March 21, 2014 Workshop Transcript: Examining Health Care Competition

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FTC Conference Center
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[START OF WORKSHOP, DAY 2]

TARA KOSLOV: Good morning, everyone. We're going to go ahead and get started. Hi. For those of you who were not here yesterday, my name is Tara Koslov. I'm the deputy director of the FTC's Office of Policy Planning. I'm very pleased to welcome you to the second day of our workshop examining healthcare competition.

I'm going to provide just very few remarks. Most of them are administrative. And I apologize for those of you who were here yesterday, but I need to read these again. And then I'm going to give a really brief overview of our road map for what's going to be happening at the workshop today.

As far as the administrative details, please silence any mobile phones, BlackBerrys or other electronic devices. If you must use them during the workshop, please be respectful of the speakers and of your fellow audience members. Please be aware that if you leave the building for any reason during the day, you will have to go back through security. Please bear that in mind and plan ahead, especially for our panelists, so that we can remain on schedule.

Please try to avoid having conversations in the hallway directly outside the auditorium while panels are in session. The background noise from the hallway does carry over into this room. It can sometimes disrupt the discussion, and it may also be picked up on the microphones for the webcast. Because the microphones we use for that are very sensitive.

For those of you who are not familiar with this facility, the restrooms are back out through the hallway to the left of the security guard desk under the elevator banks. In the unlikely event that an emergency occurs and the building alarms go off, which we very much hope will not happen, please proceed calmly to the main exit in the lobby. Assemble across the street on the sidewalk in front of the steps of Georgetown Law School. And at that point, security guards will let us know when it's safe to return to the building.

Let's see. A reminder that again today, lunch is on your own. And if you don't know the neighborhood, we do have a handout with a list of some lunch spots in the area. There's a table outside in the hallway where we have some materials. And also it's possible that some speakers

or other organizations have put materials as well. We just want to make clear the FTC does not necessarily endorse any of those materials. We just provide the table space as a courtesy.

If you have any questions throughout the day, please find one of the FTC staff that have the conference badges, or the people sitting at the registration desk. And we would be very happy to help you. Quick note also about the webcasting and social media and our Q and A process -- so hi to anybody who's watching on the webcast. We hope the technology is working well for you.

We've done our best to get all of the speaker materials loaded ahead of time so that the webcast viewers can see them. If any materials are not available during the webcast, we will be posting those on the conference website as soon as possible following the workshop. For anyone who's on Twitter, we'll be continuing to live tweet the workshop at hashtag FTC health care.

And interestingly, yesterday -- I am one of people monitoring the Twitter feed. There are a fair number of tweets coming from within the room, which is a kind of fun. So be careful who you're sitting next to. We do have comment cards that are available. You may have seen them out in the reception area.

And we're doing our best to get questions from audience members during the panels. And we go around in the aisles and collect the comment cards. It has been a challenge for us to get to those questions, because our discussions have just been so robust that we've not always gotten to the audience comments.

But I do want to assure you that we're very carefully reviewing all those comments and we will continue to look at them as part of our inquiry. So please don't hesitate to jot down a question if you have one and send it in, even if we're not getting to it. It really will be important to our discussion after the conference.

I think that is all of our administrative stuff. As far as a very brief sketch of what we're going to do today, as we were putting together the substantive outline of what we hope to achieve with this workshop, it became clear that quality and transparency were two really core issues that we thought were fundamental to looking at competition in health care.

And, although we recognize that there were individual aspects of each of those topics that we really wanted to be able to delve into deeply, it also was very obvious that there was a lot of interplay between those two topics. And in fact even in talking about them, we would struggle with trying to figure out how to separate those issues.

And so the way we reconciled that for purposes of designing today's agenda is we have separate panels on both quality and transparency, so that we can tease out the issues that are unique to those. But then we're having this round table, which will be the first session after lunch, where we're going to bring together a number of the panelists to cover both topics and try to have a really robust conversation that focuses specifically on the interplay between the two topics.

And so we hope that that will be interesting and useful to everyone. And then the final panel of the day will be a list of veritable rock stars of health care policy who are led by our own rock star, Marty Gaynor, the director of our Bureau of Economics -- our own health care policy rock star.

And we're hoping that that panel will enable some reflection on the themes that we've heard over the last two days, and perhaps also look ahead to identify either topics that were touched upon but might need more inquiry, more investigation, or some topics that we have not touched upon but that are core to looking at health care competition, and that the FTC might want to look at in some way in the future. With those remarks, I'm going to turn things over to the moderators of today's panel. And I thank you all very much for being here.

PANEL: MEASURING AND ASSESSING QUALITY OF HEALTH CARE

Moderators:
- **Gary H. Schorr, Attorney, Health Care Division, Bureau of Competition, Federal Trade Commission**
- **John P. Wiegand, Attorney, Western Regional Office, Federal Trade Commission**

Panelists:
- **Andrew Baskin, MD, National Medical Director for Quality Performance, Aetna**
- **Helen Burstin, MD, MPH, Senior Vice President for Performance Measurement, National Quality Forum**
- **Lawrence Casalino, MD, PhD, Livingston Farrand Professor of Public Health & Chief of the Division of Health Policy and Economics in the Department of Healthcare Policy and Research, Weill Cornell Medical College**
- **Kate Goodrich, MD, Director of the Quality Measurement and Health Assessment Group in the Center for Clinical Standards and Quality, Center for Medicare and Medicaid Services**
- **Patrick S. Romano, MD, MPH, FACP, FAAP, Professor of Medicine and Pediatrics, Center for Healthcare Policy and Research, UC Davis School of Medicine**
- **Shoshanna Sofaer, DrPH, Robert P. Luciano Professor of Health Care Policy at the School of Public Affairs, Baruch College, City University of New York**

GARY SCHORR: Good morning, everyone. Thanks for joining us today for this session on measuring and assessing health care quality. I'm Gary Schorr. I'm an attorney in the Health Care Division of the FTC's Bureau of Competition.

With me here is John Wiegand, who is an attorney with the Commission's Western Regional Office. Information about health care quality is of interest to patients, providers, insurers, employers, and other stakeholders. As Consumers Union noted in a comment that it submitted in advance of this workshop, reliable, trusted, usable, quality information is essential for competitive markets and for consumers to shop with confidence in the health care marketplace.

But how best to define, measure, and communicate quality information? And how can quality-related information enhance competition? We have an amazing panel with us here today who's going to help us consider these questions. I'm going to turn it over to my co-moderator, John Wiegand, now to introduce our panelists.

JOHN WIEGAND: Thank you. We're going to introduce our panelists in the order in which they will appear. First up will be Larry Casalino. He is the Livingston Farrand Professor of Public Health, and Chief of the Division of Health Policy and Economics in the Department of Health Care Policy Research at Weill Cornell Medical College in New York.

Second up this morning will be Helen Burstin. She's a senior Vice President for Performance Measurement at the National Quality Forum NQF. Then we will hear from Patrick Romano, Professor of Medicine and Pediatrics at the Center for Health Care Policy and Research, UC Davis School of Medicine, followed by Kate Goodrich, the Director of the Quality Measurement and Health Assessment Group in the Center for Clinical Standards and Quality at the Center for Medicare and Medicaid Services -- short, CMS.

And then we'll hear from Shoshanna Sofaer, who is the Robert P. Luciano Professor of Health Care Policy at the School of Public Affairs, City University of New York. And then, rounding out our panel will be Andy Baskin at the National Medical Director for Quality Performance at Aetna. Larry, you're first up.

GARY SCHORR: And as he gets ready, just the design of the program today is each of our panelists will make a presentation. And then when they're all done, we'll have some time for questions and answers. As Tara mentioned earlier, to the extent that there are any from the audience, please pass those up on the comment cards and we'll get to them if we can.

LAWRENCE CASALINO: OK, well, thanks. It's a privilege to be here. Trying to get where I can see my own slides. So you're going to be hearing from some real quality measurement experts. And I would not put myself on their level, but I'm going to try to provide an overview of the topic as I see it.

And when I was thinking of about what to say, I really thought about it from the point of view of, if an antitrust agency was thinking about looking at a merger or a clinical integration claim or a purchase of a physician group by a hospital and wanted to think about in terms of quality, what kind of things might be thought about.

So I can give the conclusions briefly at the beginning, or can quality management be used effectively, for example by the FTC, to evaluate mergers or acquisitions or clinical

integration? And I think the answer would be, 10 years ago, I don't think that quality could have been used very effectively -- quality measures, I should say.

Today, I think they can be used much more effectively. But there are a lot of caveats, and I'll probably spend most of my 10 minutes on those. Because of the caveats, it's vital to think critically about any quality measures that you might be looking at if you're the agency, or anybody else, really. And because of the caveats in using quality measures, I think that looking at processes that an organization might be using to improve quality is still an important thing because of the limits of measures themselves.

So 10 years ago, there were relatively few quality measures -- relatively few. In general, I would say it's fair to say there was a lack of appropriate risk adjustment for clinical factors at the time. Some people would argue that still the case for some measures. And there was a lack of data, by and large, from which one could do measures.

Now if I'm not mistaken -- Helen can correct me if I am -- the National Quality Forum has approved, so far, more than 700 quality measures. And there are measures for a variety of care settings, of types of patients, and of physician specialties, and also, obviously, measures, as I said, many settings -- so hospitals, nursing homes, and on and on. So now to the caveats.

First of all, measuring the performance of individual physicians, and I might add also of medical groups, unless they're really large -- I'll come back to this -- and even some hospitals. It's difficult to adequately just for risk. We talked a little bit about risk adjustment for SES. I'll talk a very little bit about quality versus value, time lag between organizational change and change as one might see in performance on quality measures. And then extremely briefly on the use of appropriate analytic designs.

So measuring the performance of individual physicians, say, or medical groups -- it's a real problem, because of the small end. Now if you're dealing with a cardiac surgeon who's doing -- I was going to say hundreds, but this may not be so true anymore -- but doing many bypass operations a year, you may have a big enough N to do a reasonably good measurement, assuming you can get the risk adjustment right.

But probably for most physician specialties, for most things that they do, it's really difficult to get a large enough N to reliably measure the performance of that physician. There's actually some pretty good data that shows that this is true even with medical groups, even surprisingly large ones. I should have put the reference on this slide, but there's an article a guy named David Nyweide took the lead on, in JAMA a few years ago. I was actually a co-author on that article.

Looked at how large did a primary care medical group have to be, using in Medicare data, to get reliable measures that could reliably detect a 10% difference in performance between that group and other groups. And it looked at total cost to Medicare, rate of admissions for congestive heart failure, hemoglobin A_{1C} -- just ordering it really, or doing it -- -- mammography as a performance measure and ambulatory care sensitive admissions.

And the short answer is that for groups of 10 and under, which is still where probably most of the physicians and primary care physicians in the United States practice, you really could not reliably distinguish, on any of these measures, performance. And you really had to get up to 50 physicians, which is a pretty large group, as things stand, to get any kind of decent traction on three of these measures.

And even for groups of 50 and much more, for readmissions and ambulatory care sensitive admissions or preventable admissions, you couldn't do well. So I don't want to spend the whole 10 minutes on that. But this is a real problem which is too often ignored. And some people would say, it's too often ignored by health plans, for example.

So risk adjustment obviously should be done for clinical factors. It's likely there's still going to be unmeasured risk, even after good risk adjustment. And this could disproportionately affect providers who care for sicker patients that could be academic medical centers, or for socioeconomically disadvantaged patients. Probably should be risk adjustment for SES. This has not been commonly done.

There is a -- NQF has been working on this hard recently. There's been a committee that's worked on it. And it's possible that NQF is going to recommend at least that measure developers either say how their measure should be adjusted for SES, or why it shouldn't be. The

basic thought, I think, is that it's easier to have low readmission rates or high mammography rates, say, if you're taking care of affluent people in Marin County, California, near where I used to practice. than if you're taking care of people in the Oakland ghetto.

And I could go into the reasons for that, but there's not time. One thing I do want to mention is, it's often thought this is true that -- well, OK. Maybe you need to adjust outcome measures, like readmission rates for SES, but you don't need to readjust process measures, like mammography rates, for SES. I think that that's just wrong.

I would say that if the patient has to do something for the provider to get a good score on the measure, you should think about adjusting for SES. So if you're looking at central line infections in the hospital, a patient really doesn't have to do anything to prevent the central line infection. That's up to the hospital and the physicians. I don't think you need to do SES risk adjustment for that.

But if you're talking about mammography rates, where someone has to take off work and has to have their schedule organized, and has to understand why they should get a mammogram, and has to have transportation, and has to have childcare, it's different if you live in -- if you're a poor person than if you're an affluent person.

Quality versus value -- just to say that probably, ideally, an agency wouldn't look just at quality performance and not just across, but on value, which is basically quality over cost. It's easy to say that. It's not so clear how to measure value. There are people working on that.

And then just to finish up, I think it needs to be recognized that there's likely to be a time lag between when there is an organizational change -- a merger, say -- or an IPA declaring itself clinically integrated or an acquisition. Likely to be a lag between that change than any changes in quality. And in fact, because there's a disruption of changes, it's quite possible that, for a year or two after a change, quality could get worse.

It might get better after it. This poses real dilemmas, I think, for an antitrust agency that's wanting to look at an acquisition or merger, say, that could happen, or even that has happened. You don't really want to wait around two or three years to see what's happening.

And then finally, analytic design. A lot of provider organizations will say, well look, we were at x before and now we're doing x plus 2. We're a lot better, and so leave us alone. But it could be that the rest of the country is actually doing x plus 4. And so you have to -- these simple pre, post studies aren't good enough. You have to look at trends.

