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

Submission of America's Health Insurance Plans to the Federal Trade Commission on Competition Among Health Care Providers Based on Quality Information

I. Introduction

America's Health Insurance Plans (AHIP) would like to thank the Federal Trade Commission for the opportunity to share our perspectives on competition among health care providers based on quality information. AHIP is the national association representing nearly 1,300 health insurance plans providing coverage to more than 200 million Americans. Our members offer a broad range of products in the commercial marketplace including health, long-term care, dental, vision, disability, and supplemental coverage.

Our members also have a strong track record of participation in Medicare, Medicaid, TRICARE, and other public programs.

All stakeholders agree that the health care industry needs to continue its progress towards an overall system that recognizes and promotes high quality performance among physicians, hospitals, and other health care providers through incentives and other means. Such progress is both enabled by and will itself further enable competition based on quality parameters among health care providers.

A wide range of sources indicate that Americans frequently receive inappropriate care in a variety of settings and across many different medical procedures, tests, and treatments. Studies by the Institute of Medicine (IOM)[1] as well as RAND[2] and the *Dartmouth Atlas of Health Care*[3] all point to wide variations in care across the country, unacceptably high numbers of medical errors, and medical practice that is often not based on scientific evidence. While a problem this substantial and complex can require a number of solutions, the use of *information* based on quality parameters to enable and enhance vigorous competition among health care providers is critical.

Our members have played a significant role in efforts to develop and improve quality measures and measurement, and to make use of quality information in a manner that benefits both patients and providers. Patients need access to quality information so they can utilize that information in making their own health care decisions. Providers benefit as well, using this information along with peer comparisons to drive improvements in their practices. We recognize that various stakeholders, including government agencies, employer-based organizations, patient-advocacy organizations, and provider-based organizations, are essential for advancing this process. Therefore, we have committed to advance multi-stakeholder, collaborative approaches to improve and standardize quality measures and measurement.

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[1] INSTITUTE OF MEDICINE, TO ERR IS HUMAN (1999); INSTITUTE OF MEDICINE, CROSSING THE QUALITY CHASM (2001).
[2] *See* Elizabeth A. McGlynn et al., *The Quality of Health Care Delivered to Adults in the United States*, 348 THE NEW ENG. J. OF MED., at 2635 (2003).
[3] *See* http://www.dartmouthatlas.org/.

At the same time, we recognize that standardized measures, broadly aggregated data, and other collaborative efforts will best benefit patients if these efforts are accompanied by robust competition: (1) among providers, with respect to the quality of care provided, and (2) among health insurance plans, with respect to how they use quality information in structuring products, providing information to members, and offering feedback to health care providers.

Consequently, we commend the FTC's interest in ensuring that information about provider quality necessarily promotes meaningful provider competition that impacts quality of care and, thus, benefits patients. The FTC has a vital role to play in furthering these efforts, since "[c]ompetition law affects quality of care by influencing the conduct of providers and the institutional and structural arrangements through which health care is financed and delivered."[4]

Below we discuss several ways in which AHIP and its members have worked to advance quality information about, and quality competition among, providers:

- As a preliminary matter, Section II sets forth some foundational principles with respect to provider quality competition as well as AHIP's Board principles, which outline the Board's thinking on creating effective consumer health information systems.

[4] William M. Sage et al., *Why Competition Law Matters To Health Care Quality*, HEALTH AFF., Mar./Apr. 2003, at 31, 32 [hereinafter *Why Competition Matters*].

- Section III describes AHIP's and its members' participation in efforts to develop uniform processes for performance measurement and reporting and advance the process of data aggregation.
- Section IV outlines the wide variety of approaches individual AHIP members have employed to enhance the competitive process through the use of quality data. Such approaches have included: (1) empowering patients to make better informed decisions about their health care by providing them with provider quality information; and (2) creating products or programs that utilize such information, such as pay-for-performance, tiered or high-performance networks, or other consumer-empowering products. We highlight key aspects of such programs and the manner in which such programs benefit patients and are consistent with the core principles of competition policy.

