Florida Blue
An Independent Licensee of the
Blue Cross and Blue Shield Association

Florida Blue
4800 Deerwood Campus Parkway
Jacksonville, Florida 32246

April 29, 2014

Federal Trade Commission
Health Care Workshop, Project No. P131207
"Examining Health Care Competition" Comment Opportunity
Via Web: https://ftcpublic.commentworks.com/ftc/healthcareworkshop/

Dear Commission,

Florida Blue appreciates the Commission's initiative to examine Health Care Competition and invitation to provide comments. Florida Blue, Florida's Blue Cross and Blue Shield company, is a leader in Florida's health care industry. Our mission is to help people and communities achieve better health. Florida Blue has approximately 4 million health care members and serves 15.5 million people in 16 states through its affiliated companies. Florida Blue is a not-for-profit, policyholder-owned, tax-paying mutual company. Headquartered in Jacksonville, Florida, it is an independent licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield companies.

Florida Blue is committed to meeting the health insurance needs of all Floridians and applauds the Commission's dedication to informing policymakers of the impediments to competition, particularly those found in a highly regulated and complex industry that is in the midst of change. As a partner in the nationwide effort to maximize consumer welfare in the health care industry, Florida Blue has made great strides in serving the consumer by improving the quality of care delivered to individuals, families, and employers.

The letter to follow will share our thoughts in response to the questions presented by the Commission in hopes of contributing to policy initiatives that will improve our healthcare system. At the bottom of this letter, we have included illustrations of our delivery transformation footprint throughout the state of Florida.

Thank you for your attention to the contributions of Florida Blue. If you would like to discuss our comments, please contact us by phone at (904) 905-1808 or by e-mail at marc.love@floridablue.com.

Sincerely,

Gordon Bailey
Senior Director
Governmental Relations

Florida Blue Contribution to
Examining Health Care Competition
April 29, 2014

Introduction

The contributions below express Florida Blue's thoughts on questions presented by the Commission. We appreciate the opportunity to contribute to the formation of initiatives that will improve our healthcare system.

A. Practice Transformation Strategies, Resources and Opportunities

1. What recent developments have occurred in the regulation of health care professionals, particularly with respect to accreditation, credentialing, licensure, and supervision/cooperation requirements?

In Florida, the Board of Medicine decided that accredited physicians do not need a previous visit to have a telehealth encounter, which previously was a main barrier. As another aspect, doctors are not allowed to write a prescription for a scheduled drug by telemedicine. Doctors get around this rule by ordering a prescription that a local staff doctor writes.

2. What are the consequences of such regulations? To what extent are these regulations necessary to protect consumers or serve other important state interests? How do they affect the supply of services, patient safety, costs, care coordination, and quality of care?

These are new changes, so the impacts are not yet known.

B. Innovations in Health Care Delivery

14. What are the prevalent and emerging forms of health care delivery?

Integrated and team-based approaches to delivery are the emerging forms, which are often supported by financial risk-sharing agreements based on total cost of care and/or the achievement of clinical and quality measures and objectives.

15. To what extent are health care services being delivered in new formats and locations, such as retail clinics? What trends are projected in the future?

Florida Blue has demonstrated leadership in achieving delivery and clinical transformations in the forms Accountable Care Organization (ACO), Patient-Centered Medical Home (PCMH), Comprehensive Primary Care Program (CP2), Regional Primary Care Programs (RPCP), Bundled Payment Pilots, and Collaborative Care Model (CCM). PCMH, CP2, and RPCP are physician led, and ACO is hospital led. (See the end of this letter for illustrations of our transformation footprint throughout Florida.) We believe this is the beginning of collaborating with providers to help provide them resources, data, and support to maximize the efforts they make every day.

Florida Blue is piloting clinic demonstrations throughout the state which are co-located next door to the Florida Blue retail centers. The clinic scope includes primary care services, on-site lab and pharmacy

services, and care planning and coordination, via partnerships with independent contracting network providers. This integrated service model provides members with improved access to convenient, affordable, quality healthcare. A map of our retail centers/clinics throughout Florida is included at the end of this document.

16. To what extent is telemedicine being used today? What new developments are occurring in telemedicine? What role is telemedicine projected to play in the future?

Teleradiology is a new development that involves the transmission of digitized diagnostic images, such as x-rays, MRI (Magnetic Resonance Imaging) scans and CT/PET scans, to a remote location for interpretation by certified radiologists. In recent years, demand for advanced diagnostic scans has increased significantly, leading to long waiting times for patients and highlighting a shortage of specialized radiologists in many countries.

