



**Reference Pricing: Will Price Caps Help Contain
Healthcare Costs?
Alliance for Health Reform
WellPoint
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ED HOWARD: Okay. Why don't we try to get started? My name's Ed Howard. I'm with the Alliance for Health Reform and, on behalf of Senator Blunt, Senator Rockefeller, our board of directors, I want to welcome you to this program to look at what public programs, and the health care sector in general, can learn from some private sector stakeholders who are using a strategy called reference pricing to restrain health care costs while maintaining quality. Here's the 45-second, non-expert version. Under this practice, the payer—an employer or a health plan—sets the “reference price” for a particular drug or device or procedure. The individual is then responsible for charges above that price. There are important nuances to this concept that I am ignoring for the moment, and you'll be hearing a lot about them in just a few minutes. The idea is to address the sometimes wild differences in price for the same service or product. I apologize to those of you who were here on Friday because I recounted this same anecdote. Several years ago one of our board members noted that the cost of a specific surgery in one of the 50 best hospitals in the U.S. News list was double what it was for another of the 50 best hospitals a few miles away, and he asked, how can the best healthcare in the world cost twice as much as the best healthcare in the world? Same question has occurred to a lot of smart people involved in paying for healthcare in the private sector and they came up with reference pricing as a partial response. And we've assembled several of those smart folks today on our panel to explain how this mechanism works, what the challenges are in putting it in place, and whether plans like Medicare and Medicaid could draw lessons from this experience.

Now, we're pleased to have today as our partner, WellPoint, Incorporated, operator of the Blue Cross Blue Shield plan in more than a dozen states, which collectively cover about 1 in 9 Americans, and you're going to be hearing from Michael Belman from WellPoint's Anthem Health Plan in a few minutes. Let me take a couple of moments to cover some logistics. There is a lot of background information, including biographical information about our speakers in your packets. You'll also find, in hard copy, the PowerPoint presentations of our speakers. Those slides and all of the background material those of you in the room have in your kits are available on the Alliance website, www.allhealth.org. Also on our website you can view a webcast of the briefing in a couple of days and a few days after that a transcript of today's discussion.

Now, of course, if you're watching on C-Span you have a video. You also have access to all of the materials I mentioned if you have a computer as well and can go on to our website, allhealth.org, and you can follow along with the slides among other things. I would ask you at the appropriate time to fill out our blue evaluation form to help us improve these programs as we go along. Make suggestions about speakers and topics that you'd like to hear from and about, and there's also a green question card. When we get to the Q&A there are both microphones you can go to ask your question or to write it on the green card and pass it forward. If you're part of the Twitter verse you can make use of the hash tag at reference pricing, as you see up on the slide that's in view now. And that's enough of the preliminaries.

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We have, I believe, just a marvelous assemblage of folks with knowledge and insight into today's topic. You'll hear their presentations and then we'll get into the discussion and the Q&A. And we're going to start with Andrea Caballero, who is the Program Director at Catalyst for Payment Reform. And if you're not familiar with CPR, as it's appropriately abbreviated, it's a nonprofit working with large employers and other purchasers to improve how we pay for health services and to promote high value care. Andrea's had a decade and a half's experience in healthcare with a focus on benefits and payment policy, and we've asked her to provide an overview of reference pricing today, how it works and what some of the challenges are. Andrea, thank you for being with us.

ANDREA CABALLERO: Thank you. Thanks to the Alliance and to WellPoint for convening this really important meeting. I think you'll hear some really great case studies from the folks on the panel and I'll be giving a background, and actually, Ed gave actually a pretty good definition on it, I think. CPR is Catalyst for Payment Reform, as Ed mentioned, is a nonprofit national organization that works on behalf of national larger purchasers. We have about 31 purchasers that work with our group and they include eight state agencies. And of those state agencies we do have four Medicaid plans. So to the previous point about can state agencies and Medicaid programs learn from some of this, I would say that, at least in the work we're already doing, there's a lot of shared learning that's occurring.

One thing that the CPR members agree to do when they join is to work on a shared agenda, and I'm not going to get into all of the details of our shared agenda, but the middle section there, on the right-hand side, will talk about our innovations so I'm going to touch on three of those today. The first, obviously, is reference pricing and value pricing. The second is price transparency, and the third is market power. And all three of those items are really closely related and you can't really talk about reference pricing without also talking about market power and the need for price and quality transparency.

At its core, CPR has—our strategies fall into two categories and it sounds simple but it actually can be kind of complicated. But basically, we're trying to create a critical mass of purchasers to send the same messages into the marketplace at the same time and that's how we think we'll really change the market. We've got a lot of noise, a lot of people asking for different benefits, different payment, different ways of doing things, and that can really exacerbate confusion. So the CPR purchasers are trying to use common tools, common language, common priorities to send messages into the marketplace about what's important. And of course, the second is to shine the light on the urgency for payment reform, as our name is Catalyst for Payment Reform, after all.

So, this might be a little difficult for you to see in the orange text, but if you look at your printed version it might be a little easier. As Ed mentioned, reference pricing really is just setting a standard price for a drug, a procedure, a service and then, once you've set that price, that's the amount—the allowed amount—that a health plan or a self-insured

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employer will pay, and above that amount the consumer is likely to have additional out-of-pocket financial liability.

If you look at the graph there, on the y-axis you see price variation. This is really just for illustration purposes. You'll see different variation in prices ranging from \$1,000 up to \$20,000. And then, along the bottom, you see the frequency of these services. And the blue line kind of shows how often these procedures are taking place and at what price, and then where do they go up. And this is the kind of analysis that has to take place. So you can set a reference price, but it's actually quite complicated in doing that. A lot of analysis has to go into that. I'll give you an example other than the way CalPERS and Kroger, which I'm sure they'll explain, but Safeway is an example where they did an analysis of how much they were paying for colonoscopies in the San Francisco Bay area. And the prices ranged from \$900 to \$7,200 with no correlation to quality. So that's an extreme variation in price. And once they did the analysis on the price and they saw the frequency of how many visits were at a certain price or below, they pegged their reference price at \$1,250. So then, their benefit design, as they implemented it, is that if you are a consumer, Safeway employee, and you seek care from a provider that is at or below the reference price--\$1,250—then you either have no cost sharing or your regular cost sharing. If you seek a provider at that \$7,200 at the top of the list then you are going to be responsible for the difference between the \$1,250 and the \$7,200. So, that's the mechanism of how reference pricing works. Some actually consider it to be a pretty blunt instrument in the marketplace and I think you'll hear how it's a blunt instrument; that it really is intended to shake up the marketplace and really shine the light on not only how things are being paid for, but what are the prices for things and how there's just extreme variation without any correlation to quality.

I'm sure you'll hear from my colleagues that there are really four key elements of reference pricing. They'll probably go into more detail about these different elements, but basically there's benefit design. You really only want to implement reference pricing when it's elective and when you have a wide availability of providers. Obviously this isn't going to work if you have one or two providers providing a service in an area. That is not going to create the level of competition that you need. So one, the procedures have to be elective, and there's time to shop; and two, they're available from multiple providers.

The next two are really interrelated and I think are very on topic for conversations in this room, which is price and quality transparency. You can't implement a reference price without giving consumers adequate information about the price of the procedure or the quality that they're receiving. Most consumers still equate higher price with higher quality and we know that not to be true. So you really need to arm consumers with plenty of price information so they know which providers are at or below the reference price, and you also need to arm them with the quality information. How often are these providers performing these procedures? What is their volume, what is their outcomes? And if you have that information then consumers are better armed but it would be really

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unfair to implement a reference price if you aren't going to arm them with that kind of information.

That goes into the next one, which is consumer education. And I think there will be case study examples of how informing your employee population and educating consumers about the price and the quality and the correlation between the two will be really very important because you don't want consumers to get into a got'cha situation where they didn't know that someone was above the reference price and now they have a pretty extreme financial out-of-pocket liability.

And then the last one is adequate networks, and network might not be an appropriate term here because usually these are providers within an already established network, so I use the term network loosely. But you want to be able to make sure that you have plenty of providers who can offer these services, these procedures, at the reference price so consumers have the ability to choose and they don't feel overly limited; they have plenty of options, including the option to seek the care from providers over the reference price, but that's their choice.