II. Foundational Principles Related to Provider Quality Competition, Including AHIP Board of Directors' Statement

A response to the Commission's question concerning how to enhance competition among health care providers by expanding quality information is best premised on specific initiatives proceeding in the market today, based on the following foundational principles:

1. Quality measures can and should include structure, process, and outcomes measures. A structural measure is an assessment of professional and organizational resources associated with the provision of care.[5] A measure that assesses the

[5] *See* INSTITUTE OF MEDICINE, PERFORMANCE MEASUREMENT: ACCELERATING IMPROVEMENT, at 172 (2006) [hereinafter *IOM: Performance Measurement*] ("Structure refers to the attributes of the settings in

implementation and use of an electronic health record (EHR) would be considered a structural measure. Structural measures can promote the adoption of systems and tools that can improve quality by streamlining and standardizing care processes.

A process measure is an assessment of "the services that are provided to or for patients or by patients themselves on medical advice."[6] An example of a process measure would be percentage of patients who are prescribed beta-blocker therapy after a heart attack. Process measures assess whether or not a care activity takes place and therefore are the most actionable by physicians. Process measures should also be closely tied to health outcomes.

An outcome measure is an assessment of "changes that are observed in the person's health status after allowing for everything other than health care, such as the patient's illness, severity of the illness, and availability of effective prevention or treatment."[7] An example of an outcome measure would be risk-adjusted operative mortality for coronary artery bypass graft patients. While publicly-reported outcomes measures are not yet abundant, outcomes measures are highly valuable and should be part of quality assessment. Indeed, there has been a movement towards greater development of

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which providers deliver health care, including material resources (e.g., electronic health records), human resources (e.g., staff expertise), and organizational structure (e.g., hospitals vs. clinics). For example, a cardiologist may use a disease registry to track whether a patient with cardiovascular disease is receiving drugs for lowering cholesterol.")

[6] R. Heather Palmer, *Process-Based Measures of Quality: The Need for Detailed Clinical Data in Large Health Care Databases*, 127 ANNALS OF INTERNAL MED., 733 (1997), available at http://www.annals.org/cgi/content/full/127/8_Part_2/733 [hereinafter *Process-Based Measures of Quality*]. *See also IOM: Performance Measurement*, *supra* note 5 ("Process of care denotes what is actually done to the patient in the giving and receiving of care. Building on the example above, the provider could review whether an eligible patient has been placed on an angiotensin-converting enzyme inhibitor to help prevent future heart attacks.")

[7] *Process-Based Measures of Quality*, *supra* note 6. *See also IOM: Performance Measurement*, *supra* note 5, at 172 ("Health outcomes are the direct result of a patient's health status as a consequence of contact with the health care system. In the above example, the patient's receiving the preventive medications mentioned above could decrease the chance of dying from a heart attack.")

outcomes measures[8], greater recognition of outcomes measures[9], and expansion of outcomes measures for physicians as well as hospitals.[10]

As with so many other aspects of quality assessment, outcome measures and process measures can be interrelated. For example, some process measures (e.g., immunization rates) are strong proxies for outcomes measures (e.g., rates of communicable diseases). To move to a more direct assessment of outcomes, however, AHIP encourages the establishment of national medical registries that collect longitudinal outcomes on patients, assess performance of providers, and meet the registry criteria developed by the AQA--a multi-stakeholder alliance.[11]

2. Cost of care measures are equally important for patients. Too often, patients and others confuse higher cost with higher quality. In fact, it is well recognized that, "lower cost can itself enhance quality."[12] Cost of care measures, in conjunction with quality measures, allow the identification of providers who provide both high quality care

[8] Some outcomes measures can be found in state-based registries, which report hospital outcomes measures such as mortality, readmission rates, and average lengths of stay for select conditions. Examples of state registries that include outcome data are:

1. **Florida's** Hospitals and Ambulatory Surgery Center Data, which reports performance and outcome data and information on selected medical conditions and procedures. Available at: http://www.floridahealthfinder.gov/CompareCare/SelectChoice.aspx.

2. **Maryland's** Hospital Performance Evaluation Guide, which reports hospital quality data, including volume, average length of stay, and readmissions for select conditions. Available at: http://mhcc.maryland.gov/consumerinfo/hospitalguide/index.htm.

3. **Pennsylvania's** Health Care Cost Containment Council, which reports hospital mortality, readmissions, and length of stay data. Available at: http://www.phc4.org/.

[9] For example, hospital readmission and average length of stay measures have been endorsed by the National Quality Forum (NQF).

[10] New York, for example, began publicly reporting cardiac surgery mortality rates for both hospitals and surgeons. *See* New York's Cardiovascular Disease Outcomes reports, which cover surgeon and hospital risk-adjusted mortality. Available at: http://www.health.state.ny.us/statistics/diseases/cardiovascular/.

