellPoint called Health Core and it's a totally, it is a separate subsidiary and it has to be, because it does clinical research trials, and it retains that objectivity. I don't even have a pass. My office is actually 30 paces from their office, but I don't have a key to get in. I have to knock on the door and ask Marcus to let me in. But this is a group, the importance of this is that we are seeing large investments and implementation by them around real world evidence and, it's when we can start to pull in the real world evidence where you're combining the longitudinal administrative sets and the clinical data. That's when we are going to be able to start get the answers from the previous question and then a more robust response, like you are talking about here. It's no far off. We are bringing providers online with our claims data. We are brining pharmaceutical partners, like AstraZeneca, and so this new world is right around the corner, it's just hard to get all the data sets lined up to do this right. But, you know, stay tuned, it's happening.

ED HOWARD: Jordan?

JORDAN RAU: I was just going to say, and Lewis eluded to this, that one of the main purposes of having electronic

health records, which is what was included in the stimulus bill and to help fund hospitals and doctors to have these is to have much better data. Right now, what's used is mostly very coarse data which is from the billing records which doesn't tell you as much about what is going on with the patient as the actual patient charts. So the idea is, and this may be utopia, is that at the point that you have most places getting the actual clinical chart data what the doctor has, you can risk adjust and you can get a better sense of what is going on. The other thing is there is actually a fair amount of clinical information out there, that various societies for surgeons have that is not public, that you can't take a look at them. Most of the surgical society, the doctors, can find out, say thoracic surgeons, they can find out how they compare to other surgeons because they do all submit the data to these closed societies, but that isn't publically available right now. So, there is good data that is out there.

ED HOWARD: Actually, a piece I was reading from our material described the changes in the ACA to the rules applying to the registries that some of the societies operate, that are going to standardize and potentially made public the information that is in those registries and that's making some folks nervous and I wonder, actually I'm looking at Jim Fasules from the Academy of Cardiology who has one of the most

sophisticated registries and I wonder if he had a comment about that.

JIM FASULES: Yes, I was going to comment on clinical data versus claims data and I think it's already been said, putting the two together. What got changed is in the Taxpayer Relief Act that now registries can be used to, qualified registries can be used as participation in PQRS, the Physician Quality Reporting System, or whatever it is. And, that's going to add a lot to the speciality services because now the speciality services' quality can be geared towards what they do, not geared towards primary care which the PQRS is geared towards. I see it going on in the QRUR, which is the Quality Resource Utilization Report, that is part of the whole quality program that is now going to be able to be geared towards a specialiSt. But I think the important thing is the registries need to be done in an opened format. They can't just be simple things that physicians can easily obtain, but they will follow the data and then with the claims, the longitudinal administrative data, which you get a lot of outcome stuff from, you'll be able to risk adjust and you'll track for better quality measures. The other comment would be on choosing wisely which is very, looking at five things that the patient should ask their physician about what they should do, and we have actually seen some effects on that. From cardiology

standpoint, we actually have appropriate use criteria and we very easily could say what you shouldn't do because of what we had there and working with the tools with AIM and others.

ED HOWARD: Bob?

BOB ROBE: Bob Robe, EMJ. We've talked a lot about price and quality, but it is almost always in the context of delivery of care and of treatment of interventions in that sense. How do we work it backwards further because we know that prevention is the best quality measure and it's also the cheapest in most instances. How do we work prevention more into this discussion. Because it is, to this point, has been pretty much absent from, you know, today's discussions

LEWIS MATTISON: Can I dive in? So, this is where we get to the evolving reimbursement. There's a lot of things that providers aren't reimbursed for today, under the old reimbursements that we want to see, we want to help them do. So as I started to explain a little bit about what we've done with our patients and our primary care strategy, it's much more of an initiative. It's where we are going and, you know, we want to help provide tools to primary care physicians and the organizers of that primary care so that they can do these things that they otherwise aren't getting paid for under the different archaic, archaic is the wrong word, but you the production based fee-for-service reimbursement that has been

around for a long time. It is at the root of the charges that we talked about earlier. And so as we look for ways to, I am going to quote a conversation that I was in with one of our health plan executives and a few executives from a large integrated delivery system where we talked about financing the right things. So reimbursement has its own connotations around paying for those specific actions and services. As we get to accountable care and try to put in place more risk-based payments, then a provider has the ability and hopefully the economics to be able to do all these actions and so I think we need to be thinking about how we collaborate with providers to finance the right outcomes around the patients and the economics can follow. So you are seeing it with accountable care. We've got, I think it's now 20, the number increases. I think we have between 26 and 29 ACO's, I think it's 29, but the last number I had formally looked at was 26 about a month or two ago. But as we are trying to enable these and we put in place the right risk financing with our provider partners, that is a way to get toward that, but that is, again, trying to add length to the rudder of the ship we are trying to steer.