Telehealth has become a growing, viable alternative to traditional health care to treat basic, episodic medical conditions. Benefits associated with telehealth include:

- Improved patient access to healthcare
- Reduced medical costs through reduction in Emergency Room (ER), Urgent Care and Office Visits
- Established competitive advantage or market parity
- Improved member satisfaction

17. What are the competitive implications of the increased use of telemedicine on the supply of services, cost, quality, and access to care? Does the increased use of telemedicine raise any patient safety concerns?

Increased use of telemedicine should promote health care industry objectives regarding quality of care, access, and cost. Through more ubiquitous use, it is important that the quality of care delivered in telemedicine be comparable to traditional in-person visits. It's also important to demonstrate the potential for lower costs, or an ability to address cost, for services that should appropriately cost less. Finally, telemedicine should provide increased access in all areas of a region, urban and rural.

Comparable quality is a key concern with an expansive roll out of telemedicine in the years to come. Critics of telemedicine cite the importance of the in-person experience and relying on human senses to make appropriate diagnoses. For example, in telemedicine, a clinician cannot smell ketoacidosis of a diabetic patient or the necrotic tissue of a foot injury. However, if advances in technology allow a camera to zoom over fifty times closer than the naked-eye can see, is that not an appropriate "trade-off" for care quality?

The ability to address cost is paramount for the future of telemedicine. Generally, a telemedicine visit costs the physician less overhead and utilizes less clinical time. Florida Blue and other proponents of telemedicine normally cite these savings as accountable care at the population level. These savings are realized as profits for an appropriate provider participating in risk-sharing capitated arrangements like Accountable Care Organizations, Patient-Centered Medical Homes, or Collaborative Care Models.

However, in a fee-for-service environment, this type of arrangement can be problematic and lead to overutilization of services.

An ideal arrangement for Health Plans would be universal use of telemedicine, at a lower cost, high volumes of patients, with a defined scope of services. Lower costs should be the rule, not the exception. The exception should be when telemedicine allows patient access to the best specialists in the country. That exception is deserving of higher reimbursement for that specialist because better outcomes are known to be produced with that clinician.

18. Are there regulatory or commercial barriers that may restrict the use of retail clinics, telemedicine, or other new models of health care delivery? If so, are there any valid justifications to support such restrictions?

Florida Blue does not support legislative activities that would mandate payment amounts or the in-network participation status for telehealth providers. We are currently evaluating a variety of telemedicine and telemonitoring scenarios as opportunities to expand its telehealth footprint in Florida. In general, Florida Blue supports:

- The expansion of telehealth services to enhance Floridian's access to convenient, affordable, quality healthcare
- Relaxing the existing legislative and organizational barriers with inhibit the maturation of telehealth capabilities.
- The free market approach for payment of telehealth services, whereby payers and providers negotiate reimbursement and other contract terms consistent with market demand and our customer's expectations.

22. How are new health care delivery models reimbursed for providing services?

Florida Blue believes that incremental alignment of financial models will bring about change. The alignment of these models is necessary to ensure that change is meaningful. Practice patterns are dependent on the revenue potential, given the need for a practice's sustainability. The alignment of financial models, and the funding thereof, must take into account the availability of services and how that availability corresponds to services needed.

23. Do regulations governing retail clinics, telemedicine, and other new models of health care delivery affect reimbursement? Could these regulations be modified in ways that would improve reimbursement for services provided under new models, better align incentives to implement new models, or otherwise promote innovation?

Regulations should continue to permit flexibility in the innovation in care delivery and payment models. Innovators must focus on specific areas where meaningful change can be achieved. These areas of focus may to some degree differ by organization but should consistently focus on the key drivers of change and the alignment and effectiveness of the rewards.

In the delivery space, health plans will continue to develop programs that focus on achieving deeper, broader, and sustainable integration. Offering provider organizations flexibility on measure-based requirements might allow them to achieve meaningful milestones and realize their highest potential, while at the same time broadening and strengthening their level of integration. One key challenge to integration of this type is the lack of interoperability between electronic medical records, lab systems, and medical devices.

Aside from the work that health plans are doing to transform care delivery, provider entities are venturing to assume full insurance risk. Such entities are, in effect, insurers, and a full-insurance-risk entity entails sound business planning, governance, risk management, and capital resources. The Commission should acknowledge the value of existing insurance regulations, compliance stipulations and other protections, such as marketing and benefit rules, designed to protect beneficiaries, and the importance that they also apply to full-insurance risk provider entities. For example, Medicare beneficiaries would not be insulated from the ailing financial health of an Accountable Care Organization or similar entity. Given the desire to further innovation and foster competition, the Commission should also acknowledge that a level playing field among full-insurance-risk entities is most appropriate for ensuring that consumers are offered secure and reliable health-care choices and that public investment in the health care system is optimized and protected. The importance of preventing any exemption from insurance rules comes down to ensuring the organization possesses the appropriate business, actuarial, information technology, and financial expertise.