[11] The AQA criteria are available at: http://www.aqaalliance.org/files/RegistryPrinciplesDocumentV1Approved.doc.

[12] *Why Competition Matters*, *supra* note 4, at 35. "When costs are high, people who cannot afford something find substitutes or do without." *Id.*

and do so in a manner that does not involve the unnecessary costs which often result from providing care in a manner not consistent with the best evidence. While cost of care measures create significant measures for consumers and others to consider, they are not and should not be the sole basis for consumer or health care entity decisions. Indeed, the quality of care provided must be considered as a key data point when analyzing a cost of care measure.[13]

3. Promoting flexibility to design innovative tools and approaches that recognize and report performance is critical. That flexibility allows our members to use quality information in a variety of ways, such as:

- making the information available to providers for assessment of their own quality performance and for use in their own efforts to improve quality;
- making the information available to plan members for informed decision-making affecting care and treatment options and choice of providers; and
- structuring products (such as tiered or high-performance networks) that utilize the information to identify high-performing providers for patients.

Each use has an impact on competition among providers, some more directly (e.g., competition driven by the desire to qualify for a high performance network or peer-to-peer competition), while others may do so less directly (e.g., competition driven by the desire to improve the information available about a provider).

[13] Indeed, AHIP's November 2007 Board of Director's Statement on such programs, discussed below, stresses that "Information about the quality and value of care should be presented together and in a manner that gives consumers information about the relative significance of each factor included in the evaluation."

In addition, AHIP's Board of Directors has laid out its thinking on creating effective consumer health information systems, including adopting detailed principles providing more guidance on this subject, and AHIP and its members have been key supporters of other efforts to set appropriate principles for evaluating and rewarding quality, most notably the Consumer-Purchaser Disclosure Project's "*Patient Charter*."[14]

Board Principles: AHIP's Board of Directors has long considered provider quality information, and competition based on that information, to be critically important in creating and supporting effective consumer health information systems. It also has recognized that the success and usefulness of such initiatives depends on such initiatives being well-structured and supported by various stakeholders. In November 2007, the AHIP Board of Directors issued a Statement containing eight key principles on Creating Effective Consumer Health Information Systems:[15]

- Consumers, physicians, hospitals, public and private purchasers, and other key stakeholders should continue to collaborate to develop an expanded core set of performance measures that will drive improvement in priority areas that yield the greatest impact on improving health care outcomes.

- Measures, data specifications and methodologies, such as attribution, risk adjustment and the relative importance given to different types of measures, should be clear and transparent so that consumers, purchasers, physicians and other stakeholders understand how performance is measured.

[14] On April 1, 2008, AHIP joined other stakeholders-- including major physician, consumer, employer, labor, and quality groups-- in supporting a standard set of guiding principles, on physician performance measurement and reporting. The principles were developed by the Consumer-Purchaser Disclosure Project, and are embodied in the Disclosure Project's *Patient Charter for Physician Performance, Measurement, Reporting, and Tiering Programs (Patient Charter)*. More information about the Consumer-Purchaser Disclosure Project is available at: http://healthcaredisclosure.org/, and more information about the *Patient Charter* is available at: http://healthcaredisclosure.org/activities/charter/.

[15] The full November 2007 AHIP Board Statement is available at: http://www.ahip.org/content/default.aspx?bc=31|44|21530.

- Physicians, hospitals and other health care professionals, as well as consumers and other appropriate stakeholders, should be involved in the development of provider performance reporting programs.

- Before performance information is made public, clinicians and hospitals whose performance is being reported should have an opportunity to review and comment on the results. In addition, mechanisms should be available to consumers for resolving disputes about performance reporting programs.

- Information about the quality and value of care should be presented together and in a manner that gives consumers information about the relative significance of each factor included in the evaluation.

- Physicians, hospitals and consumers should be notified in a timely manner of significant changes in evaluation methodology, data sources, or network structure in efforts to measure, recognize or report performance.

- Recognizing the importance of transparency, external validation and confidence in performance reporting activities, programs should be reviewed and validated by independent entities.

- To generate quality information and reports based on the most comprehensive data, progress should continue toward establishing uniform processes for the aggregation of data across public and private payers.