And ideally, you would look at trends both for the organization that's under review and some comparable set of organizations. And this is a circle difference in different studies. This is easy to say, but not necessarily easy to -- it's not necessarily easy to find good comparison group in practice.

So just to conclude, I think it is worthwhile to try to evaluate quality. The available data may not be decisive, and the time frame may be a problem because the data may not be decisive. I think it's still important, and will be for some time to come, to take a careful look at the processes that an organization is using to improve quality, and to try to evaluate, are they plausibly likely to actually use quality.

This is the method that the FTC has used, to some extent, in the past, in evaluating, for example, clinical integration programs. This slide is actually inappropriate, since I'm the first speaker. But we can consider it after the last speaker speaks as well.

JOHN WIEGAND: Helen.

HELEN BURSTIN: Hi everybody. It's a pleasure to be here with you today. Do I pull up my slides? They just keep coming? Aha. Magic. So I was asked to take a -- no, it's fine. I could just press down. Thank you, though.

So I was asked to do more of a quality landscape, give a historical perspective sort of where we are and where we're going. So I'll try to do that this morning and in 10 minutes. So I was also asked just to give you a little bit of background on NQF, if you don't know who we.

We are a public-private partnership, a nonprofit that is a standard setting organization that's responsible for coming up with the national standards for health care quality. We have more than 400 organizational members, and across a wide range of groups. And I think what's

really unique about NQF is the fact that our governance structure has a majority of consumers and purchasers helping to make those final decisions.

So, different than many tables where they're often not at the table -- they're in the table, and actually in the majority. But also, get to have that interplay of health plans, providers, health professionals, industry, all the table at the same time, trying to come to consensus. As you might expect, it can be a little messy, but it's quite interesting.

And part of what we do is really try to catalyze improvement through trying to think about how we can foster improvement, endorsing these consensus standards that I'll mainly talk about today. But also I think, important prospective issues for us is, how do we start getting feedback on measures that are in use? Are they working, are they not working? Are they leading to any unintended consequences? -- to make sure that what we're actually doing and investing a fair amount of dollars in, and measuring is actually both meaningful, accurate, and driving improvement. And if it's not, we need to pull back on those.

So why do standardized measures matter, the endorsement work that we do? I think a big part of this is ensuring that providers know how they're doing, because they can benchmark and compare to others; allow payers to purchase on the basis of value rather than volume; guiding patients and purchasers who buy on their behalf to seek out and find good medical care, and alert them to any safety issues.

Finally, really making sure we can reduce the burden that's associated with lots of the cacophony of measures in use. We had a meeting just yesterday, actually, talking about measure alignment all day, and what could we do to reduce -- almost the way FDA refers to lookalike drugs – there are a lot of lookalike measures out there that people are using that are just slightly different, that don't add value but actually kind of add a lot of noise to the system.

Just a little historical view on this. We think about quality of having been around for a very long time. But in fact, if you really look back, it's not as long as many of us would think. But it really does go back to the early '90s. Some of the early work that NCQA did around HEDIS for example.

And then moving on to some early reports. For example, the President's Advisory Committee on Consumer Protection and Quality in Healthcare that actually recommended that an NQF be created as a result of that, to have a place where everyone could come together and decide how we could get quality measures. And to Larry's point earlier, we didn't have very many then.

We actually have a good number now -- not always in the right places where we need them. And that really then was followed on by the very important seminal IOM reports of "To Err is Human," around patient safety, followed up by "Crossing the Quality Chasm" in the early 2000s. And then a national framework came forward to really think about how we would measure and report quality.

More recently, and I think pretty pivotal, and especially as you think about your role, the whole value-based purchasing piece that you'll hear more about certainly from Kate, really began around 2004-2005. And that has gradually grown over the years. And I think that is increasingly becoming a major focus of health care quality, and particularly outcomes measurement.

And then, over time, increasingly getting a sense of what national priorities are important, building towards the release of the National Quality Strategy in 2011. But also the many quality provisions in ACA as well, that are also really driving additional work in thinking through quality measurement and improvement. And those six national priorities that emerged through the National Quality Strategy really give us a road map of where we want to go.

As you think about where we are now versus where we want to go, these six priority areas show us where we really want measures. And in many of those instances, many of those cross-cutting areas are exactly where we don't have measures. We have very few measures, for example, around care coordination or person and family-centered care, effective communication.

And that's where we increasingly are trying to drive where measure development needs to go, and of course affordability being a cornerstone of this, all built on the triple aim of better

care, healthy communities, and better care. So just a couple thoughts about a high level view of where quality measurement is going.

I think increasingly, we're seeing a move towards people wanting to see measures that reflect high performance rather than the standard of care -- more optimal measures, more idealized care, rather than what feels like almost measuring the bar. And we've seen more efforts coming forward on that -- increasingly, efforts to align measures across setting, across providers so that we don't get different measures in different settings that don't make sense.

Hopefully, if we get to more of an electronic platform, one of the things I mentioned below, we'll also stop measuring constantly, for fear we'll miss something that in fact is already in a record that we could have picked up on. I sometimes tell the story of my father when he was very, very ill before he passed away. He was in a hospital and very sick with sepsis and somebody came into his room to say, Mr. Burstin, have you had a pneumococcal vaccine? The man was so sick. Not the right time, not the right place. But in fact it was a standard they needed to meet. But in fact he'd been at that health system for all of his care for a decade. It would've been so easy to know he already of course had had one. And he was so sick. This was not the right place or the right time. So measurement should happen when it's appropriate, when it drives improvement, and not just constantly to meet a standard. We need to move to measures that are more patient-focused, more patient-centered.

There's a real move towards patient-reported outcomes, for example. I've already mentioned the transition to the electronic platform, and I'll come back to that. And we also need to move towards broader measure types, like a composite, where you can take multiple measures that are all related, put them together in a single score.

It's not only more meaningful for consumers and other purchasers of care, it actually becomes more meaningful as well to clinicians, to understand the broader picture of what they're doing, rather than slicing and dicing everything down. And lastly, hopefully with better systems we can increasingly address disparities in all we do, prospectively rather than retrospectively looking to see if there were disparities present that we should have been tracking.

There's also a significant preference now for outcome measurement over process measures. And increasingly, we wanted to make sure those outcomes of care, as much as possible, are linked to things we could do something about. But if we are going to continue to measure process measures, they should really only be done if we know they can move the needle. By measuring this process, you can drive improvement.

If they're just process for process sake, we need to stop it, because it's just adding burden and not adding value. These are the way we do our criteria, just to make the case that these are a hierarchy. The most important thing is, is it important to measure and report? And if it's not, we should stop.

Secondly, if you pass that test, is it valid and reliable? And if not, we truly just stop our evaluations but then get into additional issues of feasibility, usability, and use which includes both whether a measure is useful. But also, increasingly in this environment, is it leading to any unintended consequences -- something that I think is becoming very important as more and more dollars and reputation are being attached to quality measurement.

Lastly, the issue I mentioned of harmonizing, make sure we're really not having the current cacophony, but picking the best measures for the best uses. I was asked to just put a couple of thoughts in here about reliability and validity, since it comes up a fair amount. And we really do want to try to get to measures that are both reliable and valid, sort of hitting that target. We don't want measures that are inconsistent but wrong, or consistent but wrong to look at reliability and validity here. It's a really important piece of our work and the work that developers do to make sure we're actually getting a true quality signal, as a result of looking at those measures. And there are some really important threats to validity. We want to make sure it's a relevant outcome, as I've mentioned.

If it's not a reliable measure, it also can't be valid. Differences in patient mix, as you just heard from Larry are oh so important, in terms of outcomes and resource use. We want to increasingly avoid incorrect data that's just kind of systematically missing, and particularly an issue as we move towards electronic health record systems.

The transition to measures for electronic platform -- we know we've got to move to this platform. It is not going to be an easy transition. But increasingly, we want measure development starting from the idea of saying, what could I build differently?

If I start with the idea, I could use data that could be an electronic health record systems rather than building measures from the perspective of what is in a claims system that isn't going to give you the value that you need. And just a last thought about another piece of this that was really missing in our current health care system is the idea of feedback. Very important.

I remember a very important IOM report a couple of years ago -- really made the case that to do our work well, we have to have a continuous learning system. And then we've got to get feedback on whether these measures are actually helping out there. So lastly, just a broad view of this.

We really need to get to the point where measure development begins with the idea of prioritizing those gaps, those really important measurement gaps we have -- catalyzing that gap filling, endorsing measures, selecting the best measures for different uses in different programs, promoting alignment across different programs, evaluating the impact of that, and really making this a learning health system as it should be.

I always end with these slides, these two quotes, because I think it sums it up beautifully. Albert Einstein supposedly said this. But it's in dispute. It was hanging in his office at Princeton. We don't know if he was actually the author of it. Supposedly, an English sociologist may have said it first, but I like it being Einstein.

He said, not everything that counts can be counted, and not everything that can be counted counts, which I think is kind of where we are in measurement at the moment, in quality. So much more we want to get to. But we also know we can improve what we don't measure. Thank you.

JOHN WIEGAND: Next, we'll be hearing from Patrick Romano from the perspective of development of different measures of quality.

PATRICK ROMANO: OK. Good morning, everyone. I'll just disclose at the outset that I have no commercial relationships, but I do a fair amount of contract work with public agencies that are involved in measure development. Are the slides coming up?

TARA KOSLOV: You just have to keep -- just keep going down, Patrick.

PATRICK ROMANO: I come to you from Sacramento Valley. Sacramento is perhaps the second most important capital in the country. It's also home of my university, UC Davis, which is the top land grant college, food and ag school in the country. So some of my analogies will come from that sector of the economy.

So first let me just start with the broad definition of quality. If we want to measure something, we have know what we're measuring. So quality has been defined by the as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes, and are consistent with current professional knowledge.

Note two components of that definition -- the focus on outcomes that Helen has described, as well as a focus on what we know -- evidence-based practice. Similarly, Bob Brook, Beth McGlynn have highlighted the importance of positive changes, or slowing the decline in health. Mark Pauly, along with some economists, have argued for a broader definition that may include amenities.

But that's not widely accepted, by certainly the NQF or other stakeholders here today. So this graph shows how the IOM has conceptualized the domains care in its recommendations for the National Healthcare quality reports. They describe six components of a high performing health system -- effectiveness, safety, timeliness, patient centeredness, access, and efficiency.

And these five domains apply across all types of care -- preventive care, acute care, chronic disease care. Equity and value are seen as cross-cutting themes. In other words, everything else that we do here, we should do equitably and we should do with value. So these are our critical themes.

Now an analogy from food. This is my medical center, UC Davis Medical Center in Sacramento. On the upper left is Wright County Egg in Iowa which housed 15 million chickens, and was the producer that was at the epicenter of a salmonella outbreak a few years ago.

And what's interesting about this is when you look at the food safety process that preceded this epidemic, this was the state's inspection of this facility. And what's notable for the state's inspection is that it lasted 15 minutes. And most of the different features that you would expect to be relevant here were NO, not observed.

So why was that? Well, they said, well, somebody else is doing it. The USDA is doing inspections. And they've always been a good producer. So here's the USDA inspection. And sure enough, in this inspection they do report S's for satisfactory -- a couple U's. But what's notable here is that they only inspected the shell egg plant, which is where the eggs come. And they're washed and they're cleaned and they're checked. And they're put into the cartons. But nobody was actually checking the facility where the chickens lived.

And so when that facility was later inspected, they found that it was so full of fecal material that it was literally exploding out the side of the facility. So the message here is that we have to measure everything to have a safe and reliable health care system. We have to have more measures, not fewer. Because whatever we don't measure is what will break down.

So I'm going to talk about the perspective of people who use information. Shoshanna will be talking more about consumers. But we have to realize that health care market's an interesting market, in which physicians are often making decisions on behalf of their patients, recommending hospitals or nursing homes, as well as payers and purchasers maybe steering patients toward particular health care organizations or providers.

When I think about an efficient market that works well, that provides information about cost and quality, I think about food. I think about the farmers' markets that I go to. And for those of you who were shoveling snow last weekend, this was our farmers' market in Sacramento.

And what's nice about this kind of setting is that everything is right there. Everything's transparent. You can look at the quality of the produce. You can look for rot. You can look at

the prices that are clearly posted. You can see whether they meet standards for organic production or not. And barriers to entry are low.

So here's a market in kitchen appliances, where the barriers to entry are high. But there's great information, as a result of Consumer Reports and others that describe not just the features of the appliances, but also their reliability, user reviews, so forth. So how do we get this kind of well-functioning market? What do we need to know?

Well, I think we need to know more about the accessibility of care -- how soon can I get it -- about the quality of the service, about the safety of the service, about its reliability, particularly over a long period of time, and its value. So these are my quick ratings of how we're doing in general, in these domains. I think in terms of accessibility, there are some measures of patient recorded experience from the CAHPS program.

But Yelp may be able to help us more, with some anecdotes. I'll show you an example in a second. In terms of service quality, we're doing pretty well. We have pretty good measures of the process of care, and what doctors and hospitals and nursing homes do in the course of providing care.

In the area of safety, we have a good portfolio of measures now. But mostly just for institutions, hospitals, and long-term care, not much outside there. And for long-term reliability and value, I think we're doing pretty lousy.

Just a few slides to illustrate what's currently available to consumers and decision makers in the market. So this is from the medicare.gov hospital compare site. You'll hear more on that in a couple minutes. But you can see that they report information about patients' experience, timely and effective care, 30-day readmissions, complications and deaths, and some other things.

Accrediting agencies like the Joint Commission also put some information out in the public domain. This tends to be focused on specific service lines, specific areas of care -- heart failure, pneumonia, diabetes, in this case surgical care. States, in many cases, have got into this reporting business on their own.