C. Advancements in Health Care Technology

25. What is the current state of competition in health information technology markets serving institutional providers, health care professionals, patients, and payers?

The competition in health information technology is quite broad given the various functions of technology, from revenue cycle products to integration system. Over the years, the migration of technology solutions has generally been towards using a single-vendor solution. The predominate rationale being that a single-source solution for multiple functions eliminates differing and often incompatible software interfaces, thus increasing overall administrative efficiency. However, the migration to single-source solutions will not eliminate all interfaces.

There are still ancillary software products that will cause fragmentation. Moreover, there will continue to be new large-scale entrants, especially with respect to population management. United's Optum is a good example. Optum is not a traditional health care software vendor but is realizing and creating efficiencies in spaces that a health plan cares about, namely health management capabilities. Options in this vein are also in the market and can add to the fragmentation via multiple health plans. For example, a health-plan-related software vendor will offer solutions to plans lacking a technology partner.

26. Do innovators in health information technology face barriers to entry? If so, are these barriers significant impediments to competition? How might these barriers be reduced?

Barriers for innovators will vary by the segment of health information technology. Some systems, like payment systems, are very mature. For that segment, the market has been saturated over time, and a new

entrant would have to provide something extremely innovative to enter. It is difficult for an entity to remove and replace a large-scale technology implementation. However, even in the context of mature systems and technologies, there may be gap-filling opportunities that innovators can fill.

Innovators are challenged to understanding the needs of the market, the proxies of legislation and regulation, and the finances and brand management association with potential customers. The health care system and its markets are changing, so the new innovations that are coming out may be ahead of their time in places. The ability of those forefront innovators to succeed in the market will depend on their purchasers' understanding of the landscape and the feasibility of making a change.

The market is not ready to adopt many of the emerging innovations. Health care providers typically are not at the head of the curve for adopting new technology. There is also the consumer aspect and their willingness or impetus to engage. The consumer engagement piece can be pivotal. On one hand, the consumer can be provided with tools for interfacing, while on the other hand, the consumer's desire to engage the tool may be wanting. The Commission should acknowledge the unique role that a health plan can play in engaging consumers. In this regard, consumers should be engaged to focus on meaningful outcomes and not just individual episodes. Patients generally follow the physician's lead, and physician hesitancy to change may be a barrier to consumer transformation.

From our perspective, there is a lot of competition and change across the health care system is creating it. There will likely be many niche opportunities that emerge. Over time, there will be mergers, such as with EMRs, for example. But the value of one technology will not be as great as it as competition is driven to different points of value across the system. The commoditization of technology products can imply that there is no more "innovation" left and direct participants and new entrants to find new areas for innovation.

29. To what extent are information technology vendors and health care providers sharing patient health information? Are there significant impediments to the useful flow of patient health information to improve health care coordination and quality?

Information flows can be limited to the exchange medium. In a closed health information exchange, the flow is most effective. However, when information sharing is opened up further, interface and work-flow issues arise, and sharing becomes a much more challenging and time consuming effort. The barriers to broader exchange of information include inconsistent interfaces, varying and often burdensome processes, and the trust among participants. The trust issue, though, appears to be dwindling.

30. Do recent health care technology advancements raise standard-setting, network effects, or interoperability issues?

Interoperability issues are always raised whenever new technology emerges and lead to establishing and updating applicable standards.

31. What has been the impact of health information technology advancements and policies on physicians and other caregivers? What has been the impact on patients?

The evolution of standards around financial transactions have reduced costs and removed deficiencies. Similarly, clinical transactions, as they take shape, should show improved quality outcomes. EMR interoperability, for example, should lead to improved outcomes. Improvements in quality related to the use of technology should come in conjunction with shifting decision-making to the consumer. The Commission should acknowledge the important role of health plans to engage the consumer and harness and encourage meaningful and efficient use of technology to improve health outcomes.

32. Does the adoption of particular health care technologies lead to increased switching costs and customer lock-in issues?

The adoption of certain health care technologies create lock-in and increases in switching costs. Large-scale integrated delivery networks, for example, that implement a $500M to $1B dollar system will be locked in for sometime. Lock-in is not limited to large-scale adoption, though. It occurs at smaller-scales and where there is dependency, such as rural group tapping into to a larger parent system.