Previously, in November 2004, AHIP's Board of Directors issued a statement containing principles on Promoting an Effective and Efficient Health Care System Through Rewarding Quality Performance.[16] While many of the principles cover concepts similar to those covered in the November 2007 principles, several bear highlighting in this context:

- Programs that align payment methods with the goal of improving quality of care for acute and chronic conditions will play an integral role in encouraging the transition to a health care system that achieves optimal health care quality.

- Programs that reward quality performance should promote medical practice that is based on scientific evidence and aligned with the six aims of the IOM for

[16]The full November 2004 AHIP Board Statement is available at: http://www.ahip.org/content/default.aspx?bc=31|44|14164.

advancing quality (safe, beneficial, timely, patient-centered, efficient, and equitable).

- The involvement of physicians, hospitals and other health care professionals in the design and implementation of programs that reward quality performance is essential to their feasibility and sustainability.

- Disclosure of the methodologies used in programs that reward quality performance will engage physicians, hospitals, and other health care professionals so they can continue to improve health care delivery.

- Rewards, based upon reliable performance assessment, should be sufficient to produce a measurable impact on clinical practice and consumer behavior, and result in improved quality and more efficient use of health care resources.

Together, these principles have shaped our work with respect to determining, recognizing, and rewarding quality performance by providers.

III. Initiatives to Improve Measures and Measurement—AQA and NDAI

As noted above, AHIP and its members are deeply committed to improving both measures and measurement, in a broad-based, multi-stakeholder fashion. It is axiomatic that any effort to provide patients the benefits of access to quality information, and provider competition enabled and enhanced by that quality information, will be of more value as the quality information that is made available and utilized becomes more robust, more consistent, and more comprehensive.

While insurers, employers, and other stakeholders have already made excellent use of the quality information currently available, we know that the information can be improved, its uses expanded, and its benefits multiplied. AHIP and its members have been actively

involved in several endeavors that seek to advance just these goals, including the AQA and the National Data Aggregation Initiative (NDAI).[17] Through the AQA, AHIP has participated in multi-stakeholder efforts to improve and make more consistent the measures by which provider quality are assessed. Through the NDAI, the AHIP Foundation, with other stakeholders, has taken an important role in *advancing a standard methodology for data aggregation*, to ensure that quality assessments are based on more meaningful data.[18]

The AQA: In 2004, AHIP, along with the American Academy of Family Physicians and the American College of Physicians, and the Federal Agency for Healthcare Research and Quality (AHRQ) established the AQA.[19] The coalition, which now has more than 135 participating organizations, including consumer groups, physician groups, hospitals, accrediting organizations, private sector employers and business coalitions, health insurance plans, and government representatives, has as its goal the development of uniform processes for performance measurement and reporting – a fundamental building block needed for consumer health information systems. Its processes would: (1) allow patients and purchasers to better evaluate the quality and cost of care delivered, and (2)

[17] AHIP's involvement in quality-improvement related efforts is not limited to AQA and NDAI. For example, AHIP is an active member of the National Quality Forum (NQF), a not-for-profit membership organization created to develop and implement a national strategy for health care quality measurement and reporting. More information about the NQF is available at: http://www.qualityforum.org/.

[18] The AHIP Foundation is a non-profit 501(c)(3) organization furthering the educational, charitable, and research goals of AHIP. The Foundation seeks to build on the health insurance plan industry's dedication to innovation and advances in care delivery. The Foundation strives to create, support, and enhance programs in health insurance plans which will improve quality, effectiveness, and value in health care through research, education, information sharing, and other activities which strengthen and reward exemplary practices by individuals and organizations.

[19] More information about the AQA is available at: http://www.aqaalliance.org/.

enable practitioners to determine how their performance compares with their peers in similar specialties.

To date, the AQA has approved 232 *quality* clinical performance measures in 38 different ambulatory care setting areas, many of which are being incorporated into health plan provider contracts. These measures represent an important step in establishing a broad range of quality measurement. The AQA has also approved a prioritized list of conditions for which *cost of care measures* should be developed, and the group continues to make further progress towards that goal. This priority list is being utilized by Dr. Kevin Weiss in his work through a complimentary Robert Wood Johnson Foundation grant to create a standardized, transparent process for measuring resource allocation across an episode of care.

In addition to its work in the area of performance measurement, the AQA has created a pilot program in six sites across the country that combines public and private sector quality data on physician performance. These pilot sites, now known as the Better Quality Information or BQI sites, are being supported by the Centers for Medicare and Medicaid Services (CMS) and AHRQ. This program is testing approaches to aggregating and reporting data on physician performance, while also testing the most effective methods for providing patients with meaningful information they can use to make choices about which physicians best meet their needs. Ultimately, we anticipate that the results of this pilot program will inform a national framework for measurement and public reporting of physician performance, which is an important step toward providing reliable

quality information for consumer decision-making, advancing quality-related initiatives, and enhancing quality-based competition.