Many states use a portfolio, a set of tools that's developed by the Agency for Healthcare Research and Quality, called the AHRQuality Indicators. And this website is produced by a tool called MONAHRQ, My Own Network by AHRQ, which allows users to input all pair claims data from hospitals, and output data on various aspects of hospital performance and utilization.

Employers have gotten active in this space, so the Leapfrog Coalition does an annual survey of hospitals' safety practices. They also harvest publicly available data on safety-related events. And they compile a hospital safety score. Consumer Reports does something similar to this now.

And then you can go to Yelp or a couple of other websites, and you can get star ratings. But what's nice about this is you can also get these kinds of individual reports. It's kind of richer information about the patient experience. So there's a lot of stuff out there. We've learned a few things along the way. We've learned that quality measures are hard to develop and validate.

It's often not clear what the best measure is, what the gold standard is. There are a variety of biases, and Larry's talked about a couple of these biases that are involved in quality management. These measures are expensive to collect if they're not based on readily available administrative data.

We don't have -- like I just heard the Boeing 777 that's disappeared has 3,000 sensors on it that automatically track all aspects of the performance of the airplane. So once we find the airplane, then we'll be able to figure out what went wrong. But we don't have any system like that in health care.

Quality does vary across providers. We know that. But we know that quality is not a single construct. So some hospitals do really well in one area, not so well in other areas. Very little consistency across different aspects of care. Also, the quality gaps do tend to diminish over time.

So as we go through experience over a few years with measures, the performance tends to rise, which is a good thing, and gaps tend to diminish. We also know, as Helen's alluded to, that the structural and process measures that we traditionally focused on are weakly correlated

with outcome measures, which should tell us one of two things. Either there are patient characteristics that we're not adequately accounting for, as Larry's described, or there are unmeasured aspects of physician performance, of health system performance.

And I think in the case of hospitals and nursing homes, it has a lot to do with what nurses do, which is often under-appreciated, because it's so hard to measure that important aspect of care. This is a CMS slide just to show how complicated this process is for developing, testing, and implementing measures.

This is from the AMA's physician consortium for performance improvement, showing that there's a life cycle of quality measures -- that they're born, they're implemented, they're tested, they're adapted, they're refined, and then eventually, perhaps, they're retired. So this is an ongoing process.

An anecdote from my experience, and then a couple of conclusions. So my 87-year-old uncle lived with us for a few months. And he decided to give up, in his wisdom, his Medicare benefit, because he thought he was going to retire to Panama, and he would never use Medicare again. So why have Medicare? But during his time with me, he became depressed.

And I did my best to try to find someplace for him to go for support. But anyway, he took it on his own to go into the emergency room one morning. He didn't go to this website, but he could have, any would have seen that the wait at my medical center was 40-some minutes, which is a bit longer than the national average, but very similar to the other hospitals across town.

So, seemed like a good place to go. Sure enough, everything looks very clean, very efficient. When you go in there, everybody's very nice. But absolutely no mention about price or value. And then the bill comes -- $11,000, basically for getting a referral which turned out to be useless, and a prescription. $7,000 for 45 minutes with a psychiatric social worker, $700 for a blood alcohol test, because he might have been drunk at 9:00 in the morning.

So -- I'm going to skip that -- so what am I worried about as we go forward in this area? Well, I think that reliable and valid quality measures will increasingly drive competition. But

there are incentives, as the measures become more important, to gain these measures through under-reporting of complications, through risk selection.

So we have to be vigilant to those potentials. There is a potential for increasing disparities affecting those who are left out of this information economy. And there's this continuing tension between the cost and value of measures.

There may be increased competition among plans in the federal and state marketplaces, but there's evidence of decreased competition among vertically and horizontally integrated providers. The effects of that consolidation on quality vary. I'm sure we'll be talking about that later today. But they're often negative.

And what we found is it's very time consuming to evaluate each perspective measure individually. There are always claims about quality that are being made, and they have to be debunked, one by one. And it's like constantly trying to knock down this meritless claim that keeps coming back up.

So this is going to be an ongoing challenge for the antitrust agencies. So my takeaways -- healthcare markets desperately need information about quality. There's a lot more that's available now than there was 10 years ago. But we still need more measures in certain domains.

The gradual shift to outcome measures must continue, but there does need to be attention to risk and disparities. This process is painful and costly. That can't be avoided. And we need more measures, not fewer measures. And antitrust agencies do need to protect competition, or we'll surely see increased prices with no quality benefit. Thank you.

JOHN WIEGAND: Next, Kate is going to speak to us from the perspective of CMS.

KATE GOODRICH: And I think I'm going to stay here because I don't have any slides, if that's OK. So I'm going to start off talking a little bit about the CMS performance measurement strategy, although I hope you all remembered everything Helen said, because what she spoke about really is our strategy.

So I only have to reiterate a few points there, which is why NQF has been such an amazing partner for us. We're very aligned in how we think about it, I think. I'm going to shift the conversation a little bit more to talk about, in a little bit more detail, about transparency of quality and performance information, what we're doing at CMS to increase the transparency of information, so that it is more usable by consumers.

I'll speak a little bit of the specifics about the Physician Compare site, because there's been some significant changes to that site recently that a lot of people have been very interested in. And I'll also talk a little bit about the Medicare Blue Button, and finally end with a few words about price transparency and some recent efforts by the agency to make prices more transparent.

So on the CMS performance measurement strategy, as Helen noted sort of historically, the landscape of measurement has been that we're very much measuring in silos, even across like programs within CMS- for example, the physician programs or the hospital programs. We may have had different measures within different programs.

And what that does is that really increases the burden of reporting on providers, where it becomes this chore that has to be completed for multiple different payers, or even for the same payer. It also really increases the noise out there in the system. If you have so many measures that -- the way I've always kind of thought about it as being kind of scattershot -- measure here, measure there, without any real strategy behind how we should be measuring.

And that has really started to change since, in particular, the publication of the national quality strategy that Helen alluded to in 2011. We recently published our CMS quality strategy, which builds upon the national quality strategy, and goes a little bit deeper into the specifics about how we plan to address each of these six priorities that were identified in the national quality strategy.

And there's a measurement construct around each one of those. So we've really been focused lately on, as Helen pointed out, moving to outcome measures, sort of rebalancing our portfolio of measures to be less process measure-heavy. Doesn't mean that we think we need to remove all process measures.

Some of them do have value -- a lot of them don't -- but really trying to rebalance so we have more outcome, appropriate use, safety -- and I think in particular, we need to do better on safety in the outpatient setting -- cost, resource use, care coordination, et cetera. And patient-reported outcome measures have become a big priority for us as well.

And this is especially important as we move into a value-based purchasing construct across the different types of providers. Our goal is to move more towards electronic measures and use of registries and potentially input of electronic measures to registries, so registries can give frequent feedback, or even at the point of care feedback to providers.

We still use a lot of survey-based measures, like the CAHPS family of measures, which are patient experience measures. And we still think administrative claim measures have some value. They do need better risk adjustment. We are starting to develop hybrid measures that use clinical information from electronic health records that can be combined with the administrative claims for our outcome-based measure.

So we're starting to test that concept. And of course, the alignment of measures not only across programs within CMS, but with private payers and with states. Very, very difficult task, but there's a lot of goodwill and interest in doing that from all parties. So it is, I think, an optimistic time.

I wasn't going to do this, but I can't help myself. And I may be a little sorry that I have -- I'm going to just say a word about the whole SES adjustment thing just very briefly. This is a very complex issue. So I don't want the takeaway necessarily to be that there's a universal opinion about how we should do it, and even if we should do it.

NQF has been convening a panel on this. We've been very involved with that. Our position has always been not to risk-adjust for socioeconomic status within our measures because of the concern about masking disparities, and potentially rewarding providers who provide a lower level of care for minorities or poor patients.

But it is not a black and white issue -- sorry, no pun intended there -- because I think we talk about race at the same time as we talk about SES and whether we should adjust for that. But just to say, that is something we are still grappling with within the agency, and I think

grappling with a lot of people who are on this panel, as well. So I just want to make clear that it is, I think, not a settled issue yet. So, just to say that.

A little bit about public reporting -- so we have been developing a public reporting strategic plan. We have identified consumers and patients and their families as the primary audience for our public reporting sites. However, we know that others include researchers, providers, policy makers, are also audiences for the website.

So we've been working hard to try to make the quality information more accessible to consumers, but also addressing the needs of these other audiences, because we think that's really important. So we've been thinking about what would our ideal state be for public reporting? And knowing we can't get there right away, we're in the process now of identifying what the next future state would be for our compare site.

So one element of that is that we are moving all of our compare sites to five star ratings. So currently, Nursing Home Compare, Plan Finder, Physician Compare, and starting in 2016, healthcare.gov when we start putting up quality measure information on the health plans, are all in the five star framework. But currently, Hospital Compare, Home Health Compare, Dialysis Facility Compare are not.

So by the end of 2014, or at latest, very beginning of 2015, we will have started that transition to five star rating, where we plan to have star ratings for the different domains of the national quality strategy, like safety, clinical outcomes, care coordination, that kind of thing, where we have those measures.

And ultimately, by the end of 2015 or early 2016 that we are fully into the star rating mode, including having global stars for the different providers. We also do reports. Some of our more technically complex measures through data.medicare.gov again for researchers and others who are interested in that.

Moving to Physician Compare for a moment, in 2010 we re-purposed the medicare.gov health care provider directory to create Physician Compare, as was required under the Affordable Care Act. We use the underlying PECOS system, which is information about physicians and other clinicians.

That system, though, has historically had a fair number of inaccuracies in it. So in 2013, we launched the redesign of that website, which had some major enhancements, in particular improving the underlying database about physician information, so linking the PECOS system to claims, in order to verify the information in PECOS.

We also implemented an intelligent search function, so that patients can go on and search by body part, because patients and consumers may not always know the name of a specialty, like neurology or urology. So this, I think, made it a lot easier for searching by patients and others.

And it really provided the foundation for inclusion of quality measures. So this has now become sort of what we think of as our current state. And we do know that it needs to continue to be enhanced, but it is a big improvement, we think.

So February 21st of this year, we released for the first time performance information on large groups and ACOs, on five quality measures around diabetes and coronary artery disease. First time we released performance information on physicians or physician practices.

By the end of 2014, we plan to publicly report results on CG caps -- that's the clinician group caps measure. It's a patient experience measure for groups of 100 or more and ACOs. And that in 2015 we plan to expand the set of measures that are reported by groups of physicians.

And the reason we're starting with groups is it's a lot easier to start with groups. This is really, really hard stuff to be able to get to publicly report performance information down to the individual clinician level, which is our goal, but which requires a lot of data validation and thinking through exactly what the right measures are to put out there on individual clinicians. So we are working towards that goal. We hope to get there by into 2015, 2016. But there's a lot to do along the way to get there.

The other thing is that we have a new reporting mechanism for physician groups -- sorry, not groups -- for individual physicians, for our physician programs, called the Qualified Clinical Data Registry. And what this is, is this allows physicians who are already reporting to a local quality collaborative for their medical specialty board or for their specialty society to use

that performance information for the CMS program purposes, so for the physician quality reporting system and the physician value-based modifier.

So one of the things we proposed last year but we didn't finalize was that those clinical registries publicly report the clinician information. So we did require they have a plan for public reporting, but our goal is ultimately to be able to publicly report that information one way or another, either on Physician Compare or by the registries themselves.

And I think in our ideal state, we'd be able to link performance on quality measures by individual or groups of clinicians to the healthcare.gov website. So when a consumer goes on to choose a health plan, they will be able to also link to the physician performance information of physicians who are under that health plan. A couple of words about my Medicare Blue Button.

This is -- Blue Button generally is a broad initiative across payers. It's not a CMS initiative by itself. We launched our Blue Button program in 2010. And what this does is this allows patients to go on our website and download information about essentially claims data, so what's been paid for services that they have had. And so far since 2010, about 1.1 million claims files have been downloaded by 800,000 beneficiaries. Some private companies have developed smartphone or tablet tools to allow receipt of that information in a much simpler format that can be shared with their provider or with family members.

Prior to talking about transparency at the NQF meeting two weeks ago, I downloaded my mother's information. So I'm responsible for the care and keeping of my mother, a 76-year-old Medicare beneficiary. And so I downloaded her information, and was shocked to find that Medicare paid $10,000 for her colonoscopy the previous year, which by the way could not even be completed, and so had no useful information.

So we were both a little bit surprised by that. But it was really neat to be able to see what was paid for each separate service. And of course now, my mom thinks that she is single-handedly depleting the Medicare trust fund, which I'm trying to assure her is not the case.

But I think that is such useful information for patients to have. And finally, a couple of words on price transparency. If there are questions about this, I will try to answer. I will say this work has not been in my group. But it's very exciting work that's been happening.

So you all may remember in May of 2013 that CMS released hospital-specific charges for more than 3,400 hospitals that were paid under the Medicare IPPS system. We released average charges for the top 100 most frequently billed discharges, and this represented about 60% of total Medicare inpatient discharges.

And then in June of last year, we released additional data on hospital outpatient services, including about 30 different types of hospital outpatient services such as echo cardiography, clinic visits, and endoscopies. These have been downloaded and viewed more than 600,000 times since being released and we've received a lot of great feedback about this from a lot of different stakeholders, researchers, consumer advocates, who have long called for greater transparency in prices.

And then in January of this year, we published a federal register notice which modified our longstanding policy on disclosure of physician payment information. So under our new policy, we will be evaluating requests for individual physician payment information on a case by case basis. And we posted a blog in January of this year that said we planned to generate and make available aggregate sets of Medicare physician services for public consumption.

And so we should be releasing this sometime in the near future. I don't know exactly when. I don't have a website to give you, but that should be coming up soon. And I will stop there.