33. Are there other factors that should be considered when analyzing the competitive implications of emerging health care technologies?

Health care industry is evolving significantly, even beyond health care technology. Provider organizations are entering the insurance industry, for example. A topic we address above, under Question 23. As we see more change in the industry, new forms of health care technology will emerge. Mobile devices, while innovative, may lead to severe disintegration. The burden an organization may face to play in all applications will grow, no different from the requirements of participating on Facebook, Twitter, et al. The potential for massive disintegration may cause a significant delay in adoption of such technologies.

D. Measuring and Assessing Quality of Health Care

36. What challenges are encountered when measuring quality? Do these challenges differ depending on whether process or structure measures are used, versus outcome measures?

One notable challenge to achieving desired outcomes is the expectation of the patient. Such expectations are derived from advertising, education, and historical and customary experiences. Oftentimes, a patient's expectation or demand for service will not align with the relevant quality guideline or standard for care. These situations result in exceptions or deviations from the desired transformation. The point-of-care scenario is a human engagement that traditionally has not focused on a joint patient-doctor effort to balance the needs of the patient with the availability and appropriateness of treatments offered by the doctor.

39. How is quality information shared with various health care decisionmakers, including patients, providers, employers, and payers? Are there better ways to convey such information?

The sharing of quality information operates on the premise the information will be used meaningfully. There is broad concern that providers are burdened by the complexity of measure-based compliance. A large number of measures, as opposed to a select few, can be overwhelming and challenging to

aspirations for results-driven management. Health plans have forged successful delivery models through an innovative framework focused on a few key goals that an organization accomplishes sequentially.

Competition on quality must derive from existing context of measurement-based compliance and the differences realized through related activities. The Commission should encourage the evaluation of set of measures through the lens of a value-stream analysis, which could yield findings that would allow for a prudent redesign of measure sets and methodologies, which vary per health system and stakeholder (e.g., Medicare v. Medicaid v. private market). There may be value in reducing the number of quality measures throughout the system. In terms of increasing competition based on quality, alignment and simplification of measures may facilitate quicker development of sustainable quality practices, thereby allowing an organization to subsequently shift its focus, in a sequential manner, to other measures and then allocate the resources and attention necessary for a subsequent success.

40. Does available quality information empower patients, providers, and other health care decision-makers to choose more cost-effective and better care?

Florida Blue has found information sharing to be very helpful and an essential part of bringing about transformation. To share an example with the Commission, Florida Blue makes information available through a provider scorecard, consisting of information on quality measure achievements and care gap closure opportunities, along with total-cost-of-care benchmarking. The report card is backed by an online provider portal, called the Quality Efficiency Reporting Portal (QERP) that allows providers to reference more granular data and add information that Florida Blue can use to modify their data.

The scorecard is provided to participants quarterly and presents of a rolling outlook of performance that is supplemented with monthly updates of data packages. Participants are given the ability to manage PCP-attributed populations by product and track member health risk statuses by month for past 24 months. Practices are also presented with a Generic Dispensing Rate that is compared to peers for the past 12 months. In total, there are 31 different quality measures in five different categories, which are compared to the state's mean. These quality categories include pulmonary management, preventive services, pediatric immunization, diabetes management and cardiovascular care. The display of quality measure gaps and opportunities is a source of actionable information. Participants log-in to the online portal to drill down into the analytics of their scorecard and update quality care-gap information and identify the health status of members. The financial component of the scorecard displays total cost of care by medical cost category to identify performance improvement opportunities. Per member per month information and utilization trends from prior reporting period are also presented to identify cost drivers.

Practices enjoy having additional Florida Blue resources at no cost and third-party resources at a reduced cost to help them in their transition to a patient-centered medical home (PCMH) as well as in obtaining PCHM recognition. We continue to collaborate with our providers to provide them with real-time, actionable data. We also update quality goals based on yearly changes to the HEDIS measures. The program is designed to improve quality and control cost and, fundamentally, the program has not changed since its launch. However, we continuously work to improve reporting, communications, and goals, knowing ongoing changes will be required as we move forward.

41. Does available quality information facilitate improved care coordination?

Yes, continuous quality improvement through the use of technology and the effective use of evidence-based guidelines help transform practices to bring increased value to their patients. In addition to the use of quality information, Florida Blue has been successful in initiating transformation by transforming practices where they are and then offering them a path to further improvement through collaborative exchange. Under this principle, a transformed practice is one that adopts a culture of prevention, empowers patients, and understands what motivates patients. Equally important is helping practices embrace the role that cultural, religious and health literacy play in motivating patients: Speaking to patients in "living room language" to reach them where they are.