National Data Aggregation Initiative: Key to efforts to enhance quality competition and improvement is the advancement of tools that will allow quality data to become more robust, broadly-based, and consistent. The America's Health Insurance Plans Foundation (AHIPF) has taken a leading role in this effort through its National Data Aggregation Initiative (NDAI). This initiative, funded by a grant from the Robert Wood Johnson Foundation, is designed to demonstrate the feasibility of an industry standard data aggregation methodology using consensus-based measures. It also is structured to aggregate commercial data with data from CMS and U.S. Department of Health and Human Services (HHS) physician group performance measurement efforts.

AHIPF's partner in the NDAI is the Quality Alliance Steering Committee (QASC), a collaborative effort among existing quality alliances, government, physicians, nurses, hospitals, health insurers, consumers, accrediting agencies and foundations to dramatically improve the quality of health care across the U.S.[20] The NDAI is consistent with the QASC's efforts to work towards consistency in measurement and reporting of quality and cost of care information nationwide. Working with specific multi-stakeholder advisory committees, the NDAI will demonstrate the feasibility of an industry-based data aggregation using a select number of common, broadly accepted process of care

[20] More information about the QASC is available at: http://www.brookings.edu/projects/qasc.aspx.

measures (such as HEDIS measures[21]) involving multiple health plans. The project will begin by "piloting" the methodology in select regions before expanding to a broader multi-region and national focus.

The NDAI will address many of the challenges that efforts to calculate, understand, and utilize provider quality measurement have met to date. For example, some challenges faced by such efforts have involved ensuring that results are: (1) statistically valid, (2) meaningful to patients, and (3) trusted by providers. The NDAI addresses these issues in several ways:

- By its nature, the NDAI aggregates data across measuring entities, *increasing the number of quality observations* for each provider measured and therefore offering statistically more powerful information;
- By design, the NDAI utilizes *transparent, standardized methodology*, improving the quality of information available to patients and other stakeholders, as they will be able to conduct regional and national comparisons.
- By its *reconciliation and reconsideration* features, NDAI offers providers the opportunity to view the source data underlying their results to ensure accuracy and the opportunity to correct and augment data.

It may be useful to discuss the reconciliation and reconsideration features as an example. These features address the concern expressed by some providers that they may not have access to the information used to evaluate them or that they may not have the ability to correct problems with the information even if they do have access to it. The NDAI

[21] HEDIS is a tool used by health insurance plans to measure performance on important dimensions of care and service. It is offered by the National Committee for Quality Assurance (NCQA), a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality. More information about NCQA is available at http://www.ncqa.org, and more information about HEDIS is available at http://www.ncqa.org/tabid/59/Default.aspx.

allows providers to obtain a reconciliation report reflecting their patients across all of the plans participating in the data aggregation initiative. Further, the NDAI will allow providers to submit reconsideration details to plans, with such information being used to create revised reports. All of this will be done with protection of protected health information (PHI) and with appropriate audit features to ensure that the data is used appropriately and in a manner that maintains its integrity.

All stakeholders are well-served when quality assessments are based on broad datasets, methodology is consistent and understandable, and those being assessed can ensure that the assessments are based on the best available data. The NDAI will advance quality assessments in this manner, and offers many other potential benefits, including a more efficient approach to aggregation, advancing the underlying goal of leaving more resources available for the quality improvement efforts based upon the aggregated data.

IV. Competing to Provide Patients with the Full Benefits of Competition—the Range of Health Plan Uses of Quality Information

The ways in which provider quality information can be utilized to further competition are numerous and growing. Many health insurance plan initiatives in this area, however, fall into one of two categories:

- Empowering patients to make better informed decisions about their health care by providing them with provider quality information.
- Creating products that utilize such information, such as pay-for-performance, tiered or high-performance networks, or other consumer-empowering products.

