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25 September 2008

Federal Trade Commission
Office of the Secretary
Room H-135 (Annex F)
600 Pennsylvania Avenue, NW
Washington, DC 20580

RE: Emerging Health Care Competition and Consumer Issues – Comment, Project No. P083901

To Whom It May Concern:

WellPoint appreciates this opportunity to respond to the Federal Trade Commission's solicitation for comments on competition among health care providers based on quality information. WellPoint commends the efforts of the FTC to examine emerging health care competition and consumer protection issues.

WellPoint, Inc. is the largest publicly traded commercial health benefits company in terms of membership in the United States, including more than 425,000 MA enrollees. WellPoint, Inc. is an independent licensee of the Blue Cross Blue Shield Association and serves its members as the Blue Cross licensee for California; the Blue Cross and Blue Shield licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (as Blue Cross Blue Shield in 10 New York City metropolitan counties and as Blue Cross or Blue Cross Blue Shield in selected upstate counties only), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.), Wisconsin; and through UniCare Life and Health.

In addition to the comments below, WellPoint would like to ensure that the FTC is aware of several resources and ongoing efforts in this area. For example, the National Quality Forum (NQF) has white papers available on performance measurement and reporting at the clinician level (http://www.qualityforum.org/pdf/news/Issue%20Brief%20Performance%20Measurement%20at%20the%20Clinician%20Level%208.08.pdf) and national voluntary consensus standards for hospital care (http://www.qualityforum.org/projects/ongoing/hospitaleff/index.asp). The Agency for Healthcare Research and Quality (AHRQ) is also doing a lot of work in this area. The Consumer Purchaser Disclosure Project has also worked with stakeholders from across the health care system to develop its Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs. The Patient Charter creates a national set of principles to guide measuring and reporting to consumers about doctors' performance

(http://healthcaredisclosure.org/activities/charter/). WellPoint strongly urges the FTC to engage with these organizations as it conducts research on this issue.

WellPoint would also like to point out that the questions posed by the FTC were rather broad, which made it difficult to determine how to respond in some cases. WellPoint would be happy to discuss any of these questions/topics with the FTC in greater detail should the FTC wish to do so.

WellPoint appreciates this opportunity to offer our perspective on competition among health care providers based on quality information. We look forward to working with the FTC on this endeavor and would be in interested in the FTC's workshop on this issue. Should you have any questions or wish to discuss our comments further, please do not hesitate to contact me at (202)628-7840.

Sincerely,

Elizabeth P. Hall
Vice President, Public Policy, WellPoint, Inc.

A. Purchaser Decision Making and Quality Information

1. What decisions do quality information help different types of purchasers make?

Just like with any other good or service, information on quality helps purchasers make several types of decisions. For example, quality information may help a health plan determine which providers may join a network and it may help an employer determine which health plan gets its business depending on whether or not the health plan is making this information available. Consumers want this information about providers. However, health plans and the government are still trying to identify the best way to deliver this information in order to help consumers in their decision-making processes. This area is quickly evolving and not too long ago the only information available to consumers was from other consumers via word-of-mouth. However, health plans and others are working hard to provide better and more robust information to consumers. Ideally, quality information should inform each step of the consumer's decision-making process. However, even when quality information is readily available consumers will assign different weights to this information when considering all of the diverse factors in selecting a provider.

2. What are the relevant times at which purchasers make health care decisions? What quality information about health care services and providers should be presented at these critical junctures?

Relevant times can vary among purchasers making health care decisions including anytime a good or service is being contemplated or when a specific need arises. For example, someone that is choosing a physician versus someone that needs surgery.

Depending on the situation, different information should be presented. These indicators should help the purchasers address their particular needs.

3. What quality information is the most competitively significant for different types of purchasers? Are different types of data (*e.g.*, licensing information, compliance with process measures, customer satisfaction, outcomes, outcomes per dollar spent) appropriate for different purchasers and purchaser decisions? How should any differences in measurement of the same provider or service (over the same time frame) be reconciled?

We would like to note that we do not believe there is viable and credible information to appropriately measure outcomes per dollar spent at this time.

From a health plan perspective, health plans that can report out to employers and members quality information have a major competitive advantage as these purchasers see a significant value in having access to this information.

As we continue to utilize nationally endorsed quality measures (as prescribed by the Consumer Purchaser Disclosure Patient Charter), there should be less difference in the measurement of the quality of the same provider or service. The use of all-payer data should also help to minimize these differences.

4. Does health care quality vary based by medical condition, provider, and patient? Does it vary over time? If so, how should quality measures be adjusted to take these differences into account?

Yes, health care quality varies based on medical condition, provider and patient. To help take these differences into account, data should be adjusted for certain factors, such as case-mix, and the period of time over which quality is measured should be consistent.

5. What information is needed to measure the efficiency of a provider? What is the proper weighting of quality and resource use in an efficiency measure?

These questions are somewhat premature as work is still being done to try to figure out how to do this. In particular, the National Quality Forum (NQF) is currently discussing the most appropriate way to measure the efficiency of a provider.

6. How broad a range of differences among health care providers and services is needed to motivate purchasers to switch service providers?

The evidence on this is not clear. Furthermore, personal preferences and values will determine what differences in quality are significant enough to affect their selection of a provider.

7. How should regional variations be accounted for in showing the results of quality measures? Should local, state, regional, or national benchmarks be used to show differences among service providers? Why or why not?