42. Are there ways to improve quality information so that it is more useful to patients, providers, and other health care decision-makers?

Transparency in health care has been defined as providing reliable public access to accurate, timely, and understandable information about health care quality, cost and efficiency. The purpose of transparency is to facilitate informed decision-making by patients, providers, payers and others to achieve better health outcomes. Florida Blue supports the following proposals to encourage greater transparency in the delivery system:

- Provide sufficient funding for the establishment of a viable health information network. Such a network could enable the efficient and effective collection and distribution of data needed to promote transparency. Successful network implementation requires measures to protect privacy and educate users.
- Compare the effectiveness of new health care products and services to those already on the market. Comparative effectiveness research should demonstrate clearly net benefits and customer value. This will encourage transparency and inform decision-making among consumers and payers.
- Develop and implement transparency models that support clinical integration and quality over quantity. Provider and patient incentives must be aligned. Data must be appropriately adjusted to equalize comparisons, allowing for the correct measurement and evaluation of those incentives. Transparency models must include uniform data elements to measure the cost of care. Quality measures and metrics must demonstrate the effectiveness of the delivery system, including health care providers and the procedures they perform.
- Provide value-added and easily accessible resources and engagement tools for consumers, agents, and providers that provide information, facilitate decision-making, and promote wellness. Health insurance plans have a responsibility to provide their customers with tools to decipher complex health information. Florida Blue strongly supports efforts to increase transparency to inform consumers about provider quality, procedure prices, and plan performance. These tools should be data-driven by standardized quality and cost indicators to allow for meaningful comparison; however, standardization must be limited so as not to impede valuable innovation. Tools should be easy to use, product-appropriate, provide actionable information, and produced by consumer-trusted resources. These tools and services must be linked to incentive programs to promote adoption and encourage continued use. Employers should also be encouraged to strategically inform employees regarding the wellness benefits of certain behaviors and educate by illustrating a path to healthier behaviors.

- Support tools, such as government rating systems, that provide fair, valid, and useful information to consumers about health plan choices. Ratings systems, public or private, should employ performance criteria for which plans can be held accountable. Government ratings should abide by guidelines for administrative simplification and avoid intergovernmental duplication of effort.
- Share relevant and aggregated health plan data with regulatory agencies and others in order to facilitate decision-making. Health plans retain voluminous data about how consumers behave and the tendencies in the marketplace. Regulatory agencies and non-governmental organizations could benefit from the availability of aggregated, non-identifiable data to facilitate decision-making that affects public policy.

43. Is a standard measure likely to emerge that would allow patients, providers, and other health care decision-makers to effectively compare providers based on quality?

Florida Blue recognizes the need and opportunity for quality improvement in the health care system and supports an agenda to improve patient safety and health care quality that encourages: collaboration between the public and private sectors; price and quality transparency for consumers of health care; and transformation and innovation of the health care delivery system. Specifically Florida Blue supports the following proposals:

- Compare the effectiveness of new health care products and services to those already on the market. It is essential to have objective analysis of the incremental benefit a new device, procedure or drug will bring to the health care system. This effort should seek to define a set of standardized and manageable metrics to provide an objective understanding about the impact of medical interventions.
- Continue efforts to explore alternatives to fee-for-service payment models that will emphasize quality and integration over quantity.
- Advocate for competiveness in the delivery system. It is always important to maintain an environment that invites healthy competition within a market so that consumers have choice, receive quality at a fair price and are privy to value added innovation.
- Development of a viable health information network. The ability to share vital health information quickly and accurately is essential to patient safety and overall improvement of health care quality.
- Develop, and encourage the implementation of, primary care models that evidence has shown to improve quality and lower costs through better coordination of care. This includes models where patients have a “usual source of care” and where primary care providers provide first-contact care; comprehensive care; long-term person-focused care; and coordination across providers.
- Promote engagement of the consumer. Consumer engagement is essential to compliance with treatment programs and the adoption of healthier behaviors, which leads to improved quality of care and better outcomes.
- Initiate robust efforts to address health care disparities and health literacy. Actionable research that identifies which cultural competence techniques work and the best way for health care providers to learn those techniques is essential. Furthermore, improved patient health literacy and education will create a more informed consumer, which is an essential component of a well-functioning market.

Florida Blue does not support prescriptive, duplicative, and costly requirements relating to quality mandates for health plans. Additionally, quality management should be appropriate to the type of product and delivery model that is being used.

44. Are there other factors that should be considered when analyzing the competitive implications of quality measurement and assessment?