I won't go through the detail of all of this, but this is just a schematic of the range of reference pricing. You can have very basic referencing pricing all the way to really more mature and sophisticated. And CPR also likes to talk about value pricing. Reference pricing really refers to commodity type services like lab, imaging. On the commodity services, that's really where, for services, where quality is thought not to vary. When you move into value pricing you're actually adding a quality component and quality can vary. And so, as you get to the higher end of that spectrum that's when quality gets inserted. And, again, when you look at the Safeway, when they applied reference pricing to their colonoscopies, and they've now applied it to other procedures, they were able to hold their per capita healthcare spending flat, and I think you'll hear from CalPERS about the savings that they were able to achieve. And I think, as we go into what's next for referencing pricing, you'll find that reference pricing is going to gain in popularity. Only about 5 percent deployed this strategy in 2013, but we expect closer to 15 percent in 2014, that's from our recent Towers Watson and BGH study.

I want to go back to this issue of price variation because one of the things reference price does, like why implement reference pricing? One of the main reasons you do it is to really bring a huge spotlight on the price variation and how it is unwarranted. And market power will drive the price and price is the leading cost of healthcare growth today. And so, reference pricing is a way for employers, purchasers, those that we work with, to really say that that price variation is no longer tolerable.

What's next for reference pricing? Just a couple of things. Price transparency and quality transparency. As reference pricing grows in popularity so will the price and quality of transparency tools. They will have to keep pace. The other thing is, the last bullet on here, is that we really expect reference pricing to ultimately be paired with bundled payment,

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and this is important. CPR partnered with HCI3, the Health Care Incentives Improvement Institute, to write a paper on how, if you pair reference pricing with bundled payment you actually can move the market and educate consumers along the way. And it's actually a natural fit. Bundled pricing, excuse me, bundled payment, is a package price for lots of procedures within a particular service, let's say a hip or a knee replacement. You see multiple providers and multiple settings. A bundled payment is for all of that. And then, if you set a reference price at that, you really are making it very clear what's included in the reference price. The providers are very clear about what's in the bundled payment, and we see that really as the next generation. Once we get a little more experienced with pure reference pricing and, as providers get more experience taking bundled payment, I think we'll see a pairing of bundled payment and reference pricing.

So, with that, I guess I'll turn it back to you, Ed. Thank you.

ED HOWARD: Thanks very much, Andrea. We are, indeed, next going to hear from David Cowling, who's the Chief of the Center for Innovation at CalPERS, the California Public Employees Retirement System. You may know that CalPERS does a lot more than you might imagine from the title of its organization. It administers health and retirement benefits for more than 3,000 public schools and agencies and state employers, covering more than a million and a half in their retirement system, 1.3 million in health plans. And David's here to tell us about CalPERS's referencing pricing program and its impact on healthcare and costs as Andrea said that he might, and promised that he might. Thank you for coming.

DAVID COWLING: Thanks, Ed. I'm going to talk about CalPERS reference-based pricing program for a hip or knee replacement. As Ed alluded to, CalPERS provides health benefits for about 1.4 million members statewide, that includes active and retired state employees and about 1,200 local agencies including school districts. About a third of those end up in the preferred provider organization with Anthem Blue Cross of California, and we spend about \$7.5 billion annually in health benefits and I don't know about in Washington, but in Sacramento that's a little bit of money.

So, the impetus for reference-based pricing was a variety of studies, and they all had different purposes, but they ended up kind of helping guide reference-based pricing for hip and knee replacements. The first one looked at cost drivers for CalPERS and it turned out that osteoarthritis is one of the drivers and about a third of those osteoarthritis costs come from hip or knee replacements. In addition, a deeper dive showed that from 2005 to 2008, there was about a 40 percent increase in that cost for hip or knee replacements. One of the other studies we looked at included looking at kind of regional variation in costs, but, when we looked at that, we also saw not only those regional cost variations but also a lot of variation within region, and I'll have some charts to show you that kind of variation towards the end.

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In addition, you know we, as Andrea alluded to, a lot of the literature in our in-house study suggested that the hospital cost had little to do with the quality of, the clinical quality, of hip or knee replacements. And so, as you go through kind of the four requirements for reference-based pricing you have variations in the costs, cost driver potential that volume might increase quality, and then the last one is that the procedures could be scheduled. So, on January 1, 2011, CalPERS, along with Anthem Blue Cross of California implemented the reference-based pricing program for hip and knee replacements.

Forty-six facilities met the quality costs and geographic variations. In addition, there was a volume gate. In addition to those quality gates, the volume gate included that they conduct 10 hip and 10 knee, total hip replacements, in the previous 18 months. The value of \$30,000 was chosen as the threshold, and I think Dr. Belman will talk a little bit further about this later today, but about two-thirds of the facilities charged less than that and included a large number of facilities that were well known and had a good geographic representation.

When we look at the implementation, Anthem did a lot of working with providers and orthopedists on outreach. You know, a lot of times they act as the gatekeeper, or the steering of the patients. In addition, a lot of outreach was done with the members themselves. Not only was provided in the brochures and the coverage, evidence coverage kind of materials, but also, whenever there was a pre-certification or a pre-notification to the patient, that included the reference-based pricing facilities, and a description of the program, as well as if there was time between the pre-certification and the actual surgery, Anthem would call up the patient and advise them of the program as well. In parts of northern California there's lots of travel needed and so there's not actual facilities there, so included in this is a travel benefit for the member and their companion. And then, the last one is that one important, very important part of this, the reference-based pricing was only for routine procedures. Any non-routine procedures would have a medical exemption.

So, I'm going to talk about the evaluation results of the program and these results are mainly from a study that we did with UC Berkeley, Jamie Robinson, and Tim Brown, which was published in *Health Affairs* in August of this year and that, I think, is in your packet. So this is looking at utilization. This is the volume of hip or knee replacements. And the first three lines in this charge have to do with CalPERS-Anthem enrollees, but what's unique about their study was, they were able to get from Anthem the non-CalPERS enrollee data as well. And so we can look at where our members were going before and after the implementation of the program. And so the first line is the volume, the number of procedures, and then the second line is looking at what percentage of our members went to the reference-based pricing facilities. And we can see that it was about 50 percent or so before the implementation of the program and then there was an increase up to about 63-64 percent afterwards. If you look at the non-CalPERS members it was about 55 percent before the program to the reference-based pricing facilities, then it

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slightly dipped and then came back. I have a visual representation of that next. The dark blue line being the CalPERS's reference-based pricing usage. You could see it went up dramatically after the implementation of the program. And we can see, for the non-CalPERS, it was fairly the same over time.

So, this is a charge, or a table of the average prices charged, for hip or knee replacement surgery. Again, for CalPERS members and non-CalPERS members. And so, the first line here is for average of all facilities and we can see that basically for all of the, across all the groups, that there was an increase from 2008 to 2010. And the average was about \$35,000 in 2010 for the CalPERS members, and then, after the implementation of this program, dropped to around \$25,000-\$26,000, in that range. What's really interesting is that the reference-based pricing facility costs stayed the same from 2010 into 2011-2012, virtually the same. What was surprising was this impact in the non-reference-based pricing facilities which went from around \$43,000 and dropped dramatically down to \$28,000-\$27,000 after the implementation of the program. So, by having comparison with the non-CalPERS—Anthem group, we can see that, for the most part, those charges stayed the same outside of CalPERS. And again, I have a little chart showing that. So the solid blue line is the CalPERS reference-based price facilities, which is pretty stable over time, and then we see the implementation of the program which is the dotted blue line, and you see this dramatic drop in prices.

I have one more chart kind of getting at what Andrea was talking about with the variation in cost. I don't know if they show up, but these pink dots here, or orange, but they were pink originally or orange originally—I think they're pink now. But the reference-based pricing facilities, the blue dots are for the reference-based pricing facilities who were participating in the program and the pink dots are the charges for the non-reference-based pricing facilities. And so what we see is that in 2008, 2009, 2010 a lot of variation with the pink dots kind of clustering around \$45,000 in 2008 going up in 2009 and about \$50,000, a little cluster there, in 2010. And then after the implementation of the program the pink dots now start clustering around the \$30,000. So, we reduced variation on the high end, the bottom end of the cost for procedures stayed pretty much the same.