Providers should be compared to other providers in their practice area and their state. However, we also believe there is value in national comparisons. The challenge in providing quality information in these different ways is ensuring that performance reports are statistically valid. Reporting schemes that place providers into discrete buckets (e.g. a star system) need to ensure that the performance of providers in the different buckets are significantly different. Likewise, the different performance buckets should be meaningful in absolute terms. For example the national average for administration of beta-blockers at discharge after heart attack is 89 percent. Assume that in an individual state, the performance ranges from 90 to 100 percent. In statistical terms there might be no significant difference in the scores of some hospitals scoring 100 percent and some scoring 90 percent. Likewise, it is unclear if a hospital that scores say 98 percent is better than a hospital that scores 96 percent even if the scores are significantly different in statistical terms.

8. How does the framing of quality information affect the purchasers' decisions? Do symbols and summaries affect purchaser understanding of health care quality information?

How quality information is framed is incredibly important for purchasers. Quality data are complex and although several Health Plans have utilized symbols or other means to frame quality, it is an area we believe still requires attention and a greater understanding as to how information can/should be presented.

Another issue around the framing of quality information to affect the decisions of purchasers is related to the use of disclaimers regarding the data. While it is appropriate to have disclaimers

to communicate the limitations of the data, these disclaimers can cause consumers to become overly wary of the data and disregard it in their decision-making.

9. What has been learned from public and private quality reporting initiatives that can aid the competitive process?

The goal of quality reporting initiatives is to increase quality by providing information and fostering healthy competition among providers. However, at this time, consumers aren't engaged enough for this information to change the competitive landscape. There is also fierce competition among health plans to make these data available to employers and members. It is important that this competition amongst health plans does not create a so-called "race to the bottom" in which health plans use poor quality measures or inaccurate data simply to be able to make quality information available.

10. What are the tradeoffs between quality-based competition and the availability of health care?

Given the unavailability of health care in areas with provider shortages, there is not likely to be much impact of quality-based competition given the lack of competition more generally.

On the other hand, if all consumers begin to insist on seeing the highest quality providers, there are likely to be access issues as these providers will have to create waiting lists and stop seeing new patients.

B. Barriers to Developing and Implementing Quality Measures

1. What barriers – clinical, marketplace, regulatory, or other – restrict the measurement, collection, and reporting of health care quality information? Can health care quality be measured such that it is of value to purchasers in their decision making?

There are many barriers at this time, too many to list that restrict the measurement, collection and reporting of health care quality information. That being said, it must be done and is ever-evolving.

2. Do providers and insurers have business reasons to develop and implement public reporting of quality measures?

Yes. For example, WellPoint's mission is to improve the lives of the people we serve and the health of our communities.

3. How should quality measurements deal with organizational variation on the supply side (*e.g.*, solo physician practitioners, small physician groups, integrated physician groups, etc.). If so, how should the measures be adjusted to consider this variation?

This is not an easy question. That being said, standards have been developed by the National Committee for Quality Assurance (NCQA), as part of its Physician and Hospital Quality Program (PHQ) standards, to address this issue.

4. How does the development of reimbursement and payment reform affect the development of quality measurements?

The development of reimbursement and payment reform directly affects the development of quality measurements. However, it is the implementation and operationalization of the quality measure that is key. One example of how reimbursement and payment reform affects the development of these measures is the Prevention Quality Indicators (PQI) program. When CMS announced that it was going to implement PQI, it resulted in the development of many measures.

5. Several private and public entities have developed standards to measure health care quality. Are concerns about provider capture of these organizations relevant in this context?

This question is unclear.

C. Federal Policies to Facilitate Quality Information Collection and Reporting

1. What federal policies can help overcome any marketplace barriers to the measurement, collection, and reporting of quality information?

A continued effort to use and develop nationally endorsed quality measurements is a key driver in gaining engagement and reporting quality information. In addition, continued efforts to assist in the implementation and deployment of technology such as EMR's or e-prescribing can help remove barriers to measurements and collection of critical quality information.

2. How can government use its role as a payer (*e.g.*, Medicare, Medicaid) to facilitate the development and use of quality information more broadly?

One area where federal policies can help spur the reporting of quality information is through reimbursement reform. By tying reimbursement to outcomes and performance, as well as the long term value of a service (such as for a colonoscopy or a comprehensive geriatric assessment), CMS could spur the marketplace to overcome the barriers listed above. CMS has proven that it can drive behavior in the health care marketplace.

3. What are the costs and benefits of a single entity developing the quality measures, collecting and analyzing the data, and reporting the results? What are the costs and benefits of governmental involvement in these activities?

While in an ideal world having a single entity develop quality measures, collect and analyze the data, and report the results is a great idea, it presents many challenges.

With respect to developing measures, many organizations, such as NQF, already do this. It is also important that this process continue to be consensus-based and include all if the relevant stakeholders.

Collection and analysis of data, even on a regional level, has proven to be problematic. RHIOs (regional health information organizations) have struggled to do that and often times funding

becomes a problem. Even when the RHIOs have been able to collect the data, aggregating it in a useful way has proven to be challenging.

4. How should federal, state, and private sector efforts to measure and report on health care quality be harmonized so that purchasers obtain the benefits of cost and quality information?

There are several steps that can be taken to help harmonize the measurement and reporting of health quality data. The first is to develop a framework for measuring and reporting quality such as what the Quality Alliance Steering Committee is doing. It would also be helpful for CMS to come up with an agreement with AQA on what measures should be developed, as well as what specifications and attributions they should include.