Competition should support practice transformation that decreases cost, increases patient access and improves quality. Competition should drive improvements in collaborative financial models; models that focus on quality, patient satisfaction, and decreased re-admission through improved and collaborative transition of care models. Patient access should look for ways to increase telehealth for rural areas—crossing state lines where it makes sense and transforming license requirements for those providers willing to participate in telehealth programs. Quality improvement should focus on educating and empowering patients to make informed healthcare decisions thereby increasing their engagement, their satisfaction levels and their overall health.

Florida Blue uses financial data as pivotal a performance benchmark. Practices are presented with information on total cost of care by medical cost category to identify performance improvement opportunities. Per member per month information and utilization trends from the prior reporting period are provided to identify cost drivers, and data is risk adjusted to provide more accurate peer comparison.

The Commission should acknowledge the value of these models along with the need to understand systemic, organizational and stakeholder dynamics. Health plans provide specialization in the financial risk management that encompasses improving condition management and health outcomes of members.

- Systemic issues include how the requirements of public programs interact with private multi-payer programs; the potential impact of these models on the quality of, and access to, care regarding vulnerable populations; and the impact of the contextual environment in which Patient Centered Medical Homes (PCMH) and Accountable Care Organizations (ACO) operate (e.g. population health status, economics, culture, politics and health care infrastructure).
- Organizational issues include desired leadership characteristics needed for organizational adaptation to change; feasible financing models; allocation of financial and nonfinancial resources; workflow; and the flexibility needed in PCMH models to address diverse populations and settings.

Importantly, an evaluation of the local market is needed to determine if the area is underserved for clinic services. An assessment of the demographics of the population should be performed to determine the type of services that would be better served for the population (e.g.., Medicare or Medicaid). An evaluation of the local hospital, health systems and physician groups should be performed to evaluate the market to identify available resources for referrals to specialty care services.

E. Price Transparency of Health Care Services

45. What types of benefit designs (e.g., co-insurance, high-deductible health plans, reference pricing) utilize price transparency as a means to control costs while maintaining quality? What degree of transparency is necessary to achieve each type of benefit design?

Florida Blue is sensitive to the need for transparency and believes that member education is a key factor in using transparency to encourage care choices that offer the most value. Health plan literature is an important source of information for members, as it alleviates confusion while creating awareness of benefits. We believe that the private industry plays an important role in creating alternative benefit structures that can control costs while maintaining quality. However, the flexibility in benefit design now possessed by MA plans is must be preserved and not stifled by overregulation. Generally, plans design cost-sharing appropriately in accordance with the needs of their membership. For example, the benefit designs of Medicare Advantage plans protect members from significant cost-sharing imposed by the Original Medicare benefits. In turn, the beneficiary's financial obligation can be reduced substantially under an MA plan, especially in the case of a very long hospital stay.

We recommend acknowledging that innovative benefit designs can serve to improve incentives for providers to decrease costs and improve quality and encourage consumers to seek lower prices and without compromising quality. It is important, therefore, to avoid policies that restrain flexibility on benefit design. Overregulation of benefit design can stifle innovation and, in turn, increase costs and reduce value. Concerns over flexibility in benefit design, such as the lack of standard information causing member confusion, should be addressed by making appropriate information available across the foundational communication mediums that exist between the plan, provider, and member.

Using benefit designs to improve quality and increase value:

Florida Blue has a dedicated interest in incentivizing members to receive care from providers that meet or exceed quality and performance standards. The health care system will need to migrate purposefully, yet strategically, toward value-based reimbursement models that align incentives and encourage providers to improve the quality and efficiency of care. The ultimate objective in care delivery is providing high-quality care that will sustain the quality of life for members. Meeting this objective requires delivering the right care at the right place at the right time. Members deserve a choice of care, and it is important for a component of that choice to be based on information related to provider performance and also appropriate for such choices to be further incentivized where possible through innovative benefit designs, such as cost-share tiering. We are committed to furthering our ability to offer members options to use providers associated with achieving the highest and best member outcomes.

The use of tiered cost-sharing is in ways similar to the concept of value-based insurance design (VBID), which is an Affordable Care Act (ACA) provision that enables health plans to modify benefits in a way that encourages the use of the most effective services. Integral to the ability to incentivize both members and providers, is the flexibility to create plan designs that are distinct by counties or patterns of care within a service area. For this reason, we believe concepts of value-based insurance design may have value to MA. The wide array of health care delivery methods must be considered with the best interest of the patient in mind and implemented in way that adds value and does not contribute to unnecessary utilization. Therefore, we believe the Commission should caution against initiatives that would reduce

flexibility in market engagement through benefit design and, in turn, hamper facilitation of delivering the most effective services by the most effective providers. The Commission should acknowledge that flexibility in benefit design will be an important tool for bringing about positive changes in how and where health care is received and caution against policy that could be too restrictive and possibly deprive plans of the ability to discourage low-value options.