So, jumping into the results and conclusions, Jimmy Robinson at UC Berkeley concluded that there was about a 5.5 million dollar savings over the first two years. This resulted in an average cost decrease of about \$9,000 per procedure, or a 26 percent drop in cost for us, CalPERS. Also important to know is that the clinical quality, and Dr. Belman will talk about this in a little while, about the study they did, but the clinical qualities got better or stayed the same for CalPERS, or for the reference-based people who went to the reference-based pricing facilities.

So this turned out to be a hospital market story as much as a consumer enrollee story. Reference-based pricing induced enrollees to go to the reference-based pricing facilities but also it really changed the market as well. Jimmy Robinson concluded that about 14

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percent of the savings were due to market share and about 86 percent were due to the reduction in prices.

So, another important thing is that it's working in the market as well. We've expanded the program from 46 hospitals at the beginning in 2011 to 61 now. And so, we've expanded reference pricing and, as Andrea alluded to earlier that you know, we have these low volume high costs for hip and knee replacements and we've moved to, in 2012, this kind of more high volume low cost procedures looking at cataracts, colonoscopies, and arthroscopy in 2012, and we're in the middle of evaluating how that's working. And again, I would reiterate that those three procedures are a kind of checklist which was the cost variation within region. A focus on volume increase may increase quality, they can be scheduled at a substantial cost to us, and the last thing is, we have a variety of initiatives around kind of educating the consumer, and kind of the price transparency, trying to get that information across, we're moving forward with that.

Thank you for hearing our story today.

ED HOWARD: Great. Thank you very much, David. We're going to hear next from Theresa Monti. She's the Vice President of, and this is very impressive, Total Corporate Awards at Kroger Company, which most of you know is a Cincinnati-based corporation that's the country's largest grocery store chain. It's actually the fourth largest retailer of any kind in the world. And Theresa's in charge of Kroger's Health, Welfare, Retirement, and Pay Plans—pretty broad portfolio. And Kroger's had some experience with reference pricing as well, as you've heard, an experience we've asked her to share with us. Theresa.

THERESA MONTI: Thank you, Ed, and thank you for coming today. I just wanted to spend a little bit of time talking about what we're doing around reference-based pricing. We happen to call it target pricing because we thought our associates might relate to that a little better, and so I might refer to it as target pricing throughout my discussion today. But I wanted to start just by giving you a little bit of information about the Kroger Company so that you can get a flavor for what we're all about and where we focus our efforts.

We employ about 343,000 associates, all U.S.-based. We operate in about 35 states across the country. In the company healthcare plan we have about 85,000 eligible associates. The rest of our associates are represented under collective bargaining agreements, and their benefit plans are provided through Taft Hartley Health and Welfare Funds. So, where we innovate and where we try new things are really within the company plan, and that's where the target pricing initiative is today, so that's where I'll focus our discussion for this afternoon.

Mainly we operate grocery retail centers throughout the country but we also have distribution centers, fuel centers, manufacturing centers, fine jewelry stores—usually

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people, I get a few eyebrows that raise when I say jewelry stores, but we are one of the larger jewelry chains in the country as well.

To talk a little bit about what our objectives are within our healthcare plan, we really focus on trying to keep it simple for 350,000 people to try and understand what we're trying to accomplish with the healthcare benefits that we provide to them. We really focus on two objectives. The first one is to improve the health of our associates and their family members. We truly believe that if we can improve the health of our associates and their family members, not only will we be able to hold down costs for the company and costs for our associates, we also think that's a better place to be as an organization, right? More productive associates, happier work/life balance. So we're very focused on health improvement. And then secondly, we're very focused on reducing costs. The grocery business is not one of high margin so we're very focused on where we invest our dollars. We spend about 1.5 billion dollars on healthcare for all of our associates in all of the benefit plans, so we're very focused on health and reducing costs. And, as we're looking at ways to reduce costs, we're constantly looking at not just what health care costs but how people access the healthcare system and where they're choosing to get care. So where are they making, or where are they able to make decisions around quality and cost as they're accessing health care when they need it.

So, a couple of initiatives. I'm going to focus most of my discussion today on our target pricing initiative, but when we implemented that in 2012, we took two initiatives at the same time and focused on target pricing, which is our discussion today, about putting a price in place for certain services. And we focused our services on high-tech imaging, so CAT scans and MRI's and the like. We also, at the same time, put in a very specific centers of excellence program to focus on knee and hip replacements and spinal fusion surgeries. So that particular initiative, which I have just one or two slides at the end, is really focused on quality of care and cost of care. Target pricing, as my other panelists today have talked about, is not so much about quality, because we're assuming that the majority of the quality in a high-tech imaging service is relatively the same, the difference is in the variation in costs. So our two different initiatives are adjusting both cost and then, on the centers of excellence piece, around quality of care.

Our target pricing program, we partnered with Anthem, Anthem Blue Cross & Blue Shield, or WellPoint, is our claims administrator for our self-insured plan, so they were very instrumental in helping us design our target pricing in our centers of excellence program. But the target pricing program really has three levels where associates and providers get involved in making the choice about where to access a high-tech imaging service. So, the first thing that we put in place is that any high-tech imaging service has to get prior authorization, or pre-certification. So the provider, or our associate, would call Anthem Blue Cross & Blue Shield before a service is received, and that is where it really starts. And so, on the slide here, you can see that AIM, or high-tech imaging. That is usually where a physician or a provider would get some education about our target pricing program to help them understand that the plan has a certain threshold of how

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much we will pay for high-tech imaging services, and help the provider then understand where in the market can they go, or where they can send their patient to stay at or below the target price. So that is the first level, and you'll see, in some of the results, that's usually where most of the services will get redirected then. The second part we call the shopper program, and that's usually where a nurse from Anthem will outreach to our associate or their family member who's due to get an MRI or a CT Scan, and help them be more educated on our target pricing program to let them know that the plan will pay up to a certain level and that there are a lot of choices in their market to help them understand what providers they can go to if they want to pay at or below the target price, or if they choose to pay more and go someplace else, that they can do that as well. So, completely voluntary program, but we do help to educate both the provider and our associate as they're making the choices of where to go to get their care.

And then the third piece is actually implementing that target price. So, in 2012 we started with five high-tech imaging services, and we started only in 10 Anthem states. So it was technically a little pilot for us and in terms of how we implemented it. So you'll see here on the slide five tests in 2012. We added a sixth high-tech imaging service in 2013, and also in 2013 we expanded it to all of the U.S. states across the country so we were able to capture a lot more of our associates in that initiative.

So, a little bit about the results that were seen. You can see here, from the three levels of the program the clinical review operational activity, so that's the first level where most of the services are getting redirected to a provider who is at or below the target price, you'll see the 2012 total year savings, and remember that's just 10 states for us and then the third quarter of 2012 year-to-date, or 2013 year-to-date savings, slightly bigger but, again, across the entire U.S. The middle of the shopper program, not as much savings, but we wouldn't expect as much there. We hoped that most of the services would get redirected, and they have prior to getting the outreach call from a nurse to an associate. And then actually implementing the threshold of the target pricing program. We have about 30 percent of our population that still chooses to go over the target price and we think that really comes down to education. So, if you think about a lot of people when they go to the doctor still aren't comfortable questioning costs or questioning quality, questioning where their doctor sends them for a service, so we still have, again, about 30 percent of the population that chooses to still go to a facility that is at or above the target price.

To give you an example of the variation in costs, in Ohio for a CT scan of the abdomen, the costs ranged from about \$260 to about \$2,600, depending on where you go. So that education alone, both to the provider and to the associate—to our associate—is critical. Right now it's all telephonic based and so getting them to really have that conversation with their provider is difficult, but we are making progress as you can see in our numbers, and really getting people educated. And early in '14 we'll be implementing an online tool so that people can access cost and quality transparency, cost information online, so that they can start to make even better decisions.

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So, what we actually saw with unit costs with the blue rows here are the 2012 results for the 10 states where we had target pricing in 2012. And, as you can see, we were actually able to reduce the unit cost through target pricing by redirecting people to a cost-efficient provider by about 12 percent on both CT scans and MRI's compared to all other states. In 2012, where we didn't have target pricing implemented, costs actually increased for both CT scans and MRI's in 2012. When you break that down by the five services, high-tech imaging services that we had in 2012, you can see each of the individual services in the 10 states where we had target pricing in 2012, all of those went down and some of them significantly. So if you look at the abdomen CT, right there in the middle of the blue section, went down by 32 percent in unit price in the states where we had target pricing compared to some of the increases in the other states for those same services.