JOHN WIEGAND: Our next speaker will be Shoshanna from City University of New York. She's going to bring to us the consumer perspective.

SHOSHANNA SOFAER: Good morning. Being a consumer is different. We see the world differently. And what I'm here to tell you is that as a health policy analyst, I can follow most of the arguments that I have heard made today, and I understand the points that people are making.

But the way that consumers think about health care, think about quality, if they think about it at all, and the way they go about making the decisions that we are trying to influence is really very different. And I'm going to try in this presentation to point out some of those differences.

But I want to begin by saying, why do consumers matter to improving quality and safety? And what it really comes down to is that in this work, our primary focus has been on the role of consumers in selecting health plans, in selecting providers, and in selecting, sometimes, even treatments.

So it goes beyond that, because sometimes, for example, if I have back pain and I decide that I want to go to a physical therapist, that right there is a treatment decision and a provider decision simultaneously. And we don't really think about that combination of how people go about it. Do I want to go to see an orthopedic surgeon or an orthopedist?

Probably, from the evidence, not, but you might want to go see a physical therapist. So there are all these decisions that people are making. But there are a lot of limits on how much choice consumers actually have, and how much choice they perceive they have. And they generally perceive that they have less choice than they actually do have.

And that, I think, is one of the problems that we're facing with rolling out strategies that build on consumer choice as a major driver of competitiveness and of improving quality and of improving safety. The theory behind public reports for consumers -- and it's a theory that I argued for in 1984, when I submitted my first proposal to get funding from what was then the Health Care Financing Administration to figure out how to provide people with Medicare on information about costs of different health care coverage options that they had at that point.

We didn't have any health care quality data in 1984, so I was looking at out of pocket costs, which is very much a kind of a traditional consumption role. So, what I was trying to do, was simplify. I was trying to hide the complexity of the making of a financial insurance decision for people who don't understand what the difference is between copay and coinsurance, who don't understand what a deductible is, who don't understand what an uncovered service is, who don't understand their health insurance.

And it was really clear that most people do not understand their health insurance. And particularly, they don't understand how it affects them financially. So, I went about the business of trying to make it easier for people by saying, let's say you had a heart attack. Let's figure out how much you would have to pay out of pocket for your heart attack, under different

health insurance coverage options. And that's what I did. I had to do an enormous amount of work to get to that number. But people didn't have to do that work. They just got the number. And this was a randomized control trial, and you know what? It worked.

People really were much more conscious of what their costs were, and they were making much more prudent decisions, based on the fact that they could see that two different health plans that had -- one had higher premiums than the other, but the one with higher premiums was also going to cost them more in out of pocket costs, which we're trying to deal with right now with our medal approach to the health insurance exchanges. But in that totally unstandardized market, this was a way to get people that information.

And one of the things that I learned about myself very early on in my life, I was never a math person. I was just never a math person. But then I actually went to work for the federal government right outside of college. And I was given a lot of work to do to revise people's budgets. And I discovered something about myself -- that when people put a dollar sign in front of a number, somehow it meant something to me. Suddenly, I was able to manipulate it. Suddenly, it was concrete instead of abstract, quite literally. So, people were able to look at these dollar amounts and say, yeah, this is what I need to know.

So, consumers make decisions in their own way. The theory that we have is that people will look at comparative quality -- hopefully, they'll also look at comparative price -- and they'll make a choice that will move the market. That's the underlying principle. And I don't think that this has worked the way we thought it would.

What we've been trying to do, for 30 years now, is provide more comparative information to help people make those choices. But what we really need to understand is that people don't even know it's there. I'm going to say that again. People don't even know it's there. We are not promoting the availability of this information.

And much of the information is extremely difficult to use, and is not relevant to the way that patients make decisions, and the way that consumers make decisions. I'm going to beat up on CMS for a minute, Kate. Please don't take it personally. I'm not going to beat up on Patrick right now.

But the first thing that you put out, many years ago, were the core measures -- these 10 process measures. And you continue to obsess with these three illnesses -- congestive heart failure, heart attack, and community acquired pneumonia. How the hell did you think that consumers were going to want to use this information to choose a hospital? What are they going to do, tap on the shoulder of the ambulance driver and say, no, I don't want to go to that hospital. I want to go to this hospital.

These are what we call in our work non-shoppable conditions. So you didn't go into the mind of the consumer to pick what kinds of conditions you would use in order to be able to open up your quality game. You would have wanted to go to childbirth, where it is a shoppable condition.

A woman becomes pregnant. She is not sick. She's well. She's got a lot of time to make a decision. She's computer-savvy. Do childbirth, do orthopedic surgeries.

Same thing, hip replacement, knee replacement. You know way ahead of time that one of these days, you're going to need a hip replacement or a knee replacement. You've got time. You're in pain, but you're not sick. You've got time to think about this.

This is the way that I think about the kinds of information that consumers need. But it is not the way the field thinks about it. And you are not the first group of people that I've shared this with, but this is a movement, if I can call it that, that is very resistant to really paying attention to what consumers think, and how they want things to happen.

So let me give you some examples of where people are. There is basically a lack of recognition of quality and safety problems among consumers. They think everybody's good. So, they don't think they need to look at these data.

When you show them the data and they see the differences, when you show them the data like you've got a captive audience, and you show them the data, then they get it. And then they are appalled by the differences.

But by and large, they don't, because they're not looking at the reports. They don't know what the differences are. And they're resistant to looking at the reports because they don't know what the differences are. So, that's a first problem.

In addition, there are real limitations of an awareness of differences across providers except in one area, which is actually the part of the CMS website that people have gone to the most, which is nursing homes. See, people think nursing homes are bad -- all of them. So they're actually more interested in looking at data about nursing homes than they are data about hospitals.

But why else aren't they interested in looking at data about hospitals? It makes eminent sense. Their hospital choices are limited by what plan they're in, who is in their network and who isn't.

But even more profoundly than that, they don't think they're making the choice about what hospital they're going to go to. They think their doctor is making the choice. And one of the things that is a real mismatch that we're facing right now is that from the perspective of a consumer and the patient, Patrick here is the most important person in the health care delivery system because he's a physician, as are all of the other people on this panel.

I know for a fact that Larry spent 20 years, very happily, being a primary care provider. And his patients thought that he was the most important person in their health care. They did not think that anybody besides their doctor made much of a difference -- besides their nurses, they do love nurses -- in their hospital care.

And what's the data that we currently are completely unable to give patients? Data on individual physicians. So this is -- I mean, I know what the technical problems are. I know what the technical problems are.

But I'm just here to tell you that what patients are really looking for is what we are not giving them -- and not just about primary care, but about specialty care. And I also hope -- and this was referred to earlier -- that physicians start using more of this information to make their specialty referrals to physicians, instead of using their old boy and old girl networks, and their prestige, reputation-based assessments, or who else is in their multi-specialty practice.

They don't have the data. They think they know, but they don't have the data either. So, these are all things that are really problematic.

Let's also talk about hospital measures. Do I really want to know about the quality of a hospital? With respect to patient experience, yes, because that's cross-cutting. But if I'm going to the neurology service, their quality may be very different than what's happening in the oncology service.

And none of what we're doing captures those differentials. None of what we're doing captures those differentials. And in fact, oddly, when we first put out the CHF pneumonia and AMI data, people thought that those data indicated, in fact, that this was how the whole hospital performed. And CMS was appalled at this because that's not what they want. That's not the impression they wanted to give at all. How am I doing for time?

GARY SCHORR: We were just passing you a note on that.

SHOSHANNA SOFAER: OK. I'm out of time. So, I have a lot in here that I'm not going to be able to cover. But I guess my basic message here is that we know a lot more about public reporting than we're using. There is a lot of research, there is a lot of evidence, there's more research being done.

For example, by the way, Larry, a couple of people mentioned this. Some people are actually studying the use of these open-ended comments in addition to numerical things, as a way to supplement the technically more valid scores. But we have a lot of evidence.

But the people who are putting the reports are -- and I'm going to tell you again, Kate, Doc, including CMS. CMS has ignored a lot of feedback that it's gotten about how consumers respond to their websites, because it's very difficult to change them. But again, if we're really serious about consumers being a part of this strategy, we have to pay a lot more attention to what they think, how they make decisions, and how they use information. And we also have to communicate to them that these data are here.

JOHN WIEGAND: Thank you. And our last speaker in this panel will be Andy Baskin. He's going to bring us a health plan perspective from Aetna.

ANDREW BASKIN: Thank you. Come over here. And I will stay here because I am slideless as well. I'll also try and filter my comments based on what I heard, so it may change the flow a little bit. So I apologize for that.

When I look at the health plan perspective, I think of myself as a consumer provider in those eyes when I make my decisions working for health plan, to be honest with you. Because at the end of the day, that's my customer.

The problem that I often say can be stated in almost one line. About five years ago, I was asked, how many top one hundred hospitals there are in the United States. And at the time, there were about six different major national surveys about rating systems out there. And it turns out, there were 394. So that's the information that's going out to the public.

I can't drive by a hospital without seeing a sign that's saying, I'm number one, number two, or number three in something. And it's not possible, obviously, for that to be the case. But that's the information that's going out there, and that's what people see. And it's a wonder that they ignore that information and don't use it.

So I certainly appreciate Shoshanna's comments about consumers not getting what they need. So I'll try and touch on a couple of topics, the first being -- I'll use the word "competition" only because I'm at the FTC and I felt I had to use it. But how do health plans compete in the quality world is, I think, something I want to say.

And in fact, today we do it differently. I'm not so sure we actively are competing, but we shouldn't be. And I mean, we should certainly be competing on quality, and providing quality, and facilitating quality, and enabling quality, and contracting for quality, and all that. But what we shouldn't be doing is competing on how we measure quality -- not just what measures we use, but the process of doing the measurement, so that you can make some valid comparisons between two entities, whether it be two physicians, two hospitals, two nursing homes, or whatever it may be.

Obviously, if we're not measuring the same measures, we're not measuring the same way, any comparison would be totally invalid. Oh boy, this is terrible. This is going to go out every 15 seconds. I'll have to learn how to make this not happen. What's that?

HELEN BURSTIN: I'll show you at the end.

ANDREW BASKIN: If you would. So we have a situation today where literally two providers can be measured on their care of the same condition. One could come out poor -- the same provider can come out poor or well, depending on who's doing the measurement.

And in fact, they can actually be measured in the same exact measure, and one could be coming out poor and one could be coming out well. And there are various reasons for that -- the data reasons that people have talked about, low denominators. Another interesting point in that from a health plan perspective -- and especially as a national carrier, but even some of the larger regional carriers -- I'm a small part of any provider's panel.

I mean, I may represent 5% or 10% of their patients. And I'm measuring them based on that 5% of patients, 10% percent of patients, and presenting it to the world, presenting it to the consumer, as if that is somehow or another a great measure of that provider's quality, when in fact, of course, this is not. So then, you get into issues about what is the right way to do that? What would be good for a consumer, and frankly, good for the provider?

So the providers are complaining about the burden of measurement, different variations on measures by different plans, by different entities, like whether it be public entities like CMS or Medicaid agencies or state coalitions or whatever else may be measuring them, then coming out different, as I said. And that burden is a lot, but it also produces this discordance of results that makes it very difficult for the consumer.

So one would argue is the ideal world, for somehow or another we all measured the same way, with the same data, with aggregated data. In other words, it should perk up the ears of people at the FTC when I use the word "aggregated." And I don't know the answer to that, except that as a consumer, the answer is obviously yes.

I want to know how this provider takes care of -- and when I say provider, I mean hospitals and physicians -- takes care of all patients with my condition, or for the service that I'm looking for, shopping for, whatever it may be. And that gives me a more valid picture. Now of course, that has other implications in that if you're a provider and you do well, that's wonderful.

But if you're being measured by everybody the same way and we're all out the same score and you do poorly, that could be a death spiral for that provider. Because it will presumably affect patients that go to that provider, affect the reimbursement, because there's a lot of value-based contracting going out there, which is incentivizing good quality care.

And in fact, it's extremely expensive to provide good quality care because there's a lot that has to be done to make that happen. There are a lot of capabilities and re-engineering of offices and IT and like to make that happen. And if you're not getting the incentives, you can't afford to do it, it's literally a death spiral. You'd never make up the difference.

And at the end of the day, the object is not to put people out of business for providing health care. It's to improve the level of health care across the system, because we do need a certain number of providers. And we need all of those providers to perform better. There have become issues here of this data aggregation, as I said.

So there are many efforts today, with all payer claims databases that are occurring in some states, some coalitions, whatever it may be, around the country. Unfortunately, most of them are done differently. So, there are not a lot of common practices amongst those particular databases or all pair claim databases, and what they're measuring and how they're measuring.

So, there's opportunity there for some shared best practices, so that we can get to more of an alignment of how they're doing it, so that not only can you shop from Philadelphia to Pittsburgh, but you should be able to compare the care in Pennsylvania to the care in Iowa. Not necessarily because you personally are shopping for care, but because there are implications on health policy and improving care across the country, and recognizing differences in care across the country, which is rather important because that variation creates opportunities for improvement.

And unless you can understand it, you can't actually do that. There are also issues about presenting data. So presenting quality information. And that of course goes to consumers, but I also mean to the providers themselves. So, we all do it differently, once again, and differences obviously causes excessive resource use and disgruntled providers.

And when I talk about differences, the opposite side of the coin is, so how do we make it all alike? Well, all alike is sort of like a word like aggregation, or no competition, or whatever. But there are reasons to all do it the same way.

So reporting mechanisms -- what kinds of reports? What do they look like? How would you display them to providers and then how would you display consumers? Different health plans do it differently. Can we all do it alike? I don't think it's, once again, something we should be competing on.