ED HOWARD: Go ahead, Sherry?

SHERRY GLIED: I would also say this is actually one of the areas where in some ways, public health and prevention are way ahead of health care. Lynn talked about some of the

examples in the Affordable Care Act so nutrition labeling, smoking labels, tax policy, those have been stable as a public health policy for decades. We have been working on the cost quality frontier in public health for a long time. It is actually medical care where we have not really done it, ironically, even though the money is there. So one possibility is one can imagine health plans and other saying this is how much it costs to get your cholesterol checked and this is what a diet that would help you address it and like do for you. We could move the behavioral stuff, which we already have a lot of the data, and we don't have the same, as many concerns about risk selection and lots of other benefits. We could be consolidating that information and putting it together some.

ED HOWARD: And the ACA does have provision making a bunch of prevention benefits available without any sort of cost-sharing. I want to get to this topic, but it is one that has come up in the conversation among our panelists as well as on this card, and it has to do with consumer-directed health plans, one with high deductibles and, sometimes, medical saving accounts attached to them and the questioner says that consumer-directed health plans initially promised more consumer information on provider prices and quality. Are their examples where the CDHP was able to pull this off and if so, what were the effects on patients and providers behavior and I might just

add parenthetically that the big deductibles that are part of these plans, means that patients are going to be paying out of pocket. More importantly, those people with insurance, not just people who are uninsured, are going to be paying out of pocket for a bunch of services before the insurance kicks in. So, what is going on with the CDHPs?

SHERRY GLIED: So the CDHPs have been at the forefront of putting quality and price information out. I think that would be fair to say, but most of the evaluations have generally found that the effects in terms of utilization are on the decision to use or not use services and there is much more limited evidence that people use the services more efficiently once they made the decision to use services. That is a very, very robust result in most literature in price shopping in health care, so a lot of it is on what we call the extensive margin. Do I actually use this service at all? Less of it is on the margin of if I use the service, where do I get it from. So, we are starting to see some action there, especially with tiering in some of those more narrow, like if you go to this doctor versus that doctor, we give you a better deal, but less on the you pay $5,000.00 out-of-pocket and so you shop more efficiently.

ED HOWARD: Okay. What information, from what services, I'm sorry, what sources do consumers find

trustworthy, is the question. How much are online services like WebMD and other used by consumers.

LYNN QUINCY: Nobody goes anywhere but *Consumer Reports*. I actually don't have hard information about, you know, how often consumers go to various sources; however, I will says that they are very sensitive to whether or not the information is coming from the trusted source. In all of the testing that we had, one of the first things they wanted to know is what is the source of this information. It could be the exact same information, it could be right information, but they don't want to know all that, they want to know what's the source. So it's a very important question. If you are trying to communicate effectively, it should be coming from a trusted source. I can't speak specifically to WebMD though. *Consumer Reports* is very trusted. I have to say health plans are not particularly trusted and, oddly, I will share one result from a study that we are bringing out in May where we tested explanation of tax credits. People, again, they want to know if this information explaining the next tax credits was trust-worthy. They trusted information coming from a government source and, I will point out, we tested in Oklahoma and Utah, and even if they felt that dealing wit the government was very difficult and cumbersome, this is a really importance nuance, they did believe the information if it was labeled coming from

a government source. So I thought I'd share that. I thought that was very interesting.

ED HOWARD: Very good. How well exchanges contribute to the transparency of choosing a health plan moving forward. What kinds of tools are, or would be, helpful to a consumer trying to choose a health plan in an exchange and are there going to be data tools like the ones Lewis was describing.

LYNN QUINCY: Everybody else can pile on, but I think what this is actually going to be a big step forward for consumers, particularly those who shop on their own or very small employers which are kind of like individual consumer shopping for coverage. First of all, we are standardizing the products quite a bit and that is going to make things easier, and that is inside and outside the exchange. They are going to be tiered into these actual value tiers; free, cost-sharing for certain preventive services. There is a maximum amount out-of-pocket and it is a hard out-of-pocket. You can't have all of those holy exceptions that consumer in the individual market faces today. It is a set of benefits that are being covered are mostly standardized. So, there are fewer moving parts, although they haven't been eliminated completely, and that's market wide. Within the exchanges, they all have robust web-based tools that will differ, depending on what state you are in, but they should be very good and something we are pushing

very hard on are what I call cognitive short-cuts, so we talked about value before combining information, this would be an example, combining information about the premium with an estimate of how much you might pay out-of-pocket under this plan. Doing that math for the consumer and then adding those two things together, there is a statistical total estimated cost that does that and then you've reminded the consumer, you don't want just the lowest premium or even the highest, you want to look at the bundle. What are you also going to pay out-of-pocket that goes with that premium that you are looking at. So, I think it's going to be a big step forward and we will be able to exploit the variation around states and see what works out the best.