So, at the same time we implemented target pricing for medical services—the high-tech imaging—we also implemented it on several prescription drug categories. So I wanted to give you just a little bit of the results from the prescription drug side as well. Kroger has our own PBM, so we use Kroger Prescription Plans to help us design a very similar target pricing initiative that we had in the medical world in the pharmacy world as well. And so we took three categories of drugs in 2012, and that's the statins, the PPI's, and the blood glucose test strips. In 2013 we added the ARB category. And that really focuses on education at the point of sale, so when someone is in our store, they're at a pharmacy and they're talking to a pharmacy tech or a pharmacist, really being able to get that education about the choices that they have to make. Because if you think about some of the drug categories, statins as an example, huge variation in cost. And we're just starting to see that drug category kind of settle out a little bit with Lipitor going generic last year, but there's a huge variation in cost and not a high variation in effectiveness in that drug category. So we've seen some really great results on the pharmacy side as well.

And here is just some statistics on what we saw in unit costs in the prescription drug side. So you can see some pretty significant cost reductions on all three of the drug categories in 2012 and utilization was not significantly impacted. I think, initially what some people might think is that individuals might forego a medication because of target pricing because some of that cost may end up with them if they choose a higher cost drug. We saw a little bit of that in statin category, but other than that, the utilization, or, I'm sorry, in the PPI's and the test strips, the utilization went down a little bit, but not significantly. And we're really watching that closely because what we don't want to happen is we don't want people to stop taking medications when they need it, but we just want them to be better educated about the cost and the quality of the services that they're receiving.

So, just a brief moment on centers of excellence, and this is the service. What we did is, we looked at knee replacements, hip replacements, and spinal fusion surgeries. Musculoskeletal conditions for us has always been one of our highest categories of spend in our medical plan, and so we looked at how could we look at costs and look at quality of care that people were receiving and could we take a network and tier it, so that we

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could pay just a little bit more and include travel expenses if someone was willing to go to a high-quality cost-efficient provider for a particular joint replacement or a spinal fusion surgery. And so we were able to do that. We actually have four tiers within the network, and we leveraged the Blue Cross & Blue Shield Centers of Excellence, or Blue Distinction Network, and we tiered it even further. We started with quality and we added a cost component. So this is some of the results from 2012 and 2013, when we implemented that.

So we had about 264 joint replacements or back fusion surgeries in the last 18 months or so. In the middle blue bar you can see the impact to the cost of someone who chose to go to the highest quality, most cost-efficient providers around the country. We saw about a 28 to 30 percent reduction in cost when you include travel, so we paid for travel and a companion to travel, very similar as to what CalPERS is doing. Again, about a 30 percent decrease in cost. And from a quality perspective, no adverse side effects. So potentially avoidable complications—there were none in the first year by someone going to a facility that may not be in their home town where they had to travel for that knee replacement. In the first year in 2012 we had about 20 facilities in the network, so we had people traveling around the country for those surgeries and had really great feedback and great experiences, and as you can see, great quality and low cost for our members or for our associates. And overall, I would say our associates are very pleased with the programs. One of the things we thought we would hear, especially on target pricing when we implemented it, is a lot of pushback. You know, you're just shifting the cost to me. And instead, what we're hearing is thank you's. You know, thank you for letting me know that there's such a big difference in cost in my community and if I know I can go someplace else and get the same quality at less cost, that's good for them and it's good for the company and so we're actually seeing a lot of positive results and a lot of positive feedback from our associates by doing things like target pricing and centers of excellence. So, thank you for your time today.

ED HOWARD: Well thank you, Theresa, very interesting stuff. And finally, we are going to hear from Dr. Michael Belman, he is the regional Vice President and Medical Director for Programs and Innovations for Anthem/Blue Cross of California. Anthem, as you have heard, is a part of Wellpoint. He has been trained as an internist specialized in pulmonary medicine, he's been with Anthem since '96 and he's a great position to discuss with us the role of insurers in reference pricing and their various partnerships with employers. By the way, Dr. Belman made a couple of changes in the slide pack from the version you have in your kits, so you will be able to get the latest version on the Alliance website after you get out of here. Dr. Belman, please.

DR. MICHAEL BELMAN: Oh, thank you, Ed. It's a pleasure to be here and thank you for coming. I wanted to start with a personal story because it's relatively recent that I think pricing has become so – such a big topic. Previously it was very much hidden and very much undercover. So my own personal experience is – and I'm going to release some personal health information here, I had cataract surgery four years ago and two

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years ago in Los Angeles and used, for the first surgery, an innovation on our Anthem website which provided the total cost of various procedures. That was the total cost that would include the facility, the physician, the anesthesiologist, the lens, etcetera, what ever you need for a cataract. And what I learned is that there was a wide variation in the cost. I live in West Los Angeles where it is not only important to look healthy; you have to look good as well. So one of the striking features was that a free standing surgical center in 90210, just around the corner from the Gucci store, in fact was a total price of \$3500 for the cataract, whereas the two largest West Los Angeles facilities – one an academic institution, and the other a very large community hospital, the academic institution was about \$6,000, the large community hospital was \$11,000. For me, as a individual who paid a 20% co-insurance, the benefit was direct to me in the sense that the co-insurance on the \$3500 saved me two to three thousand dollars out of pocket as a result of that and it also saved Anthem money in the sense that they paid the \$3500 and not the expanded fee. So I'm telling you this because my experience, although it was relevant for me, doesn't make much of a dent in these two high priced institutions and it didn't save that much money for anthem. But now what we are seeing unfolding and what you have heard today from Kroger and from CalPERS is the realization or the actualization of these differences that make a big impact in terms of the price that everybody pays. Because in fact, once these expenditures from these employers starts trending down and in some cases it is trending down, that makes a difference to the premiums that they charged the following year and that is the premiums that you pay. So this is a direct impact for all of us.

So I just wanted to emphasize that because it obviously has relevance. I am also using my iPad because as good as the cataract surgery was, there is no way that I can read that screen over there.

So the point that I wanted to make at the beginning is that the costs outside of premiums, co-pays and deductibles are typically unknown to the average consumer and I might say also to the average physician. And that is why this is an education for physicians and I commend Kroger in fact on making sure the physicians know about that, because physicians are totally oblivious to what the charges are. They know what they receive, but they do not know what facilities receive, what drugs cost, etcetera. And in fact, the recent article in The New England Journal of Medicine highlighted this dilemma and actually called the co-insurance and deductibles an avoidable side effect of treatment or harmful effect. In other words, people undergo treatments and/or receive medications and then have the unpleasantness of finding that the charges that result or the out of pocket expenses, are so extreme as to make it extremely difficult to actually pay for these. So this becomes very relevant in this sitting.

So we also know that in California, the hip and knee replacements varied between \$20,000 to \$110,000 across the network. So you saw a similar diagram to this where we talked – we had the talk from CPR and essentially this shows the range of pricing in California, of the 110 or so institutions that provide hip and knee surgery. So it was noted

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that when you choose the value of \$30,000, that you encompass a significant number of institutions with the network. It also included a wide geographic distribution. So if there was travel involved, it was a reasonable amount of travel and didn't require long distances. And this was really, I think, the basis for the number.

The other point that I think was important is that we did look at the quality and I'm going to come to that in a moment, but essentially the value based purchasing design establishes the pain and threshold for elective procedures. It limits the obligation of the payer and guarantees members the ability to choose a facility that will provide services within an appropriate cost range. One interesting term that is being used is it acts as a reverse deductible. Instead of the enrollee paying up to a defined limit and then the plan taking over, which is the standard deductible that many of you are familiar with, in this case, it turns that on it's head and the plan pays up to the limit after which, if the enrollee chooses an institution above the threshold, the enrollee is liable for the increment. The participating hospitals who are based on the procedure volume as you have heard, they met the standard regulatory standards so they were all credited at high levels by the appropriate external agencies.

And we also have an Anthem quality program for hospitals and a number of metrics are measured across a broad range of procedures and tests and treatments that the hospital provides and outcomes that they report publicly and it's combined into a score. All of these hospitals were participants in the Anthem program.