That's not valuable to the consumer. It's not valuable to the provider. There are certainly principles out there that many have developed on how to do that. Those principles are voluntary today, although certainly a lot of the larger health plans agree to them. But we should even not just agree on principles.

One would argue that we should all get together and agree on what the report looks like. What are the words? Are we using the same words? Are we using the same format? Does it look alike? Can you drill down the same way?

That would be a value to providers. And I think at the end of the day, it would provide better information for the patients as well. It was mentioned earlier about what level of measurements, so measuring individual physicians, measuring specialists. Very difficult. Not enough measures for certain specialties, certainly not enough measures of the particular services they provide, meaning measures of a doctor performing a cholecystectomy, a gall bladder removal, or an appendectomy, or a herniorraphy, some of the more common procedures done in this country.

But there are opportunities for measures, though, that measure the process of care. Is that doctor providing a discharge summary and delivering it in some fashion to the primary care physician? Is there appropriate follow-up after a mental health hospitalization? Things that are common to hospitalizations, common to services, that do improve the quality of care although it doesn't necessarily speak to the actual skill of the actual performing the event.

But there are certainly opportunities to measure in that way. And you could bring those providers into the fold in terms of measurement. I guess I'll jump down to the end here, as one minute's going on.

So a question that one asks is, do providers need to merge or consolidate to improve quality? And I'm not going to answer that question, obviously. Because that's -- you folks' job to do that. But I will say there are certain almost absolutely necessary characteristics and capabilities to improving quality, at least in my opinion. Or if they're not today, they will be in the future.

There needs to be some accountability across providers, across settings, so it's not just an individual. It's a patient experience from end to end is what we're looking for the quality. There needs to be health information exchange so that information doesn't get lost, redundancies removed, inappropriate events occurring because the information is unknown.

Obviously, care coordination was mentioned across settings. There are a lot of IT solutions involved. In other words, the ability to do data mining, the ability to do analytic work on that data. There has to be some agreement on what you're trying to improve.

We can't all individually try and improve separate things. We're in a system where different parts of the system have to be working together, whether it be you and the hospital or you and the nursing home or you and the physical therapist or the continuum of care for the patient. I think all these are necessary to get quality improvements, to sustain quality improvements.

The question is, can they occur in a virtual way, though a virtual integration, or does it really require providers to be essentially employed together and somehow one happy family? And I would say that technically, yes, all of those things can be done.

The question is, is it more difficult to do? Is there more efficiency, and is there some incremental improvement to that consolidation beyond what you can get in a virtual way, to make that valuable? And I would answer that question, but I ran out of space. So, I don't have an answer. So, I apologize. Thank you.

GARY SCHORR: I'd like to thank all the panelists for their excellent presentations. We're going to head to a little bit of a discussion and question and answer time period now. I want to remind those out in the audience if you have any questions that you'd like to pass up, please pass your comment cards to FTC staff, who are going to come around the room.

I'm not sure if we'll be able to get to those questions today, but we will use these questions in the further work that we'll do following the actual workshop yesterday and today, whether we can get to them or not. So, please pass the questions.

What we'd like to start doing with the panelists, before we ask any questions that we may have, is ask the panelists if any questions have come up in their minds, while they listened to the other panelists this morning? And is there anything that they would like to discuss? No? OK. Well, we'll move on.

And if you think of things as we go along, please do. So, we've talked a lot about the various quality measures and the types of measures and what can be useful. I'd like to take a step back and ask the question, do the quality measures that currently exist foster competition among providers based on quality? And if they don't, what can be done so that we can foster that competition?

SHOSHANNA SOFAER: Can I get a clarification of that? Are you saying -- are you asking whether the actual nature of the quality measures that we're using foster competition? Is there something about the quality measures that either does or doesn't foster competition?

GARY SCHORR: It could be that the type of quality measures, are we using the right quality measures to foster competition? Or it could be the transparency issue. Is the quality information getting out there in ways that fosters competition, or any other aspect that you can think of.

SHOSHANNA SOFAER: Our sense is -- Larry, do you want to --

LAWRENCE CASALINO: No, go ahead.

SHOSHANNA SOFAER: What we have found in looking at the impact of public reports on consumers and on quality is that in fact, there's this second pathway that we talk about, which

is the reputation pathway. And that's, in many ways, been a more powerful pathway than the choice pathway has.

So I don't think that -- we've gotten some positive results. We've gotten some improvements in quality. But people are attributing it rather to the fact that in the healthcare field, people don't want to look bad. And when they don't -- and particularly, I think the power has been in showing quality comparatively.

If we weren't doing that, I think we would be nowhere. So the fact that we're showing quality comparatively means that providers can see who else is doing better. And they don't like to look bad, so they put their energies into improving their quality.

And I think that is driving quality and it's driving competition around quality. But I think it's kind of in spite of the fact that we really aren't getting the information to users who are making choices.

LAWRENCE CASALINO: I'd make three points quickly. One is I would agree with what Shoshanna just said. I think that even lousy quality measures do foster competition among providers, with the caveat that that's large providers, so large hospitals, large medical groups.

Any kind of quality reporting is likely to foster some competition among them. I don't think that it filters down so far that much to, again, to small practices in which large numbers of physicians still practice.

The second point I'd make is that, although competition around quality's being fostered, still, the best way to increase your revenue is not to do well on quality measures, either because of any little incremental pay for performance you might get, or probably even some shifting of consumers, if there is much of that, but to get more negotiating leverage, right? So, you can make -- if you can increase -- if I can get Aetna to pay me 100% of Medicare, 180% of Medicare because I'm now in 100 physician group, as opposed to 95% of Medicare because I'm a solo practitioner, I can make a lot more money doing that than I can do from getting 1% more of revenue from doing well on quality measures.

The third point I would make is that things you need to be done right, or they create tremendous cynicism and bitterness among providers. And I think one could say, who cares what providers think. But that's really wrong. If you have cynical, bitter providers, it's not going to be good for patients.

And things are improving on that, but again, this thing about can you measure the performance of individual physicians adequately, or adequately in that way it's being done really has to be taken seriously. Just because we want to do it doesn't mean it's OK to do it wrong. The last set of quality measures I got, just before I left my practice, was from a large national health plan. It was a list of 50, allegedly, women who hadn't had a mammogram and/or a Pap smear in the appropriate time frame -- my patients, according to the health plan. We pulled all the charts. I said, how could this be, right? Two of the women were men. Five were dead. And of the other 43, there were two where it actually was true that they hadn't had their Pap smear. And I called the health plan in a rage, and they said, haven't you heard from so and so -- our medical director -- because he's calling all the physicians

No I haven't, and I never did. So that kind of thing doesn't have to happen very often to generate a real feeling of distaste, let's say, among providers. And that's not a good thing for anybody.

ANDREW BASKIN: I may say that I get the sense that as providers organize, whether it be physicians and hospitals together, ACO, some accountable care type organization, I'm finding they care more than they used to care. And these are doctors who, in their individual practice, they weren't part of a bigger system that has this kind of culture of trying to push quality.

When they weren't part of that system, they really didn't care. I was in practice as well and received similar letters, although maybe slightly more accurate than yours were. But I was literally on a phone call two days ago with a hospital who has a p for p, pay for performance contract with some quality metrics.

And we had given them the results of the metrics. And there were some dollars involved. But they weren't even going to argue after dollars. It was the quality director calling on the phone. And they literally had gone through the list of every -- hundreds and hundreds of

patients to see whether we were exactly accurate in measuring whether that patient had an adverse event or had a readmission and was it reasonable readmission or not.

But the real reason they were going through that was because, they say, when we're talking to our individual doctors -- and these doctors are not employed by the hospital, but they're part of a looser consolidation -- our doctors need to know that they're providing good care. They care about this, and I need to go back to them and tell them why we didn't do so well on this measure, whether it was good care or whether it was a bad measurement.

But the point of the matter is, they said, they are getting it hard from their individual physicians, who are extremely motivated. And these are the same docs that, five years before when I spoke to them, I couldn't get conversation in the door with them about quality. So it's interesting how that's changing.

JOHN WIEGAND: Any other responses to that? I was struck by a number of the panelists who normally rely on large data sets to draw conclusions, finding some interesting facts out of the health experiences of their own parents. And those seem to relate to the problem of teaching to the test issues, where we have unnecessary things being done so they can be counted. And I'd like to ask our panelists how severe you think this problem is, whether it's statistically significant, and what we ought to do about it if it is serious.

HELEN BURSTIN: I'm happy to start, since I used one of those anecdotes. And I think it's more just to illustrate a point, which at times use words like harmonization and things and it gets lost. And I think it does -- it takes it home in a different kind of way when you put a human face on it. I think, frankly, a good number of our process measures, which is why you've heard such a mantra, I think, on this panel to move away from process measures and more towards outcome measures. Many of the process measures truly are if, then, do this. And so, they naturally, at times, become check box measures. And I think in those instances, I think we do see some teaching to the test, people feeling like they must do this to achieve.

And frankly, in some instances where the performance measurement on a given measure is very high, we've heard stories, for example, of hospitals having people run around to grab the last three patients to get to that highest level, because otherwise their payment

goes down. I mean that's truly not using their staff well, using the resources well to do quality. So I think the more they're moving towards outcomes, it allows them to internally say, what processes do I need to look at that make the most sense, so I can try to move the needle on that outcome. I don't know it's statistically significant, John, but it's pretty impressive amount of overdone work.

KATE GOODRICH: I would definitely agree with that. So, I've worked in a hospital for the past 15 years. And tying back to the original question you asked that's related to this, at the time we were really trying to improve on the Joint Commission measures, many of which are used by CMS as well. Although we've removed a lot of them because they are topped out (because what we would find is that our performance maybe wasn't so good on a particular measure), and rather than thinking about how we improve the quality of that measure, it was how do we improve our documentation, so that ours can be better than the hospital down the street. Now that with value-based purchasing, we're using measures that are more outcome-based -- the hospital CAPS measures, I have seen my hospital really try to focus on how to truly improve the patient experience of care. Because our scores are not so great.

So we prefer outcome or patient experience, especially patient-reported outcome measures, where we have them. Because we think it does allow for more local innovation to drive improvement because what works for Washington Hospital Center may not work for GW, or whatever other hospital you want to pick. So that's why we really are trying to rebalance that portfolio.

I will say a little bit in defense of process measures. Odd to hear me defending process measures because generally we are not crazy about them for our programs. I think when physicians or practices want to use them for their internal quality improvement activities, then they are excellent for that. You'll hear people -- if you ever hear Frank Opelka talk about what they're doing down as LSU -- in their health system, to drive improvement they say their physicians want more measures.

They want more of these process measures. They're not being paid on them, but they are using them to drive to the outcomes that they need because they find them to be very

useful. And that's where I think they really have the most value. And you probably -- I can't say this for sure -- don't get as much teaching to the test in that circumstance.

ANDREW BASKIN: There is a slight concern about medical appropriateness, when you talk about measurement. Because frankly, looking at an outcome of a procedure, you probably get better results when doing more procedures on people that don't necessarily need the procedure, because they're the ones that always do well.

So I'm not saying that this is something that somebody consciously does, but it is a dimension of measurement of outcomes that has to be addressed at some point in time. It's not just how you perform a particular procedure, or whatever service you're providing, but whether the service was really appropriate and used in the right setting and at the right time for the right person.

LAWRENCE CASALINO: I'd just like to briefly mention, because I think it's important. We're actually using, or at least I'm using the word "process" in two ways. And I want to make sure that they don't get conflated. So the panel has been talking appropriately about process measures, as in, did you get pneumococcal vaccine or did a hemoglobin A1C get done or the mammogram get done. So these are process measures.

This is where the word's been used for most of the panel. But I also want to mention -- go back to what I said at the end of my talk, which is look at the processes a hospital or medical group or nursing home uses to improve the care they provide. And that's different.

That's do you use nurse care managers for patients with chronic diseases? Do you have a registry of your patients with chronic diseases, et cetera. So things that probably could increase quality and maybe decrease cost as well. And again, going back to the perspective of, if I were an agency an antitrust agency and trying to evaluate the quality of an organization, first of all I would certainly try to get whatever measurements I could. But then I would look at those measurements critically, and try to decide how much can I really rely on these?

And, secondly, because you may not be able to rely on them fully, and also because you may not be able to wait two or three years to get adequate measures from an antitrust point of view. I would look very carefully at what is the organization investing in processes to improve

quality? Processes to improve quality are not the same as process measures. I just want to make sure everybody understands that.

JOHN WIEGAND: Any other comments on that question?

GARY SCHORR: I think it was during Patrick's presentation, he brought up Yelp. And I have a question I'd like to ask the panelists regarding that. I think Yelp is a great thing when I'm looking for a restaurant.

I'm wondering when you're looking for health care, is that kind of a website or that type of information helpful or is it possibly misleading,because you're getting outliers who might have had problems, and you're not seeing the vast majority of patients who may have been satisfied? I don't know if anyone has thoughts on that.

KATE GOODRICH: There's at least -- just briefly, I know that there is at least one health care system that is doing exactly that. I forget if it's in Utah, or where it is. Somebody sent me to the link the other day. But they are actually doing that.

And what they have found is actually the vast majority of comments, and they insist they don't suppress any comments unless they're vulgar, or just unreadable, for some reason. But the vast majority of comments are positive, but they do post the more negative comments as well, and have found it to be incredibly useful for helping them to improve.

So I think also -- I was going to say the Wisconsin collaborative health care, I know, has considered doing that as well. They're not doing it yet. So, I think that's something that people have heard talking a lot more about. We've actually -- it's come up in our conversations internally at CMS as, maybe is that something we might want to do down the road? We haven't come to any decisions on that. But I think it's very intriguing.