Quality Competition through Information Dissemination

Initiatives to empower consumers by providing them with quality as well as price information designed to support decision making are consistent with the recommendation set out in the 2004 Federal Trade Commission and Department of Justice report on health care that private payers, governments, and providers "should furnish more information on prices and quality to consumers in ways that they find useful and relevant."[22] Courts also "regard abundant information as an important element of quality-based competition because it enables consumers to define and exercise their preferences along many dimensions of quality."[23] While they use a variety of approaches, these plan initiatives – often in the form of easy-to-use tools that allow patients to access secure websites – encompass providing such resources as the following:

- **Access to quality data on physicians**: Members of some health insurance plans can access information on either plan-specific or regional collaboratives' websites regarding clinical quality delivered by a specific physician, including indicators based on adverse events, clinical processes, use of health information technology such as electronic medical records, as well as overall efficiency in use of medical services.

- **Access to price data on specific physicians**: A member of many health insurance plans can type in a particular physician's name, specialty, or office address and view a menu of common procedures, and determine the cost of procedures, such as routine office visits or x-rays.

- **Access to hospital price and quality information**: Members in many plans may have access to cost ranges for common procedures at hospitals and surgery centers, in some instances separating out doctor fees from facility costs, as well as tools to ascertain the comparable value of those facilities.

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[22] FEDERAL TRADE COMM'N AND U.S. DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION, Executive Summary, at 21 (2004), available at http://www.usdoj.gov/atr/public/health_care/204694.htm [hereinafter *FTC/DOJ Report*].

[23] *Why Competition Matters, supra* note 4, at 38.

Several of our members also are participating in regional quality collaboratives that are aggregating data across a given market, combining data from multiple health plans in a region to give patients a more comprehensive picture of a physician's quality across his/her population. Still other AHIP members are experimenting with pilot projects allowing patients to access information on provider quality and cost for dozens and sometimes hundreds of common medical procedures. All are pioneering efforts designed to help Americans make value-based health care decisions.

Information dissemination has been a key component of both public and private efforts to utilize quality, price, and cost information in a manner that benefits patients.[24] These efforts give patients quality information that they can utilize themselves in selecting providers and concurrently give providers quality information that they can utilize in understanding how they compare to their peers and areas in which they can improve. As measures become more standardized, data resources become more powerful, and patients become more aware of the information available, one can expect that such information efforts will grow in scale, scope, and impact.

[24] Of course, some transparency initiatives--particularly some price transparency initiatives--can lead to the disclosure of the "wrong" types of information, which not only ultimately may prove useless to consumers, but can harm competition, resulting in higher prices. We note that FTC has played a leading role in helping state legislators and regulators distinguish between "good" and "bad" transparency initiatives. Specifically, in a number of letters this agency has opposed proposed state regulations mandating greater transparency of contractual data from pharmacy benefit managers. *See, e.g.,* FTC, *Letter to New Jersey General Assemblywoman Nellie Pou* (Apr. 17, 2007), *available at* http://www.ftc.gov/be/V060019.pdf; FTC, *Letter to Virginia House of Delegates Member Terry G. Kilgore* (Oct. 2, 2006) *available at* http://www.ftc.gov/be/V060018.pdf; FTC, *Letter to California Assembly Member Greg Aghazarian* (Sept. 7, 2004), *available at* http://www.ftc.gov/be/V040027.pdf. We commend the FTC's efforts in this area and note that more guidance may be necessary as states and others pursue transparency initiatives.

Quality Competition through Product or Program Innovation

Another powerful use of quality information is found in the creation by private health insurance plans of offerings that make use of quality information to reward high quality providers, provide incentives for providers to improve quality, and provide information and financial rewards to patients seeking high quality care. These programs go by many names--pay-for-performance, high value networks, value-based purchasing, tiered networks--but the underlying principle is the same: the offerings make use of quality information to structure products that *recognize* high quality providers, *incentivize* quality improvement by other providers, and *realize* the potential for empowered patients to themselves promote quality competition and improvement.

Unfortunately, some have taken a skeptical, even hostile, view of such programs, not reflecting the manner in which such programs improve quality, foster competition, and benefit patients. Such a view is inconsistent with the understanding of such programs, not just among health insurance plans, but among others knowledgeable about such programs, including government officials[25] and employers.[26] Indeed, such programs are consistent with the recommendations of the *FTC/DOJ Report* calling for private payers, governments, and providers both to "continue to experiment with financing structures that will give consumers greater incentives to use [] information [on prices and quality]"

[25] One example of a government program that is designed to recognize and reward provider quality is CMS's Premier Hospital Quality Incentive Demonstration. Information about this program is available at: http://www.cms.hhs.gov/HospitalQualityInits/35_HospitalPremier.asp.