So the overall impact was the shift of members to designated hospitals and shift away from non-designated hospitals. And I think it would be appropriate to re-emphasize that point, that although there was a shift to the designated hospitals, the big change was the shift away. And the decrease of total costs, and this I think was a critical point, how the market reacted to this, was the decrease in costs in the non-designated hospital, some of which prior – immediately prior to the advent of the program, lowered their price in order to be part of the network.

The other point that is made in the article by Jamie Robinson in Health Affairs is that the upward cost trend from 2008 to 2010, which went from \$28,600 to \$34,700, was reversed in 2011 with the advent of this program. So this really was a very striking example of bending the cost curve down, which I believe is the Washington phrase for the goal that has been set for the Affordable Care.

On the quality side, we use the hospital claims to look for general complications and general infections. Things that are not related necessarily to the surgery itself, but if there were results say from heart problems, lung problems, kidney problems as a result of the surgery. Or that there were infections like pneumonia or kidney infections and so on, after the surgery, and in fact in the designated hospitals these rates actually dropped slightly. Significantly, but they dropped. There was no difference in complications related to the surgical site itself in terms of the prosthesis that are place in the hips or the knees,

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there is no difference between the two sets. And no other site specific complications like local infection or bleeding and the like. We also followed the claims for 180 days after the surgery and its important to note that there was no difference in the readmissions either for joint issues or for other complications in the two populations that went to the two different institutions and also bearing in mind again, and I should have maybe emphasized this, we are also comparing it to non-CalPERS PPO Anthem members whose claims we also had. So as you saw in some of the slides that were shown earlier, there was this comparison group of Anthem PPO members in the same geography as well as the CalPERS members.

We have a number of other clients that have, as a result of this successful experience we had with CalPERS and with Kroger, have also joined the reference based benefit movement and so I have listed some of these. It's not as important as much as the fact that there is now, I would say, a shift and a number of large employers are embracing this program as a way to disrupt the continued increase in healthcare costs, very largely driven in fact by institutional pricing. So this has been a very encouraging development. In addition, we also had expanded it to include what Kroger has included and what others have used in the past, include for out-patient procedures which are for cataracts, arthroscopy and endoscopy. So this is definitely something which has really blown the lid off, I think, the veil of secrecy of the pricing together with a number of other events that have happened in the past in some recent publications including the very notorious one in Time Magazine earlier in the year, which I think was also a major impact as was CMS's actual release of Chargemasters, which occurred recently as well.

I should also just mention, because I noted in The Wall Street Journal, which was left outside my hotel room this morning, an article from the Intermountain Health System, run by very, very prominent health researcher, Brent James on the current initiatives within the Salt Lake City region and I would imagine most of Utah, to develop a – not what they call a Chargemaster, but in fact a Costmaster, where they are actually developing costs of procedures based on real data, not wishful thinking and numbers sucked from thin air, which has been the basis of most Chargemasters up till now. And I think this is really the start of a new movement where cost accounting, which has been a part of most other industries, will I think enter the healthcare arena and make it much more logical and much more sane. So that I thought, was an encouraging development.

So in summary then, our reference based pricing for the benefits, expands the transparency of medical prices, it raises the question of wide variation in price for the same procedures are justified. It is important to document that quality is not reduced and there are a large number of organizations out there that are collecting quality, but there is still much work to be done in this regard. It provides a useful means of helping purchasers and members make choices that help reduce costs both for the company, for the individual. And it's definitely a valuable tool in the overall approach to bend the cost curve down. Thank you.

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ED HOWARD: Terrific. Thanks very much, Michael. We are at the point where you can have input here. There are green cards that you can fill out a question to ask one or more of the panelists and there are microphones that you can use to vocalize your questions and I would invite our panelists as well, if you have comments about anything you have heard or if you wanted to ask one of your panelists another question, to jump right in and let's mix it up. And in the meantime the first mixer-upper, will you please identify yourself and keep the questions as brief as you can.

BILL ROGERS: I will do both. I am Bill Rogers. I'm confident in the statement that there is no such thing as a stupid question. My first question is, do all of these reference prices include the professional or physician's payment? My second question is, how do you all decide what to do in subsequent years when you reference price?

DR. MICHAEL BELMAN: Two good questions. Well, the answer to the first one is, yes. It was the total claims institutional and professional that was included in the copulation.

ED HOWARD: And Andrea, you talked about bundled payment being a part of this calculation.

ANDREA CABALLERO: Right, so I think in the CalPERS example, that is one not all reference programs include both. So that is something you need to distinguish. But if you – as this evolves and as reference pricing gets paired with a bundled payment, then yes, you will see them be bundled together and paired together.

DR. MICHAEL BELMAN: One additional comment – when you look at physician reimbursement across the state, referring now to Anthem's reimbursement, there is variation geographically minor and in some cases if there is special expertise. But the degree of variation or the standard deviation of the reimbursement is a fraction of what it is for facilities.

ED HOWARD: And how about adjustments? Those of you who are involved in this business, how do you go from year to year? Can you ratchet down further or do you have to take into account what is going on in the market?

THERESA MONTI: Well from Kroger's perspective, we looked at it at the five services that we target priced in '12. We did look at the cost data for 2013. We decided to leave the target price where it is and it's roughly around \$800 for one of those high tech imaging services, but we found that we didn't really need to adjust it at this point. But our plan is to look at it every year because what we don't want to happen is our target price stays the same, but the cost of services continues to go up. So we need to adjust that, and we will as we need to, as we move forward. But our hope is that it brings down the cost and that we have more and more people staying at or below that target price wherever we can.

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ED HOWARD: Yes ma'am?

SANDRA WILKINS: Hi, Sandra Wilkins from Senator Hendricks' office. I believe it was mentioned that education was the variable that was distinguishing between those who are opting for reference or target based procedure facility and those that weren't. I'm wondering if there is any evidence of that or evidence of any other variables that would distinguish between folks who do and don't. And also providers who opt for that. Thank you.

THERESA MONTI: Well, I will talk about it from Kroger's perspective. We have Anthem after every individual that does have an MRI or that is going through our target price program, actually surveying them and asking them a series of questions – did you know about the program before you had the service? Do you understand how it works? And what we are finding is that there is a vast majority of people that just didn't understand it. So I think there is a big education component in getting people to understand one, what their benefits are, because it's complicated. They understand deductible and co-insurance and anything past that, they don't. It's complicated. So having that initial education up front, we do a lot to communicate to our associates on their benefit plans and give them access to a lot of resources, but it's going to take some time I think, to really get people to understand that they do have choices to make and that there is a lot of variation for certain services in the healthcare system. So we are going to continue to educate and continue to give them access to resources. I also mentioned, I think, that right now we don't have an online tool where people can go to get information about cost and quality of providers in their community and we will be implementing something like that in the first quarter of 2014, so that they can access information before they go to their providers and before they have to get a particular service. So, hoping that will help further educate people.

ED HOWARD: David?

DAVID COWLING: Pretty similar to CalPERS situation as well, in terms of we – Anthem does a patient experience follow-up study and looking at members' knowledge of the program and all of the follow-up questions and their awareness. And so similar to Kroger, we are rolling out a mid-2014, much more web based and mobile tool to provide cost and quality information as well.

ED HOWARD: Okay, well you have unleashed a tremendous volume of questions on green cards and we are going to plow right in. A lot of them are very basic and I think it will help fill in some of the blanks in people's knowledge.

How do insurers handle complications in procedures that extend the cost above the reference price and are consumers forced to accept that burden?

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DAVID CROWLING: Right. So the reference price is for routine procedures, and so if the procedure becomes non-routine, then it would not fall under the reference based pricing program. And I think you see that when I was showing some of the variation in the chart. You will see some of those dots are outside of the \$30,000 or above that. And those are falling into the non-routine procedures, which are not excluded from the way that the claim state is set up.

ED HOWARD: I did want to follow-up, because there is another question in the pile that asks about how you work that medical exception. Does it happen before or after? How big is the division between the two categories, that sort of thing? Say a few more words.

DAVID CROWLING: Dr. Belman might know more of the exact details, but my understanding is that it works through – it is before and it would also occur after say, a colonoscopy gets in and they need to do some other procedure.

DR. MICHAEL BELMAN: Right, it's a question of communication between our case manager and the CalPERS staff, so that the aberrations or the exceptions are picked up and can be dealt with.

ED HOWARD: Andrea?