SHOSHANNA SOFAER: So as I mentioned earlier, there is a research project that ARC has funded going on right now that is being done by Rand and the Yale School of Public Health. These are the CAPS researchers. And they are looking at the potential for adding in, in addition to sort of normal type scores, these open-ended comments.

What I also want to share with you is a set of focus groups that we did a number of years ago with physicians, about how physicians wanted to get their comparative quality information. And the physicians said that they were very interested in getting the open-ended comments because that felt more real to them because it's sort of like they could hear the voice of their patients in it.

And so it had more power for them, in terms of affecting them, really -- affecting them intellectually, affecting them emotionally. And I know that as a professor, I get a set of open-ended comments, in addition to getting my closed-ended comments. And they're very controversial, but I find the open-ended comments to be enormously valuable for me.

But I think the problem -- and it's the problem that Rand and Yale are trying to struggle with -- is, how do you aggregate all of these comments in any meaningful way? And I do qualitative research. So I'm used to trying to code and analyze text.

And I'm actually embarking on a project now where we're going to try to do some more of that. But this is tricky from a quote unquote, "science" perspective. And I'm thinking that Helen and her colleagues are going to have, and her stakeholders, may have a hard time with getting this through the reliability and validity criteria for an NQF measure.

HELEN BURSTIN: Again, though, just one quick comment. If it's coming directly from the patient's voice, there's no filtering. There's no evidence for it. It is --

SHOSHANNA SOFAER: It is what it is

HELEN BURSTIN: -- valuable. And I guess the only other thing I'll say about Yelp is the reason it exists is because there's not great other information out there. I mean I think it is sort of where people go when you can't find anything else. I, frankly, picked my last optometrist on Yelp. Every single recommendation was positive. I needed one. It was two blocks from my office. It was convenient.

There was no other place to find an optometrist in DC who is good or bad. It wasn't my preference. If I could have gone somewhere and found better information, I would have used it.

So I think the key is we just need to get better information out there. And I think people will use, hopefully, if it's presented in a way that's understandable -- better information.

And there are probably lessons learned about the way that information is presented, to Shoshanna's point. But I think Kate talked about how we're going to change, potentially, the various CMS sites to make them more user friendly as well.

GARY SCHORR: Thanks. Anyone else have anything on that? Questions?

ANDREW BASKIN: I would just add that it's not just the content of the information which one could argue about whether it's appropriate, it's the fact that it's ease of access to that information. It's the easiest information to get. We don't make health care information very easy. I went over to the site, and let me tell you.

I tried to explain to somebody how we designate, or put there that somebody is a certified patient-centered medical home, accredited through an outside agency. And I had to go through about five drop-down boxes to get it. And so, obviously, that was the information that came to me because a consumer wanted to know that. I said, well, we do have that out there. Because they couldn't find it. So, ease has got a lot to do with it.

PATRICK ROMANO: The other thing I'd say that these consumer-facing websites and developers have done is to really kind of focus on what's the choice that the consumer's actually making? And in many cases, in like choosing an optometrist, geography might be a critical factor. So you can say, search within a mile of this location.

In other cases, a critical factor might be the particular services that are offered, whatever. But I think what we've often failed to do in this measurement enterprise is to recognize that people are only going to use the information if they have a real choice that gives them an opportunity and a need to use that information. And Shoshanna's talked about that, that we report on heart attacks but we don't report so much on pregnancy and hip replacements, elective procedures.

Another side of that is that if you were in a market situation where you don't have choice, if you're in a community where there's only one hospital, or where all the hospitals are

owned by the same organization, why bother looking? So, there has to be a choice set in order for this information to be usable, and for consumers be expected to act on it.

SHOSHANNA SOFAER: Actually, Patrick, what is happening right now within the reporting community is that we're also trying to tell people what else they can do with the information, besides using it for a choice.

So for example, if I'm going into a hospital, and it's the only hospital in my network that's convenient, and I see on the CAP scores that their pain management scores are really terrible, I might want to talk to my doctor about what can you do to make sure that when I'm at this hospital that isn't doing a very good job in this area, what can you do to make sure that my pain is managed while I'm there? And it may very well be that that's a pathway to driving quality as well. That's a very different one than the choice pathway.

GARY SCHORR: OK. I was looking at the questions from the audience and there were a couple on this issue. I just wanted to raise it in the few minutes we have left. So there were a couple questions regarding, we've talked about some quality information facilities. We've talked about for physicians.

We haven't mentioned any non-physician professionals and ancillary providers. So I guess, first of all, are these things being measured, are people measuring these non-physician professionals? And also, I guess to some extent, maybe they're tied to physicians, and how do we separate those so people can be looking at whether these -- comparing quality of these non-physician professionals?

SHOSHANNA SOFAER: Well, there's a very interesting story about a set of measures that NQF endorsed a number of years ago that are called the nursing sensitive hospital quality measures. So, these are hospital quality measures, but they're specifically measures that were identified as being measures over which nurses had a good deal of influence.

And I actually tested those measures with consumers to see which ones resonated with them, and which ones did not. And it was interesting that some of the were wildly resonant. The safety measures were just, like, off the charts.

They loved those measures because they could really get the visceral sense of, this is whether or not I'm going to be harmed. And that matters to people. Other measures were a total bust and somewhere in between. But those measures have now been disaggregated, and they've been mapped onto different kinds of groups of measures.

And those measures are also still hospital quality measures, but at least they were an acknowledgement that nurses do, in fact, have a huge amount of impact on the quality of your hospital stay and of your treatment. But I agree with the commenter. We haven't gone there at all. And I don't think we've even engaged those professions in thinking about how they would define quality.

KATE GOODRICH: On the physician quality reporting system, which by the way has the word physician in the title, which is probably not appropriate because of the 1.2 million eligible professionals, as we call them in our government jargon, that are eligible for the program, 700,000 are physicians. The rest are not. So that is a good number of clinicians who are eligible, and in many of whom do participate in the program.

So, we do have some measures for physical therapists, occupational therapists. The nursing measures -- most of the measures that are used by nurses are -- that submit to our program -- are the primary care measures. But I think it is a very valid complaint that we have received, and I would agree with, that we have not done a good job, as you said, Shoshanna, of recognizing the contributions of those professionals and being more strategic and deliberate in how we have the right measures.

I also think measures that are sort of around team-based care obviously include those professionals. In many ways, they're really the kind of measures you want to get to. We have started having bimonthly meetings with the American Nurses Association to try to get -- that's at least one organization where we're trying to get to where we can have the right kind of measures that represent the care that they provide. So I think we're starting down that path. That is definitely a valid criticism that we have not done such a good job of up until now. But I do think it's really important.

GARY SCHORR: Thank you. Anyone else?

ANDREW BASKIN: Well, perhaps to say that as we move towards accountable care situations or systems, as we move towards that kind of consolidation, and we move towards more measurement of outcomes, one would argue that the measurement of those individual components makes less sense. Very difficult to do, but thankfully we haven't done it and maybe we will never do it.

That really what I want to know when I get my hip replacement is, at the end of the day, from soup to nuts, when I entered the system to when I exited the system, that I had a good outcome. And that's dependent upon the system, meaning that physician who uses that hospital, who traditionally uses that physical therapist, who traditionally uses that home nurse or whatever other components there are. And I'm not so sure the consumer, at least I as a consumer, wouldn't necessarily want to be selecting one from column A, B, C, and D for each of those providers and try and knit together my own system. That's probably very impractical.

JOHN WIEGAND: OK. We are really out of time. We want to thank all of our panelists for preparing, for making the trip here today. And we'd like to thank all of you for being here. We had a number of questions and comments that we were not able to address.

And we want to encourage you to use the comment period that extends out until the 30th of April in order to raise questions, raise points of interest that you have which will relate to future workshops here at the FTC. So we are going to enter a 13-minute break. So we'll reassemble at 10:30. Thank you.

[SHORT BREAK]

PANEL: PRICE TRANSPARENCY OF HEALTH CARE SERVICES

Moderators:

- **Stephanie A. Wilkinson, Attorney Advisor, Office of Policy Planning, Federal Trade Commission**
- **Christine L. White, Attorney, Northeast Regional Office, Federal Trade Commission**

Panelists:

- **Robert A. Berenson, MD, Institute Fellow, The Urban Institute**
- **Áron Boros, Executive Director, Commonwealth of Massachusetts Center for Health Information and Analysis**
- **Andréa Caballero, Program Director, Catalyst for Payment Reform**
- **Patrick Courneya, MD, Medical Director, HealthPartners Health Plan**
- **Paul Ginsburg, PhD, Norman Topping Chair in Medicine and Public Policy, University of Southern California, formerly, President, Center for Studying Health System Change**
- **James Landman, JD, PhD, Director, Healthcare Finance Policy, Perspectives and Analysis, Healthcare Financial Management Association**
- **Mark B. McClellan, MD, PhD, Senior Fellow in Economic Studies & Director of the Health Care Innovation and Value Initiative, The Brookings Institution**

STEPHANIE WILKINSON: Welcome back, everyone, for the panel on price transparency of health care services. My name is Stephanie Wilkinson. I am an attorney adviser in the FTC's office of policy planning. I am joined by my colleague, Christine White, from the FTC's Northeast Regional Office. Together we are going to be moderating this panel.

Just to get started, to give a little bit of background about why the FTC is interested in examining price transparency issues. As everyone in the audience knows, the nation faces tremendous health care costs and that is constantly growing. As part of an effort to control these costs, many policymakers and industry stakeholders have implemented price transparency initiatives. Price transparency is a competitive dimension that historically has been missing from many health care markets. In recent years, however, we have seen increasing calls for price transparency and the market responses to those calls have varied significantly. Many health policy experts and industry stakeholders believe that price transparency will play an important role going forward, particularly to the extent that it enables health care purchasers to make more informed decisions based on comparisons of differences in expected costs.

Now, the format of our panel is going to be slightly different from some of the other panels that you have seen in this workshop. First we are going to introduce Dr. Paul Ginsburg to provide some introductory remarks, which will be followed by a group discussion of the current state of play of price transparency. Our distinguished panel will address these issues from their various perspectives as purchasers and providers of health care services as well as health policy and economic scholars.

We will then ask our panelists to address the market implications of price transparency initiatives. In theory, price transparency could reduce health care costs by, among other things, reducing or eliminating barriers that preclude meaningful price comparisons. However, health care markets have a number of unique features that may undermine price transparency efforts. For example, the fact that many patients are insulated from actual costs and have limited incentives to engage in price-based comparison shopping. This discussion will also address antitrust concerns such as whether price transparency initiatives can facilitate collusion or create other concerns.

I say to everyone in the audience, to the extent that people have questions that they would like to submit throughout the panel discussion, please just send those up as we go and we will try our best to incorporate those into the discussion.

I would now like to invite our panelists to briefly introduce themselves and explain their interest in price transparency issues. We can start with Bob.

ROBERT BERENSON: I am Bob Berenson. I am an institute fellow at the Urban Institute. My interest began with work I was doing with Paul Ginsburg and others from the Center for Studying Health System Change where we were doing site visits in various places and sort of found out that issues around market power over prices was real and increasing. I am interested in what we do about it. Price transparency seems to be one of the proposals.

ÁRON BOROS: I am Áron Boros. I am the Executive Director of the Center for Health Information and Analysis in Massachusetts. We're a state agency and we're charged with, among other things, price and quality transparency. We literally every day wrestle with the idea of what data do we have available, how can we make it meaningful to people, and then how do

we push it out to the world? This kind of conversation is really pertinent to the work that I do every day.

ANDRÉA CABALLERO: And I am Andréa Caballero. I am the Program Director at Catalyst For Payment Reform. Catalyst for Payment Reform is a national nonprofit that works on behalf of large health care purchasers, both public and private. We are working to catalyze how we change how we pay for health care. While we can't catalyze price transparency, price transparency is a building block to payment reform as we see it. So our interest here is that in a sustainable health care system, payment reform is not achievable without price transparency.

PATRICK COURNEYA: And I am Pat Courneya. I am a family physician and medical director for the HealthPartners Health Plan. In this panel, I want to bring the practical experience that we've had using cost transparency in an active, consolidated, very competitive market for, in our case, 15 years and its implications and how we've approached doing that.

We do have the only NQF endorsed price transparency measure, our total cost of care measure, which is the foundation and source of truth for all of our cost transparency work, both towards patients and members, towards providers and working with them to help improve performance there, as well as the way we report to our employer and government customers. And plenty of insights and thoughts on that.

PAUL GINSBURG: I am Paul Ginsburg. Many of you know me from when I was president of the Center for Studying Health System Change. I've recently taken a faculty position at the School of Public Policy at University of Southern California. I got interested in price transparency probably seven, eight years ago at the invitation of the California HealthCare Foundation, which was interested in the issue and written a number of things on it. My biggest concern at the moment is the looseness with which people are using the term. They attach it to everybody. There are a lot of, I think, low value activities going on now seen as price transparency initiatives.

JAMES LANDMAN: I am Jim Landman with the Health Care Financial Management Association. HFMA is an individual membership organization of over 40,000 members. We have member contingents in hospitals and health systems as well as in physician practices to medical

groups, health plans, health care consulting companies. And that membership representation across health care settings has enabled us to act as a convener of different industry stakeholders.

Over the past year we've been working on three interrelated task forces. Two have been focused on best practices in medical debt resolution and patient financial communications. Also, I am currently wrapping up work with a task force that has convened to try to reach consensus on recommendations for greater price transparency in health care.

The findings and recommendations of that price transparency task force are currently under review and final approval by the members of the task force, but the task force did include health plan representatives, hospital and health system representatives, employer representatives, consumer advocates, and actually a patient whose difficulties in finding prices for care were profiled in a major media outlet over the past year. The report findings and recommendations should be coming out in the middle of next month, mid-April.