46. To what extent might price transparency enhance competition among health care providers or between different treatments?

The health care system creates, maintains, and analyzes voluminous amounts of data about medical costs, health care quality, scientific research, technological innovation, and patient safety. If easily accessible and user-friendly, these data could empower consumers and enhance their health care decision-making abilities. The issue is how to achieve appropriate levels of quality and price transparency to allow consumers to make informed health care decisions, which will deliver better value to them.

Price transparency is just one important element of data among others that must be harnessed and used by industry in a meaningful and efficient way. Consumers must have access to information regarding the additional value that new products and services bring to the market, and this goal is further by the meaningful use of various types of information. The paramount goal of a sound, overarching public policy should be to improve quality and effectiveness of care, reduce costs, expand access, protect consumers, facilitate transparency, and inspire innovation.

Florida Blue strongly supports the concept of transparency because of its potential to provide critical information to health care consumers need to make informed choices, fundamental to the concept of a free market. Florida Blue has been and continues to be an industry leader with its customer support tools and network of retail centers that enhance the customer's engagement with health care. With respect to health care delivery, information sharing is extremely critical and essential to the success of bringing about transformation in clinical practices—where a practice adopts a culture of prevention, patient empowerment, and patient motivation to increase value. At the bottom of this letter, we have included an illustration of our clinical-practice transformation footprint throughout the state of Florida.

47. To what extent might price transparency facilitate price coordination among health care providers and thereby undermine the potential benefits of competition?

Confidential agreements among providers can be perceived as working against openness. However, an exception to that premise exists where the disclosure of certain proprietary information can actually inspire the type of anti-competitive practices governments seek to prevent. Disclosure of certain information might lead to the elimination of low-cost producers in competitive markets and force consumers to pay higher prices. It is at this juncture that health plans play a unique and essential role between the member and provider to ensure that services received by the member continually improve in terms of quality, outcomes, and efficiency. The Commission should acknowledge the important role that health plans play in bringing about competition among providers. Florida Blue encourages the Commission to address the benefits of a policy that supports the harnessing and driving of provider competition with respect to value.

48. Are there ways to focus the use of price transparency so that it enhances competition without resulting in negative consequences?

While price transparency is an important paradigm for helping cost and quality, it must not discourage responsible, competitive business practices. Hospitals, providers and payers have keen interests in confidentiality, and as part of the freedom to contract, agree to protect proprietary information. For example, if certain competitive information is disclosed, incentive to strive for innovative approaches that will improve quality and lower cost over time could be challenged. In light of this concern, the Commission should acknowledge the unique role and responsibility of health plans to provide their members with guidance and a means to decipher complex health information.

Florida Blue strongly supports efforts to make available any additional data that can be used to inform consumers about provider quality, procedure prices, and plan performance. We believe that price transparency can further the goals of improving the quality and value of care—cost data offers one more piece of the puzzle to support data use that increases the value and quality of care from a medical outcomes perspective. The Commission should encourage responsible and credible analyses of data, which take into account sample size, statistical meaningfulness, accuracy reasonability, risk adjustment, and the appropriateness of methodology.

49. What is the relationship between transparency of price and quality information? Is price information more meaningful to patients, providers, and other health care decision-makers when combined with quality information? Do pricing data alone provide sufficient information to enable meaningful health care decisions?

We believe that price transparency can further the goals of improving the quality and value of care—cost data offers one more element to support data use that increases the value and quality of care from a medical outcomes perspective. The following supplemental information would be helpful in establishing a greater context and thus understanding of payment data: paid claims, patient volumes, specialties, location, procedure codes, years in practice, and average practice costs. Payment data at the most granular level may improve important analyses on quality and health outcomes that directly benefit the member. Individualized and line-item detail may provide more value than higher-level, aggregate data to analyses focused on improvement the quality of care for specific members. With respect to delivery and clinical-practice transformation, Florida Blue uses financial data as pivotal a performance benchmark. Practices are presented with information on total cost of care by medical cost category to identify performance improvement opportunities. A member and utilization trend from a prior reporting period is provided to identify cost drivers, and data is risk adjusted to provide more accurate peer-to-peer comparison.