ANDREA CABALLERO: I was just going to say that, so when it falls into the exception and outside of the reference price, the normal cost sharing would apply. So just to round out the story, that if you are outside of the reference price meeting, you are an exception to the rule that would qualify you and then your normal cost sharing and your benefit applies.

ED HOWARD: Actually, one of the questions that came in before, ties into that line of observation and that is you are talking about major procedures with potentially thousands of dollars even in the co-pays. How do these potentially large out of pocket expenses square with the out of pocket limits that are supposed to go into effect in the Affordable Care Act next year? Which I think are something like \$6,400 a person per year.

DR. MICHAEL BELMAN: My impression is that at present, this particular program, where there are options to go to a reference based facility that is designated within the reference price range, is not the same as the standard open ended out of pocket when you go to any number of institutions. So there is the choice that the member has here to make to stay within the range of the expenses. That is my understanding; that is the current perception.

ED HOWARD: And can I rephrase that? That means if the patient chooses a non-participating program that doesn't meet the price point, whatever that access is, does not count toward the \$60 whatever hundred dollar out of pocket limit in the ACA? Is that a fair reading of what you just said?

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DR. MICHAEL BELMAN: That is my understanding.

ANDREA CABALLERO: That is my understanding as well. I think we have some – I think there is some resolved interpretations because one of the things as representing purchasers, purchasers work with many health plans around the country and not all health plans are equipped or able to – or want to implement these kinds of programs. So I think there are different interpretations around that particular issue, which is maybe health plan dependent. It could be other variables about why someone won't implement it, unlike WellPoint that has decided that it's viable.

ED HOWARD: Another question about the prices – how do you monitor whether the prices rise for the non-referenced price procedures? That is to say, is there some sort of cost shift going on?

ANDREA CABALLERO: Well, I'm sorry – I will jump right in and say, so one of the things, when CPR has been advocating for reference pricing or at least encouraging our purchasers to use it as a strategy. The criticism is, as I said before, it's a really blunt instrument to use in the marketplace and you just whack at it and now you've disrupted the market. But the reality is that employers do kind of have to stand up and say, we are not going to tolerate the variation anymore and I think when you send that message into the marketplace, they are going to respond with a shift in volume. And when there is a shift in volume, then you see a change of behavior.

ED HOWARD: And sort of a variation of that same question has to do with the impact on physician incomes. Has there been pushback from physicians on this aspect because the total amount is lower than it would have been otherwise? Or volume isn't flowing to the hospitals where they have privileges? Have you heard anything like that?

DAVID COWLING: I think anecdotally the orthopedic surgeons have all been pretty positive in terms of coming forth. In terms of the participation program, as was mentioned earlier, the variation in costs has little to do with the professional fees that we see. So there is a little less push back from that.

DR. MICHAEL BELMAN: Just the one point I would make, I think it's logical to assume that there is going to be disruptions and it's really part of the goal of these innovations is to reduce the cost trend. And a number of stakeholders will get impacted through various interventions. This one happens to possibly impact physicians to some extent and facilities, but there are others that impact individual's plans and so on. So I think we are all in this together that we are searching for ways to come to reasonable adjustments to the fact that the trend has to come down. But it does raise the issue both with bundled pricing and with reference based benefits, which in this case we assume that the physician's decision to operate is correct and the procedure gets done. So there is no second guessing here to say, well maybe you didn't even have to do it. So it's all very

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well to have reference based benefits or bundled prices, but you can make it up on the volume and so everybody – and so the physicians would certainly come out equal in that setting. So it's encouraging to see that some of the quality metrics that are being developed and there are registries now being developed around the country. There is one in California, the California Joint Replacement Registry, which is collecting data on pre-operative and post-operative enrollee function, pain, etcetera, so that these indices can be incorporated into the decision making process. So when the surgery is decided upon, it's based on some rational information and this tracking of provider performance in each of these metrics.

ED HOWARD: And of course the Kroger program has a pre-authorization -

THERESA MONTI: We do and I think the disruption is exactly why we are doing what we are doing. We want people to understand that there is a variation in cost that isn't necessary. And so the more that we have providers calling Anthem, questioning why the flow or the volume is going a different direction – great. That is exactly what we want to happen.

ED HOWARD: Andrea?

ANDREA CABALLERO: Yeah, I was just going to follow up on a point that Dr. Belman made, which is – while there is a risk of the payments being made up for – on other services, but I think if you sit across from a hospital CFO, they will say, well I know what my margins have to be, I know that if I'm going to take a hit over here, a haircut over here, I'm going to have to increase something somewhere else. Whether its on price or utilization or volume. And I think there is the risk of that happening. I don't know that we have any evidence of that sort of shell game actually happening. I think the insurers, once they have a little more experience with reference pricing, and as they see how charges – if they have their payment tied to charges and those change, then they will – we will have a little more evidence of whether there is that kind of cost shifting within a facility's procedures. But I think the – while it can happen, it should not limit the first step, which is to implement the reference pricing on the front end.

ED HOWARD: David?

DAVID CROWLING: Yeah, we get the same question as well for the hips and knees – kind of looping back around. As you saw in our numbers, we didn't actually see an increase in volume over the time and then on the other three procedures that we are looking at, I think we have seen a little bit of an increase in colonoscopy, but that necessarily isn't a bad thing. For a screening like that, it's probably a good thing.

ED HOWARD: Okay, yes ma'am?

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LISA SUMMERS: My name is Lisa Summers, I'm with Centering Healthcare Institute and my question is for Andrea or anyone else on the panel, but particularly given CPR's work on maternity care payment reform. Certainly OB care isn't entirely elective once you are pregnant, you have to deliver, but women certainly have months to shop for prenatal care and deliver services and we know there is huge variation in cost and quality. And it's a very high frequency occurrence with four million births a year. So I'm interested in whether or not any of you are looking at reference pricing for maternity care? And if you have thoughts about whether or not the lessons we have learned from the global payment in maternity care, which is somewhat like bundled payment, informs this discussion at all.

ANDREA CABALLERO: So I will start by saying that so far I think while we work with some very progressive employers, they sort of self-select to be that way by being part of Catalysts for Payment Reform. I don't know that maternity care will be – maternity care services will be – that's probably farther down the road in terms of reference pricing. I think maternity care is much better suited for bundled payment or a blended payment methodology. Because you have so many parts of – you do have time to look around and shop, but you also have many providers within that system and then once you are in the facility, delivering, there are other variables that can come into play. So I'm not sure that we will see maternity care be a reference priceable, if that is a word, benefit. It may be, but I haven't seen it yet. I think it's more appropriate for different kinds of payment reform like bundled payment or blended payment.

DR. MICHAEL BELMAN: The one comment I would make is that you are right that there is wide variation. We haven't looked at bundled or reference based pricing, but because of the wide variation in for example c-section rates amongst hospitals, which in California range from 22 to 50%, and the appearance or the fact that there is a – now a decreasing, but until now, a fair number of women who were induced – labor was induced prior to the 37th week or just shortly after the 37th week. Between 37 and 39 weeks, which is not recognized as a non – actually an indication that if there were no other complications, terms should be 39 plus and the rate of these non-medically indicated premature deliveries had gone down dramatically, but that particular target, plus the c-section rate, if those are reduced, can reduce costs enormously because a large number of those infants end up in the Neonatal Intensive Care Unit, where costs are astronomical. So one of the early successes we have had is with in fact reducing c-sections and with reducing premature induction of labor where it's not indicated and reducing admissions to the NICU. So that can have a big impact on total cost and out of pocket cost.

ANDREA CABALLERO: This is actually an area where the private sector can learn from Medicaid because we had several state Medicaid's and we just released a case study on South Carolina's birth outcome initiatives where it's not a reference pricing program, but it is a non-payment policy for early elective inductions. And so the commercial

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private sector could learn a lot to reduce those c-section rates and the early elective inductions, which are a major cost driver.

ED HOWARD: Yes, go right ahead.

AUDIENCE MEMBER: Hi, my name is [unintelligible name] and I'm from the National Academy of Social Insurance and I have two short questions. So in addition to consumer education, are there a new set of challenges for implementing reference pricing for orthopedic and other healthcare services versus implementing it for drugs and pharmaceuticals? And then quickly, my second question, are there examples from either home or abroad where reference pricing has not worked in bringing down either the cost of care or bringing down the quality?