CHRISTINE WHITE: Terrific. Thank you for the introductions. With that, we would like to ask Dr. Paul Ginsburg to kick us off with some introductory remarks that will help us set the table for the discussion.

PAUL GINSBURG: Thank you. This presentation is somewhat informed by a study that I've been conducting with my colleague Chapin White for the West Health Policy Center on price transparency. The study will be published in May and I think might be submitted as materials for this workshop.

I want to talk about first, why are people interested in price transparency? I think a lot of the interest comes from the concern about the level of health care costs. There's much broader interest today in using competition to constrain costs. We know that patients historically have had neither the opportunities nor the tools to incorporate price into their choices of providers. Indeed, longstanding culture of medicine is that patients should not concern themselves about prices.

What is price transparency? The initial focus of many people is about patients. It's about do patients have ready availability of price data for comparison shopping among providers?

This gets into three questions. One is, does the patient have incentives to choose lower priced providers? Many patients do not. Medicare patients do not. It all depends on the benefit design in the patient's health insurance coverage as to whether there are small rewards, large rewards, or no rewards for choosing a less expensive provider. Second point is, are the prices relevant for individual patients making the choices? For one thing, the prices need to be specific to the patient's health insurance plan. Also prices are more useful when they're for more meaningful units of service such as an episode of care or the annual cost per patient for a population of patients than for a specific service. Finally, are the data too complex to be used by many patients?

Another question is, came up in the last panel, are the services “shoppable?” For some services where the patient has the time and the mobility to choose a provider, transparency is potentially very valuable. More services become shoppable if the decision becomes a periodic choice of a health plan and its network or a delivery system. If you're choosing the network, particularly if you're choosing the delivery system, services which aren't shoppable in a sense, you've made some informed choice that's relevant to it.

Now the definition gets broader in the way many people use the term. Many of the broadenings have a lot of merits. For one thing, let's not forget some people are motivated by transparency as information for citizens, not patients, but citizens, and policymakers to assess the appropriateness of prices. So this is an aspect of “sunshine.” Many of the public releases of data presumably are being driven by that aspect of price transparency, the value of sunshine.

Some of the tools used by employers or insurers to help patients get lower prices for services are dependent on price data. I am thinking of tools such as reference pricing, tiered networks, and limited networks. Now, some of these tools do not involve the patients using any or much price data, such as limited networks. Nevertheless, these tools could not function without the insurer or the employer having the price data to create them.

Employers are another very important audience for price transparency -- both public and private employers. Basically what we've seen in our work at HSC has been that information on price transparent price variation will lead to changes in benefit design. There have been

many cases where employers have adopted tiered network designs or even reference pricing inspired by what they've learned with a very large variation in prices not explained by quality variation. Another issue for employers is getting better access to their own price data. This means price data from their own employees' use of care and their own plan so that they can support or encourage initiatives to address higher prices.

Now, insurers are another important audience for price transparency data. Because access to additional claims data -- that is, claims data on patients beyond those who they insure, this would include physician services data from Medicare Part B and data from all-payer claims databases -- can enable them to do a much better job of assessing prices for broader units of services more accurately. Basically it's giving them the sample size that they need. These would be episode of care or population spending calculations that insurers are increasingly using now as the prices as opposed to unit prices that drive their price driven benefit designs.

Accountable care organizations or entities which contract with payers for bundled payments. They have a need for price data because they need to find out about the prices for outside providers -- providers outside of their organization -- who treat the patients that are attributed to the ACO.

Finally, something that's rarely mentioned but I think we're going to see more about this is physicians. Physicians need information on prices for the different specialists or hospitals or other facilities that they refer patients to. They have very little of that today.

Also, physicians need more information on the costs for patients of alternative diagnostic and therapeutic approaches that are being considered for a patient's care. Some physicians see this as their responsibility as their patient's agents. Some, to the degree that they are engaging in provider payment reforms, need that information to respond productively to the reforms.

As an example of the patient-centered medical home that CareFirst Blue Cross Blue Shield is launching, where an important part of that is feeding to primary care physicians information on realistic measures of how expensive various specialists are in their community.

Because those primary care physicians are going to have incentives so that if they refer to the less expensive specialists they will do better in their reckoning with CareFirst.

Final audience is policymakers. There are two categories where policymakers are influenced by price information. One is creating regulations that are designed to support market approaches. These would include hospital contracting practices such as whether hospitals can refuse to contract with an insurer on the basis of tier placement.

Certainly the priorities here at the FTC and in some states are for antitrust enforcement and network adequacy requirements. I would think that how tight the requirement should be likely should depend on how high the prices are in a particular area or a marketplace.

One thing that we've seen very little attention to is price disclosure and dissemination for providers who are out-of-network. Patients often know very little about how much out-of-network providers cost or how much their plan will pay for out-of-network care. Also, for policymakers, access to Medicare or all-payer claims data for physicians is an issue that they have to grapple with.

Now, you also have concerns relating to direct regulation of prices. Price data might inspire policymakers to go in this direction. This can include limits on out-of-network charges for services where there's no patient choice. There's a long history of application of Medicare charge limits to providers to Medicare Advantage pricing. Policymakers can attempt to jawbone on hospital rates, which has happened in some states where prices have been publicized broadly, and ultimately, hospital rate setting.

I want to leave you with a few key takeaways. One is that there are numerous audiences for health care price information. Each audience has its own distinct needs. When we talk about a release of data, we should be talking about who is that for? Who's going to use that? Is that going to meet this audience’s needs? So many releases don't meet patients' needs.

The other thing is to realize that price transparency's potential is, for the most part, as a support of other tools to contain costs. Just throwing price information out there is unlikely to have much of an effect. However, benefit designs, provider payment reforms, they can be made much more powerful both by having better price data to build the tools with and then to

have the better targeted price information for the patients to be using when they're inside of these benefit designs or for physicians in a payment reform environment.

That's where the true potential of price transparency is. The simple publication of data, as our Medicare representative was talking about, such as publishing chargemasters of public charges sent to Medicare, generally, other than influencing policymakers, is not an effective transparency strategy. Thank you.

CHRISTINE WHITE: Thank you. We would like to take a few minutes to offer our panelists the opportunity to comment on the audiences or stakeholders for pricing transparency, the needs for transparency, or the potential user value of pricing transparency.

ROBERT BERENSON: Should I go?

CHRISTINE WHITE: Please.

ROBERT BERENSON: I guess we're doing this alphabetically. I will be happy to go first. I only have a couple of minutes, so I will do some high level comments and I will have a chance maybe to get a little more concrete later.

The first thing I would just emphasize is that I think health care is different. The most important article that I've read is now 51 years old, Kenneth Arrow about what makes health care different -- asymmetry of information, uncertainty and complexity, the role of the third party payer, shielding the consumer. Now that's changing and we will be talking about that later.

I want to bring up one other major difference, which I don't think he talked about, and haven't seen much commentary about it, which is that when we look at industries or other sectors of the economy where individual consumers seem to be making pretty good choices on their own behalf using price information and in many cases, not actual quality information. But they're doing well. There's a fundamental difference with health care, which is that for some of these other industries, like airline tickets or cars or computers, and Part D of Medicare, somebody else is regulating quality and safety to a large extent. Perhaps not perfectly, and there is certainly a role for Consumer Reports to have safety records on cars or repair records.

But for the most part I would argue consumers are picking amenities. They're not having to actually assess the quality of the medical service being provided. I don't want to get into this morning's earlier quality conversation. I am very skeptical that we are anywhere close to being able to provide the kind of quality data that consumers need to be able to balance price against quality and safety. I have some specific ideas about that, which we will get into. There's also evidence, which we can get into a little later, that consumers don't do a very good job in picking medical services on their own behalf. And I don't think that's likely to change with our efforts to provide quality measures.

Where I come out -- and I thought it was going to be sort of new, but Paul has already covered this territory -- is that we're missing the obvious target of price transparency, which are the physicians and other clinicians. For some other work I am doing, I have learned that in 2009 there were 105 million physician referrals in the country. Most of those referrals were made without consideration of price. Paul listed the reasons why that may be changing. I think therefore that providers and clinicians are the obvious target, and yet that's not where most of the people have been talking. Having said that, because of high deductible plans, et cetera, consumers themselves will be in the position and we will be talking about the role of price transparency for consumers as well. But the real target isn't being discussed.

CHRISTINE WHITE: Áron, did you have a brief response?

ÁRON BOROS: Sure. I will just pick up on that last point about price transparency for providers. On the one hand, I agree structurally that providers have lots of opportunities and increasingly incentives to think about price transparency. On the other hand, I am actually in the business of trying to get that information to providers and it's actually very difficult to figure out how to get it into their workflow. Providers want to be practicing medicine and providing care to patients. Thinking about those different categories that Paul laid out, each one of those categories is going to be reached in a different way and there's going to be a different format and tool that gets data to them.

If we decide, or if I as my agency decides, that getting price transparency data to providers to inform referral decisions is the mission, it informs a whole different set of choices

about what we do with the data and how we deliver it. Sitting here with this panel, it particularly is obvious to me that connecting research to practice is really important. I don't spend nearly enough time thinking about the research, because it does really inform the kind of work that I do. As you've said, going back to Arrow's work 50 years ago, those issues still exist today. As we work through these different audiences and identify where I think there will be some agreement that there's some opportunity there, it really has a lot of downstream implications about how we create tools that are effective in that space.

CHRISTINE WHITE: Andréa?

ANDRÉA CABALLERO: I would just comment that from an employer perspective, and by extension the consumer perspective, there is good news about the tools that are available to consumers and available to health plans. In the work that CPR has done we have examined some of the leading tools both on the health plan side and on the independent vendor side. There's been really tremendous progress, but there's a long way to go.

Similarly, on the state side or in the public resource and for those that are uninsured or don't have access to a tool through their health plan. We are going to be releasing a report on state price transparency laws next Tuesday. For those of you who are familiar with last year's report, the results were not all that great on what is available to the public. The results this year, while there's been some progress, they haven't advanced the way that we would have liked to see, either.

There's an upside and a downside here in terms of what's available to consumers. I think the other thing is that it's highly variable on who your employer is working with. The patient experience is going to be very different, and it could be different year to year. It could be different just if you have multiple plan offerings. This is a challenge, but I think there's some good news and I think we'll get into what still some of the barriers exist.

CHRISTINE WHITE: Terrific. Pat?

PATRICK COURNEYA: Yes. First, I want to thank Dr. Ginsburg for highlighting the importance of focusing on different audiences, understanding those different audiences well enough to know what resonates with them, but connecting what you present to them and what

you bring to them to a single source of truth in terms of how you're approaching the issue of total cost.

I want to respond in particular to the issue of providers and provider engagement on cost. Although with our experience over the last 10 or 15 years, we've got good stories to tell about all of the audiences that have been named. With regards to providers, one of the things that was very important is that we developed our total cost of care metric, partly because we were using this metric to make decisions for our own care delivery system which was the foundation for analytics that helped the providers to identify meaningful targets of opportunity for improving cost efficiency, both in terms of price characteristics and in terms of resource use. What we have seen is both our own medical group being able to tackle both resource use issues and price concerns, as well as others in our market. That response has gone all the way from small single specialty primary care groups who have identified their care buddies, as we call the hospitals that they use, and gone to them with that comparative resource use information and asked some hard questions.

An example is that hospitals that are in the same general market have very different use of high tech imaging in the emergency room. Provider organizations who are contracted with us, who will perform better financially if their total cost of care is better, are going to those hospitals and asking them serious questions about why they're out of sync with the rest of the community.

There are a lot of good examples if all of the factors are set up in our marketplace, where groups of all sizes -- all the way from single specialty primary care through large multi-specialty well integrated systems -- are using that data to make decisions and bring meaningful changes to operational detail, without setting an expectation that individual providers will have to understand the prices of all the different services in order to be effective in that. There are ways of actually bringing that to the front line in meaningful ways that have an impact on resource use.

JAMES LANDMAN: I'd just like to highlight a couple of comments from Paul's presentation that very much resonate with conversations and the approaches we had on the

HCFMA Price Transparency Task Force. The first is that when we're looking at the competitive effects of price transparency, it's going to be fairly meaningless unless it's tied to efforts with patient incentives and benefit design. The second is the move, that I think we very much agree with, to a different look at pricing that's more an episode price or an effort to get at the total price of care over a period of time is really a more meaningful measure. A third issue is the problems, particularly for patients, in navigating the difference between in-network and out-of-network care and some of the issues surrounding that. The numerous audience needs and also different information needs, but also different sources for that information and an approach that is really taking into account for who's providing the information, where does the patient or the other stakeholder go to get it. Finally, there is an important distinction between charge transparency and price transparency.

CHRISTINE WHITE: Okay. Thanks, Jim. Paul, did you have any further comment?

PAUL GINSBURG: Yes, actually I had one more comment to make. That is, as we look at this through the scope of saying that, well, it's benefit designs. Price transparency will support different benefit designs. It's not necessarily the case where the benefit design that uses the most in the way of price information is going to be the most effective.

A particular example I wanted to point out is choice of hospitals for inpatient services. I would say that a tiered benefit design is probably a more powerful tool for steering patients to more efficient hospitals than a high deductible health plan. Why? Because any time you're admitted to a hospital, you will have succeeded that high deductible. So in a sense, that apparently very championed pricing tool isn't a very effective tool in the inpatient sphere.

CHRISTINE WHITE: Before we move along, Mark, we would like to welcome you and ask you do brief introduction for yourself and then we'll let you jump into the dialogue.