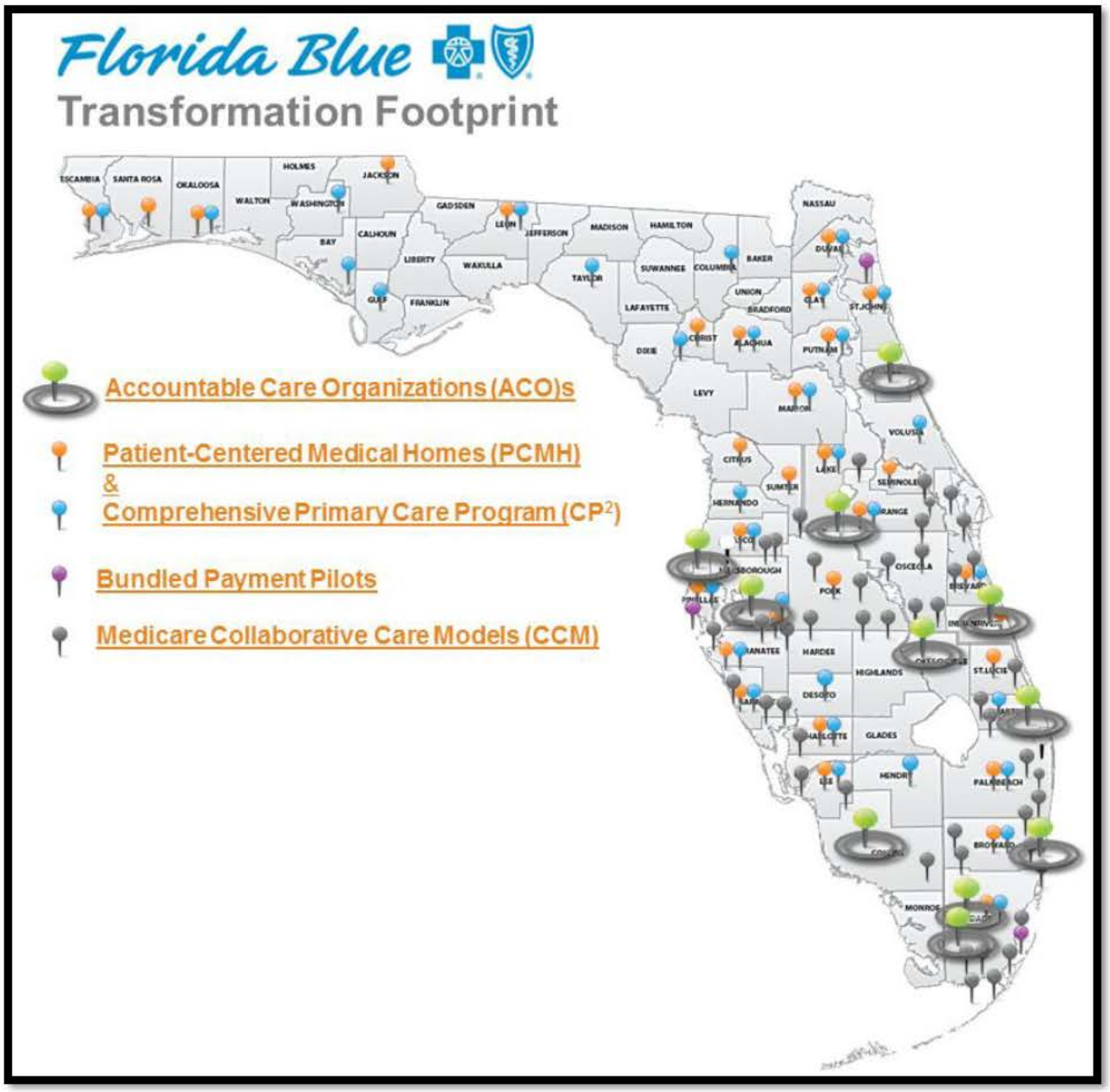
50. Are there other factors that should be considered when analyzing the competitive implications of price transparency in the health care industry?

As a health solutions company, Florida Blue uses data responsibly to present our members with accurate information that can improve the quality of care. Florida Blue stresses the importance of providing physicians with adequate deference to prevent misinterpretation of payment data by the public. Subjects should be given an opportunity to review their data prior to publication, so that errors and other discrepancies can be addressed. The Commission should encourage responsible use of price data and, to

the extent possible, prevent the likelihood of misconceptions that might unduly harm the reputation of a provider. As stated above, price transparency can further the goals of improving the quality and value of care. Cost data offers one more element to support data use that increases the value and quality of care from a medical outcomes perspective.

FLORIDA BLUE CLINICAL TRANSFORMATION MAP

Note: Pin drops represent county penetration in general and are not intended to represent specific locations.



FLORIDA BLUE RETAIL CENTERS/CLINICS MAP