THERESA MONTI: I think reference based pricing, target pricing, is still so new that it's hard to say where it hasn't worked right. We are all kind of in that version one type of initiative where we are just trying certain things. We are trying different things between CalPERS and what Kroger is doing and what other employers are doing. So I think it's a little early still to tell where it's not working. I think in Kroger's results we have seen positive results most on the quality cost side and from feedback from our associates. So we haven't seen any one of the things, either on the pharmacy side or the medical side, where it's not working yet. But we are certainly watching things like adherence rates on the pharmacy side, because like I said before, we don't want people to forgo medication when they need it because of cost. So we need to look at that very closely and make sure that is not happening. But right now, we haven't seen anything negative or something that is not working yet.

ANDREA CABALLERO: In our research, we haven't found anything either at home or abroad. I think at home it is too new. Abroad, where reference pricing on drugs has been quite common, I haven't read anything that would indicate that there is a decrease or that it didn't decrease costs and it also decreased quality, which we want to improve quality. On the consumer education piece, I don't know if anyone on the panel can answer that question? I don't know that there is – there are different challenges for implementing different types of reference pricing programs, so it's obviously when you are implementing a reference pricing program for hip and knee replacement, which is far more complex than just a lab test or imaging, you know, there are lots of variables in there. The consumer education piece has to be tailored to the type of service or if you are doing multiple services, it has to be tailored to it. I don't know – I think a lot of it would – it's around medical literacy and being able to articulate something in an easy to understand way, whether it is your lab or a knee or hip replacement. But it's highly dependent on the type of service.

THERESA MONTI: I think the other thing is, it's easier to know or to ask about a cost of a prescription drug, than it is to know about the cost of a medical service. So when you are going to the counter at a pharmacy, you can ask about different costs for different

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levels or categories of drugs – a generic versus a brand name, etcetera. And it's not so easy on the medical side. You have to do a lot of digging and a lot of research to even know where to go to get cost information on the medical side. So it's a little easier on the pharmacy side today, but we are hoping on the medical side, it gets to be just as easy and so that people can make better choices.

ED HOWARD: A couple of times in the last few minutes, we have talked about elective versus non-elective health expenditures and we have a specific question asking if we have some sense of what share of healthcare spending is elective as opposed to trying to negotiate while you are in the ambulance on the way to the emergency room.

THERESA MONTI: I don't know the proportion of spending, I could find out.

ED HOWARD: And since chronic care counts for such a large percentage of spending, particularly in Medicare, does that count as elective or not? One would think that if you are taking a preventive drug or going through some sort of service to keep you from worsening in your diabetes; that would not necessarily be elective. Could you apply reference pricing to those kinds of things as well?

THERESA MONTI: So in the Kroger program, on the pharmacy side, it's any script in that – those four categories of drugs. And the medical side with the high tech imaging and we don't do target pricing for children, although we are finding that what is happening with our associates and their family members who are over the age of 18, they are starting to ask questions when their children need an imaging service. So that is good. And we are also not doing it on emergent services, so we don't really call it elective, so if you are getting an MRI or a CT scan and it's not an emergency, target pricing is going to apply.

ED HOWARD: David, did you have something to add on that? Several people are interested in the application of your travel reimbursement policy, you might call it domestic -

DR. MICHAEL BELMAN: Domestic tourism -

ED HOWARD: Tourism. Medical tourism, yes. So let me just read them off because there are a bunch of different aspects of it. If somebody had to travel to a distant hospital or travel expenses paid before travel, in the event the patient can't afford it, what kind of expenses are covered such as lost wages for extra time off, childcare, post procedure follow up visits, expenses for a traveling companion – I think we may have heard a little bit about that. That is all on one question card. Do you pay for follow-up care for patient and family after a procedure at a preferred provider who is located far away from the patient's home? Finally reimbursement for travel expenses is good, but what about for conditions where travel is difficult and painful or people who don't have a companion to travel with them? What are the conditions under which you are requiring people to pay

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for travel impacting their mobility and ability to get to the high quality care? Lots of interest. Would you like to expand on your descriptions of the travel policies?

THERESA MONTI: Sure, so in the Kroger program, in our Centers of Excellence program, if someone chooses to travel and to use one of our – we call them Tier One Facilities, and they don't have one in their community, we have a group of professionals at Anthem that that is what they do. They help to coordinate the flights, the hotels, the meals, the companion traveling with them, all of that is taken care of so that it's not coming out of the pocket of the associate. So it's billed as a claim through our billing process that we have with Anthem. So, all of that is taken care of for them. If someone can't travel, then we have accommodations for that as well. So they are not penalized for having a co morbid condition that prevents them from traveling or some other type of barrier. So it isn't intended to be such a stiff penalty just because they can't travel. So we try that first, if it – if they are willing to do that and if they can do that, physically do that, if not than we also accommodate them to try and get them to another Centers of Excellence, a Tier Two provider to take care of that for them. So we really try to coordinate all of that. I would say that one of the challenges that we experienced early on when we implemented the Centers of Excellence program, was the post operative care. So moving someone back from a Centers of Excellence facility that might not have been in their community and getting them back into their local provider for that care. And so it's taken a lot of coordination between Anthem and the nurses that help us do this at Anthem. The surgeon and the local provider community. I think we finally got it all figured out, but that was really where the challenge was. It's not getting them to the high quality facility and getting the great services there, the challenge for us is really getting them back into the local provider community. But it's working and it seems to be something I think that barrier has been worked out for us.

DAVID CROWLING: I will follow-up with the same. Anthem has a concierge service which provides all the travel arrangements, the – also again, if they are not allowed – if they have a chronic condition that doesn't allow them, they would get a medical exception, which wouldn't force them to use the facility, so they could use something in their community if it was too far. And in California, luckily, we have enough facilities which are referenced based pricing regionally, but it only happens with a very small number of facilities in Northern California where we have this kind of issue.

ED HOWARD: And actually, this question goes in the other direction and the examples provided today, we see large insurers pushing for competition in procedures for which there are a lot of providers in an area. Do you have any thoughts on how this model might work in areas with just one or two providers and a small insurer network? Is that what you find yourself addressing when you have someone in Eureka?

DAVID CROWLING: Right. So I mean, that is the challenge right? Having enough regionally located, geographically dispersed reference based pricing facilities and then having to have that travel and the companion package. So in terms of the impact of that in

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terms of on the market, well, if there is only one facility and they are either meeting or not meeting, so it's a little difficult to look at variation in a region like that.

ANDREA CABALLERO: Yeah, I was just going to comment that if you have only one or two providers who can perform a procedure in a geographic area, you – if there is variation, which most of the time, if it's really only one or two providers or very few, they are clustering around each other, so you don't see the same variation. And therefore, you – this type of pricing doesn't necessarily have the same impact for those providers and it won't have the same kind of – and if you think about it, then you could end up in some kind of anti-trust issues where if you have two providers and they are agreeing to either set or be close to one another on price, I mean, we get into a whole 'nother area of complicated issues when you really only talk about where you don't have competition and you only have one or two providers who can perform a service. So it's not likely that these will occur there.

ED HOWARD: We have only a few minutes left and I ask you to spend those minutes not only listening to the Q's & A's, but also filling out the blue evaluation form if you would. We have another California Centric question here. You have got a market in California that is heavily penetrated by HMOs and the question wonders how the referenced based prices for Anthem's PPO compare to the prices in California HMOs? The prices that they pay.

DR. MICHAEL BELMAN: Well, the HMO in California in general is significant, although it's actually decreasing gradually over the past few years and the PPO is increasing, but there are still a very large number of HMO members. But in most cases as far as Anthem goes, the hospital pricing is a contract between Anthem and the hospital. So the professional component is where the capitation occurs on the HMO side, with the exception of about 15% of our network, which is in a full risk or more of a global capitation setting, with a contract. So the answer in short is that the HMO is currently not part of this initiative and the prices paid at those intuitions or the prices that the standard Anthem price.

ED HOWARD: Actually this is a related question, at least a poor country lawyer thinks it's related, it might not be. Why can't reference pricing be part of a carrier network contracting negotiations that discounting up to the reference price versus usual and customary. Is that a reasonable question in this context?

DR. MICHAEL BELMAN: Well, first of all, I'm a physician at heart, so [unintelligible]. But I think you are asking, is it – should it be part of the normal, contractual negotiation or rather than the negotiated price that is agreed upon between both parties. Is that the essence?