[26] One example of a private sector collaborative effort that is designed to recognize and reward provider quality is a hospital rewards program created by the Leapfrog Group, which is made up of private- and public-sector health care purchasers and suppliers of health-related products and services. The Leapfrog Hospital Rewards Program ties hospital payments to nationally accepted and endorsed performance measures. More information about this program is available at: http://www.leapfroggroup.org/for_hospitals/fhincentives_and_rewards/hosp_rewards_prog.

and "experiment further with payment methods for aligning providers' incentives with consumers' interests in lower prices, quality improvements, and innovation."[27] Similarly, while there has been mistrust of such efforts by some physicians, many physicians have come to understand the manner in which physicians, employers and other payers, and patients all benefit from well-designed programs that recognize and reward quality.[28]

Our members' initiatives to develop innovative payment arrangements through these programs have delivered positive results, including improved care for patients, greater attention to preventive care, and increased empowerment of patients to make more informed decisions.

Many of our members currently are offering financial awards to physicians or non-financial rewards in the form of public recognition, preferential marketing, or streamlined administrative procedures. Additionally, some plans are offering patients reduced co-payments, deductibles, and/or premiums in exchange for using providers deemed to be of higher quality, based on specific performance measures.[29] The categories of performance measures most commonly reported include clinical quality, utilization experience/efficiency, patient satisfaction, and business operations, which includes

[27] *FTC/DOJ Report, supra* note 22, Executive Summary, at 21.
[28] *See, e.g.*, Wayne J. Guglielmo, *This doctor made P4P work—you can too*, MEDICAL ECON., July 18, 2008, at 34.
[29] As noted by the *FTC/DOJ Report*, "[f]urther experiments with varying co-payments and deductibles based on price-and quality-related factors such as the 'tier' of service that consumers choose can help give consumers greater responsibility for their choices. Such responsibility will also likely increase consumer incentives to use available information on price and quality." *FTC/DOJ Report, supra* note 22, Executive Summary, at 21.

information technology infrastructure and practices being open non-traditional hours (such as evenings and Saturdays).

Initiatives that reward quality and tier clinicians according to how they achieve quality goals have an impressive track record. While these initiatives are impressive in their variety as well as their benefits to patients, such initiatives are driven by similar reasons and shaped by key principles, while retaining flexibility and room for innovation. Specifically, such programs involve the following key attributes:

- **Reason for Implementation:** Across the board, the programs seek to enhance and sustain clinical quality, facilitate excellence across provider networks, encourage appropriate utilization of health care services, and improve and promote patient safety.

- **Role of Clinicians:** Nearly all plans indicate that clinicians are actively involved in key aspects of rewarding quality performance programs, including program development, selection of performance measures, and determination of how rewards are linked to provider performance.

- **Emphasis on Specific Measures:** In rewarding quality performance programs for physicians and medical groups, achieving clinical quality goals plays the most significant role in the formula for determining financial rewards. In programs for hospitals, utilization experience/efficiency, patient safety objectives, and elimination of hospital acquired conditions/events tend to play leading roles.

- **Application to a Range of Providers:** Such plans can reach across the spectrum of providers. While some early initiatives focused on hospitals because of more readily-available hospital quality information, programs have extended their reach to include primary care and some types of specialist physicians as well. Some programs have even focused on the inter-relationship between the quality of care provided by different types of providers.

- **Utilization of a Variety of Measures:** Such programs have access to a several categories of quality measures--outcome measures, process measures, and structural measures—and, within each category of measures, a growing number of specific, widely-recognized quality measures. Further improvements can be driven by quality

in conjunction with cost-of-care or efficiency measures; indeed, one key teaching of such programs to date is that quality and efficiency measures go hand in hand.

- **Consumer Incentives:** Plans have encouraged patients through reduced co-payments, deductibles, and/or premiums to use providers that are achieving quality performance.

V. Conclusion

As the above discussion demonstrates, our members are committed to working with stakeholders across the health care community, particularly health care professionals who work on the frontlines every day, to *measure* as well as *reward* physicians, hospitals, and other health care practitioners for high quality performance. These efforts benefit patients, who have enhanced and better informed opportunities to select high quality practitioners; clinicians, who receive valuable feedback on how their performance compares to their peers; and the health care system, as quality information and quality competition, coupled with increased information about cost of care, leads to better informed, better delivered, and more consistent quality care for all.