ED HOWARD: And will there be variation on the specifics. I mean, aren't some like California going a whole lot further?

LYNN QUINCY: Well in Maryland. No, we are going to have some leading edge states, at least I would say five or six, that are really going quite far down these consumer decision making tools, but there is a lot of fine-tuning. This is an enormously complex subject for consumers, so even these leading edge folks like California and Maryland, I'm sure will be tuning up over time and hopefully these have got those great feedback mechanisms that help them figure out how to do that.

ED HOWARD: We have just a couple of minutes, so I would appreciate it if you'd fill out the evaluation form as we finish off these questions and don't forget turn it over and fill out the back. This question sites a section of the Affordable Care Act, 13-11-E-13. I bet that's the one I was reading this morning. That sections, the questioner asserts requires standardized data reporting on price. Given the heterogeneity of pricing discussed by Sherry Glied, how can health plans scale up price reporting for all services in a way that's meaningful to consumers when the actual service provider might be varied from the bundles presented in a consumer comparison.

SHERRY GLIED: I don't know exactly which provision that is, do you know, Chris? Sorry, I will throw out just an idea that Hoover Reinhart had actually suggested some years ago, which is that providers could, for example simply quote the multiple Medicare rates that they charge for everything. In other words, I'm a 1.2, that means everything I do, I charge 20% over medical rates, and that way, at least, you wouldn't have to worry about whether there are low-cut low-priced supplier for this service and a high-priced supplier for the other service, just an idea, not mine either.

ED HOWARD: Time for one more question. We talked a lot about informed patients and the importance of their role in

reducing coSt. The office of National Coordinator, the Health IT, has launched an initiative completely dedicated to consumers and getting them to be players in the electronic space of patient data. For example, there is the blue button pledge program where data holders can pledge to give patients electronic access to their data. Are patients actively using this tool and I bet this was directed toward Lewis. Is WellPoint a blue button adopter?

LEWIS MATTISON: That's a trick question. I do need to formally figure out if we are blue button adopters. I think we are, but I'll take that as a homework item. I spent a bit of time in the office of National Coordinator for Health IT when we started out. So if you don't mind me addressing the importance of the consumer here and my belief, my opinion on why it was sequenced and why the time is now. So I helped with David Brailer and we set up the office of the national coordinator. He was the first coordinator and we were there for a two year sprint. And the focus there was really engaging the private sector where all of these investments and the right things around the patient happen. So trying to help the electronic medical record companies come together and try to come up with some standards. I mean there were standards all over the place for electronic health records. Why didn't they work? Well, you just had to pick the standard you like. I

mean, you just implemented the way you wanted because they did not interoperate. So we focused on that. Then we focused on the levers that would help these things get adopted, so we saw the stimulus act where a lot of the legislation, not legislations, but a lot of the policies that our group had written while I was there, they actually made it into the stimulus act and you will see stuff around the certification, electronic records which gets at the interoperability, the funds that will give 40ish some thousand dollars to doctors to be able to buy electronic health records.

So, the importance sequencing there was to create a supply with which demand could happen. So we took an economic approach to how to make this market move because there had been a market failure. So now, you see these things being adopted and they are the right things to be adopted. Now they, I'm not there any more, but I'm still with them in spirit. Now they're able to, by the way those are the two hardest years of my life and I have worked some pretty hard jobs [laughter], but now is the time that consumers can actually demand something and we used to joke around and say, why don't we have anything from the Ad Council. You could walk around Washington, D.C, get any subway station, and you'll see these different ads for this and that and then made you think I should do this, I should do that. They always made you think, they are really good. Why

didn't we have one. Well at the time, there wasn't enough adoption of electronic health records for a patient go up and say to their doctor, do you have an electronic health record? Although it would have been a very disappointing question and it would have fizzled out for another 20 years, or 10 really, because by the time everybody dates online, you'll at least be able to, you know, access your health care online. So, that was our strategy with the physician community was as the residents were coming online and graduating and most of them dated online, we figured they'd at least adopt EHRs [laughter]. But now is the time for the consumer and the consumer has really tried to make their information portable from one provider to the other so that their providers know what tests have happened. They and tier providers know what some of the interpretations were on this test before they even walk in the door. And, so this is the time and think the National coordinator's office has sequenced this quite well and I am glad to see it happening.

ED HOWARD: Okay, well, we have come to the end of our time and I have to say, this one of the liveliest discussions that we have had in a briefing. Maybe we need to start things sooner in the day more frequently. I do want to thank you for getting here at the appropriate time and getting here, means meeting the appropriate place and contributing to the lively

discussion. I want to thank David Bear, his colleagues at WellPoint for their help in putting this event together and ask you to join in thanking our panel for an incredibly good discussion of health issues. [applause]

[END RECORDING]

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