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ED HOWARD: I guess that is right. That as you establish a network that is willing to meet that price, can you leverage that into going to those who are outside that range and negotiate that as part of your new contract?

DR. MICHAEL BELMAN: Well, I'm probably not going to venture too far into that, other than to re-emphasize the fact that there was that pressure on the non-conforming institutions with the CalPERS initiative to actually bring the prices down, which actually happened without it being a direct goal, so it may well be that it could be effective.

THERESA MONTI: From a payer's perspective, its where we want it to go, right? So we want to be able to bring the cost down of all of those services in a particular category, so hopefully target pricing in a reference based pricing is eventually going to lead us there, it's just one of the initiatives trying to get costs more aligned in a community.

ANDREA CABALLERO: I think it's really important to understand that, I mean, reference pricing is ultimately a benefit strategy, it's not a payment strategy, so while you are capping the payment, you could still pay for it on bundled payment or fee for service or in other methods. So reference pricing is a benefit design, so while CalPERS, I don't want to speak for David here, but CalPERS implemented reference pricing without having to re-negotiate contracts and Anthem didn't re-negotiate contracts during that period. They looked at the data and they set the benefit design price at \$30,000 and then hospitals moved accordingly and then surely in, I would imagine, in subsequent contracting cycles with those facilities that were either outside or at or below, that becomes part of the conversation. But you don't have to implement reference pricing through a contract negotiation, although once it's occurred, it probably does become a part of it.

AUDIENCE MEMBER: Right now on a Taft-Hartley fund, but anybody who has a relationship with a good carrier like Anthem or the [unintelligible] they say we will give you a guarantee discount of 60%, but its based on the usual and customary and what I am suggesting is we would have a lot more man power if our carriers weren't just negotiating on my behalf or Kroger's behalf, but on their book of business and telling some of these facilities we will take a 60% discount, but up to a reference price as opposed to the usual and customary, which is more supply driven. And so it's a really kind of out-of-the-box way to think, but its something that I think everybody in the room could benefit from if they have stronger negotiations while we still have a chance, before network negotiations go away because everyone in the country is going to have insurance and a hospital won't take a discount anymore.

ED HOWARD: That is a very improved formulation of your question from mine. Does it illicit some further response from any of our panelists?

DR. MICHAEL BELMAN: The point I would make is that this whole area of pricing has been changed as a result of the – the shroud is being lifted and so the previous

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discussions that occurred on discount or the desired target price, were discussions around – argument about percentages off. Now the discussion is different and those high priced institutions from my own personal experience in California, are aware of the fact that their price are now out there and can be seen by the public. And so it is a different discussion to the extent that you – the end point you have described, I can't speak to that, I'm not an expert at that, but I believe the nature of the discussion has changed because of the fact that when the target prices are put out by these institutions, they are – they could be recognized as way out of range of averages and reasonableness. I think it's a positive; I'm not sure exactly where you want to get to here.

ED HOWARD: By the way, one of the best illustrations of the impact on the non-participating hospitals is in the chart, and we have heard some discussion just before, but Jamie Robinson and we have our friends at NICOM to thank for these very readable one pagers summarizing Jamie Robinson's article. There is a lovely chart on that second page that shows you the impact on the pricing of these services in the hospitals that were not participating in the CalPERS experiment. Yes, Bob?

BOB GRISS: Bob Griss, with the Institute of Social Medicine and Community Health. With all the discretion that the payers have in setting reference pricing that you have disclosed in this panel and with the tendency of employers to cost shift onto employees, usually in the form of greater deductibles or co-payments, what are the protections for consumers from reference pricing which sets a standard price and expects the consumer to pay anything over that reference price? It seems like a very dangerous precedent even if it's in the interest of the payer in the short run. You haven't given any indication that this is a way of actually reducing total healthcare costs. We don't know whether the hospital is going to follow this procedure with regard to other payers or whether they are going to shift those costs onto other procedures. I'm not sure how comfortable we should feel about this particular short term strategy to help payers reduce certain costs. The panel itself is telling one story and we don't have on the panel, providers or consumers who have been discriminated against because their unique needs did not fill the – you sort of assume that quality remains the same, but in fact that may not be the case in most healthcare situations.

THERESA MONTI: Well, for us, I think it's about being an informed patient and it's completely voluntary for our associates and their family members to choose where they get care. So we don't tell them they have to go anywhere, the choice is theirs. And they have an opportunity to be informed before they obtain a CT scan or an MRI or get a particular prescription and to make a choice as to whether or not they want to stay under the target price or if they prefer not to. So the choice is completely theirs. For us, it's about information and about helping them be informed consumers of healthcare and to make a choice from that perspective. So they know whether or not they are going to be paying more, if they choose to do so.

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DR. MICHAEL BELMAN: It is a very question and I would say to the issues of patient protection, there is the protection that if the enrollee or the member stays within the defined reference based network, then the share is fixed as to whatever benefit structure they have with their employer. The only time they would be subject to additional cost is if they went outside the network. So I don't think it's necessarily bad in that sense. The quality issue is relevant and I agree that when you are talking about quality in general, there are a large number of metrics out there and a few hundred that are being developed by very prestigious organizations – [unintelligible] and so on, but when it comes to specific quality issues within these very detailed procedures such as hip and joint replacement and so on, there is a lot of quality metrics that – or a lot of quality information that hopefully will come out of registries. What we have at the moment is not completely adequate. So in terms of the overall success, I would just say that there are a number of initiatives that are being put out there and there are various organizations that describe various initiatives for bending the cost curve down. Very many of them have failed. And this is one of the few that at the moment, has had some success. And it had success as well documented not just by CalPERS and not just by Anthem, but by any partial third party here with the health economist at UC Berkeley. So I think there is some validity to this study. I'm pretty sure it is, these are very good researchers. And I think it is a success story. Now whether or not it can be replicated across the country, what is going to repeat itself, that remains to be seen, but this has been a successful initiative and I'm biased of course, but I think it has done something to push the knowledge and the practice of healthcare delivery along.

ED HOWARD: David?

DAVID CROWLING: Okay. CalPERS is extremely sensitive to this question, given who we represent and in fact in the Jamie Robinson article, it includes an analysis of the out of pocket to the payer's – I didn't include it today because it gets a little complicated talking about co-insurance, co-payments, deductibles, but we did see that the out of pocket actually went down to our members over the time with the implementation of the program. And in general, if you think about – so in that case, with hips and knees, the deductible plays a big role in terms of how that out of pocket hits you. Something with the more – the colonoscopies, the cataracts, the co-insurance still plays a role there and so the lower costs are going to benefit your out of pocket, and so that is going to be included as well as when we do our follow up economic analysis of those three other procedures that we are doing on reference pricing. In terms of total costs, that was also included, looking at out of pocket plus the net pay and the allowed costs and so that went down dramatically as well. As I said, for the hips and knees and that may have been due to the deductible being breached in a number of cases. And then I think your last part was a little bit about talking about the bubble – if you push down on a balloon here, it comes up over here, so I think that is just for CalPERS is something we will have to look at in the future and be aware of and be concerned about.

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ANDREA CABALLERO: I just want to comment that I think there is awareness on behalf of the payers and the purchasers that this is somewhat of a short term fix. But it is one of the few short term fixes that actually is seeing positive results. And so in the absence of being able to look at the total and being able to bend the total cost curve down, I think the strategies are having to be – they have to be a little bit more piece meal. So it's not that we are not conscious of the impact that it could have. It's just that sometimes things have to occur incrementally and as Dr. Belman said, some of the incremental things haven't worked so far and this is actually an incremental step that is starting to work and then we will have to see what lessons can we learn from this to look at the more total population costs and the total costs and not having that cost shifting occur and the balloon impact. But part of this is disruption and innovative disruption that can help with short term costs, which we are all struggling with, and then learn from that to see what are the long term lessons and strategies we can put in place.

ED HOWARD: That is a fittingly big picture end to this discussion. Final comment anyway, if not the end. This has been quite edifying for your moderator anyway, I learned an awful lot about the way this mechanism works and might work for others in a similar situation. And I would ask you to – while you are filling out the evaluation forms, that you have not had a chance to do yet, note that we are indebted to our friends at WellPoint for helping us think through this session and put it together and for your great questions, which covered a number of aspects of this that weren't all that clear. And finally, ask if you would join me in thanking our panel to help us understand this concept.

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