MARK MCLELLAN: Thank you very much, Christine. Sorry to be a few minutes late, but it sounds like you've got no shortage of good opinions on price transparency. I am Mark McClellan and I am the director of the program on health care innovation and value at the Brookings Institution where I am a senior fellow.

Hopefully not duplicating anything that's been said, I did want to highlight several points about transparency from a CMS standpoint. One of my priorities while at Medicare was to try to promote more availability of quality and cost information for both Medicare beneficiaries and for hopefully driving broader changes in the market. As you've just heard, just making list charges available or just making even actual prices available in Medicare or other programs isn't necessarily useful information by itself. What's much more actionable is information that actually matters for the individual's own decision making.

This was a key principle in the steps that we took to implement the Medicare Part D drug program. As you all may recall, that's a competitively designed benefit where Medicare beneficiaries get a fixed sum of money towards the purchase of a range of competing plans to provide drug coverage. There was a standard benefit in the law that had a deductible then 25% coinsurance and that famous "doughnut hole" and then catastrophic coverage on the back end. But plans had flexibility to design other actuarial equivalent benefit structures. And that's what they did. So there was an awful lot of frustration at the time from Medicare beneficiaries. I can't tell you how many beneficiaries I heard from going around the country complaining about why can't the government just give me a drug benefit? They use a few more expletives than that usually. Because they did have 20, 30, 40, 50 choices to look at.

But in setting up the choice system, we tried to listen to our beneficiaries and ask them what they really wanted to know in order to be able to compare drug plans. We started out with some focus groups that relied a lot on our kind of expert advisers and things like, well, there are four people who are, say, 65 to 70. There's a small chance they might go on to develop a serious chronic disease, like diabetes, and therefore need more medications or heart disease or something like that. We tried to talk to our focus groups about this. They didn't want to hear much of it. They said, "What? I don't have those conditions. What are you telling me about all this for? Are you just trying to bring me down? What I want to know is what are the costs of my drugs in a drug plan? How much money am I going to be paying for the drugs that I need in terms of premium and out-of-pocket cost?" So, okay.

We set up a new system where Medicare essentially requires as a condition of participation in the Part D drug program that every plan would provide an accurate price for

every drug at every pharmacy in their network in the United States, along with a complete list of the pharmacies where they provided coverage, so that beneficiaries are able to go on the website or they could call 1-800-MEDICARE, tell us the drugs they were taking, and they would get the out-of-pocket price information, both on a per prescription basis and on a monthly estimated amount. Although it was very frustrating for a lot of people to take the time to do all this, especially in the first year the program -- it was completely new and we certainly hadn't worked out all the kinks -- people did it and the results have been pretty dramatic. People did pay attention to the out-of-pocket cost for the drugs, but also to the premiums for the plans, the premiums that turned out to be lowest cost. Therefore the plans that turned out to be lowest cost, and therefore lowest premiums, were ones that had exactly the kind of tiered benefit design that Paul was just describing where you didn't just pay a fraction the cost of drugs, but the more cost-effective drugs, basically, the ones that meet Medicare beneficiaries' needs at a lower cost and get on the lower tier.

The generic drugs that work same way as brand name drugs, regulated the same according to the FDA, were essentially free. They cost like $1 or $2. The drug plans would negotiate lower prices with several drugs out of a particular class of similar outpatient pharmaceuticals like cholesterol lowering drugs or oral drugs for diabetes or non-sedating antihistamines. Those would be maybe $30 each. Most everything else would be covered.

Seniors seem to prefer plans with very broad formularies. But you can see that not only is there transparency about the price that they actually pay for their drugs that didn't happen before, but also there's a big differential in what they paid. The seniors basically got most of the savings when they switched from, say, a brand to a generic under these kinds of tiered benefit designs compared to traditional approaches to insurance design. If Mrs. Smith was on a brand name high blood pressure medicine that cost $90 and switched under a traditional benefit, she might save 20% of that if she switched to a generic, like $15 or so a month. Under the tiered benefit design, the price would go literally from like $90 to $2. So $88 in savings. That's something that seniors definitely paid attention to.

Use of generics has gone up to over 80% of Medicare prescriptions from under 50% when the program started. It's a huge amount of savings. There's also been a lot of shifting

from non preferred to preferred brand name drugs and it's I think had a pretty fundamental impact on the way the drug industry actually innovates now -- with a lot less attention to the “me too” kinds of pharmaceuticals.

I will start with one kind of background example from my own experience of where transparency can really make a difference. Unfortunately for the rest of health care services, it's not that easy. There are not clear indicators of quality that seniors or people generally accept as they accepted that a brand and a generic are basically the same. That's how people are acting today. There is no easy way of coming up with exactly what the price is, as you can do with a specific prescription that you're getting filled for 30 our 90 days. But I think these principles show that there's a lot of potential for price transparency, along with meaningful confidence about the quality of the alternative services presented in a way that is actionable for people, meaning that focusing on their out-of-pocket costs can really make a difference.

STEPHANIE WILKINSON: Thank you. That's a really good example of a price transparency initiative that was implemented by the federal government. I'd like to pose to the panel, maybe we could elaborate on what is the range of price transparency tools and models that are currently being utilized by providers, health plans, and state government agencies? As we go through the discussion if people want to place their name placard on the end then we'll know who to call on. Dr. Courneya?

PATRICK COURNEYA: I can talk about what's really becoming the dominant strategy for price transparency in our market. Our total cost of care measure, which we described before and I will describe more later today, has now been adopted by our Minnesota Community Measurement Transparency Collaborative as the way the provider groups want themselves to be represented in terms of total cost of care. That they made some minor choices about attribution, but it's largely the same as our model. This is really, from my perspective, very profound.

First of all, it reflects community and provider understanding that price transparency is going to be a part of their world going forward. It reflects an acknowledgement that addressing issues of cost are legitimate in the conversation about what we do for our members, our

patients, and our communities. And, it is tied to an approach to using that total cost of care transparency that's meaningful to providers, that can also be a meaningful source of shoppable episodes of care for patients for the specific diagnoses that they have. We have 250 examples that we have on our website right now that are not just price, but total cost associated with the provider group. The patients get both their out-of-pocket costs and the total cost of that episode that we pay -- that is, the allowed charges plus their costs.

By giving that kind of information, it sends signals not just to the patients who are making those choices who may be blowing through their deductibles. It also gives signals to others in the marketplace. Because it is total cost of care, which is a collection of the prices that are associated with all the different services and facilities that are used for those episodes, it doesn't necessarily create an opportunity to game the system. It creates an opportunity to identify opportunities for more efficient use of resources.

It also helps to solve one of the problems that I, as a family physician, have had for my entire career, and that is making referrals to specialists without the kind of information that I need, both in terms of quality and in terms of costs so that I am helping actually to counsel the patient much more effectively. In a meaningful package that doesn't force me as a provider to subdivide all the prices and to figure out, overall, what it's going to mean for the patient. That set of tools in that environment is one of the reasons why the care delivery provider organizations in our community have accepted that as a way of representing their performance on cost.

STEPHANIE WILKINSON: Thank you. Jim Landman?

JAMES LANDMAN: Yes, I want to talk from the provider perspective of a group that we haven't discussed a lot yet, which is the uninsured. And really for uninsured patients, the provider's going to have to be their primary source of information on price transparency. We are seeing a number of models emerging.

Some hospitals have established central pricing offices where you can call in and they promise a response within 24 hour or end of next business day. Some are starting to publish average estimated prices out on their website. One particularly effective example we've seen

puts that average estimated price in the context of what the hospital receives for Medicare, what it receives from Medicaid, and what it receives from the average insurer as well.

There's some context for the uninsured patient to see what the price that they're going to be charged relates to other payments that the hospital's receiving. That website also does a particularly -- the uninsured and out-of-network patient really do kind of elide -- that website also does a very effective job in making clear to the patient that the price that they're getting is for hospital services and that there might be other providers doing procedures or providing services as part of the procedure that are out-of-network. It gives the contact information for the major medical groups in pathology, anesthesiology, et cetera, to assist the patient and identifying who they may have to go to get some additional price information.

STEPHANIE WILKINSON: Okay, thank you. Andréa?

ANDRÉA CABALLERO: Sure. As I mentioned before, CPR did an analysis of four national health plans and eight private vendors on their price transparency tools. It's not just their price transparency tools. It includes a lot of information and also some quality. But focusing on those particular tools, what we found was that there is significant variation from one end of the spectrum to the other. You have very deliberate different strategies that are attempting to get to consumers in different ways.

In some respects you have everything online in a consumer portal that is specific to your plan. Your plan design is there, your co-payment is there. Where you are in your deductible, real time deductible, seems to be very common in those types of tools right now. That's one set.

Then you go down the spectrum and then you have very high touch consumer price transparency tools, which are all just phone to phone service. They're concierge services and they're considered a price transparency solution because the consumer has a benefit design that requires them to do the research and understand what their options are. These are very high touch options.

And then you have, everyone sort of has probably, a website now moving into a mobile application. But to Dr. Courneya's point, what is available to the consumer is very different.

Some will almost always give you what is my out-of-pocket? What is the consumer's out-of-pocket? More and more employers are now asking for that total cost to be displayed to the consumer. So the consumer sees their out-of-pocket cost alongside what the entire cost is. We're starting to introduce some of that sensitivity into the market even though their own personal out-of-pocket is still right there.

What we're still falling short on in terms of what's available of tools in the market today is this concept of value. I know value means something different to every consumer. We'll probably get into more in this afternoon's discussion, but on the pairing of quality information and price information, and convenience versus quality, and the personalization of the information that's available to you. We have a long way to go for a consumer to be able to personalize all of this information and say what's important to me as I am making this choice.

The other thing in terms of what's available on the market, CPR did a study, National Scorecard on Payment Reform, which we released last March 2013. We found in that survey that 98% of health plans offer some type of a price transparency tool. And I would imagine in our survey that we're going to release in September of 2014, it will be 100% of health plans are going to offer this tool. It's just competitive in the marketplace. They need to have it. Its driven by a benefit design. The gap we have is that only 2% of consumers are actually using these tools. Or at least that's the study we found. Each vendor might tell you they have different engagement. There are lots of different levels of measuring that. In terms of what the health plans have reported is they're offering it. This is a situation where if you build it, they won't necessarily come. That is to Dr. Ginsburg's point; it really isn't just the availability of the information alone that will really drive consumer behavior. It is a variety of things, including benefit design, including payment reform.

There is good news -- I know this isn't the topic today -- but there is fierce competition for these price transparency tools in the market today. Fierce. They all believe that they are speaking to consumers in the way that consumers want to be spoken to you and they are all very different. That, of course, doesn't get to any of the uninsured and how the other public information that's available.

While there are certainly limitations to the charge information that's available by states, charge information that Medicare puts out, think CPR doesn't see that necessarily as a valuable resource for consumers' actual use. But it sends a very important signal into the marketplace that we're in an era of transparency, we're here to stay, and it's only going to grow from here. It is a signal that will continue. And, these tools are going to evolve rapidly.

STEPHANIE WILKINSON: Okay, Áron.

ÁRON BOROS: I want to pick up on a theme that has been going through more the beginning of your remarks and then some of the other folks spoke to this, starting with Mark. The question of what price you're reporting is really an interesting one.

In some areas of health care there are some things that are close to commodities. So there are MRI services that are relatively close to being a commodity. Then there are drugs, which are in some cases more like a commodity and in other cases harder to compare one drug to another for the same condition. Then there's the vast majority of health care where the service that you will receive in the future has an unknown number of specific codes and treatments and length of time and potentially even diagnosis. We heard about the HealthPartners approach with 250 bundles of care. That's a reasonable approach. But even then, you don't know exactly whether or not your experience will fall into a bundled definition. That is something that we are really wrestling with.

I use all of that as a segue to talk about what we do in Massachusetts, which is an admittedly imperfect solution, as maybe all of these solutions are. But our first step is something we call relative price. We have the happy ability to have a regulatory collection of data. We can actually tell health plans exactly how we want the data from them. What we've said for relative prices, is that we need a very standardized measure of how prices vary within your networks and it's sort of on a fee schedule basis. It's not influenced by the sickness of the patients or anything like that. It's really the services that you're providing on a fee schedule basis. What's the multiplier for any given provider? The benefit of that is that for my health plan I can look at hospital A and I know they're 1.3 and I can look at hospital B and know that they're 0.9. I can really see that hospital A is roughly 40% more expensive than hospital B.

On the other hand, it's the highest level of abstraction about what these prices might actually mean to me as a patient. I don't have any dollar figure on that and I don't know my deductible, like you mentioned. I don't know all of that really personal data. That's the solution that we've started with and then we're going to move more and more in different levels of specificity and customization. I think that's maybe the move to the end of Andréa's comments.

STEPHANIE WILKINSON: Thank you. It's been helpful to hear some of the types of transparency tools and models that are currently being utilized. I guess I'd just follow up to ask, what types of data and information are necessary to achieve price transparency? Is that information readily available currently?

ÁRON BOROS: I said -- I am sorry I should have raised my card --

STEPHANIE WILKINSON: Go for it.

ÁRON BOROS: Like I said, we have the ability to collect data directly. Even with that ability it's not easy, right? Because every health plan or hospital that sends us data has it in a slightly different format, and even when we standardize intake specifications, it's always different. I guess what I would say, as a short answer to give other people a chance to speak, the data is available and it's very complicated to work with and to turn it into information. We have data, but turning it into information is a huge challenge.

STEPHANIE WILKINSON: Jim Landman?

JAMES LANDMAN: I would say that data is available depending on groups. Certainly I think for insured patients there are tools out there to help them with out-of-pocket payment. I do agree with the comments that both Pat and Andréa made that it's also useful for insured patients to understand the total price of care. That's a very important data point for them.

For uninsured patients, that varies. Navigating the complexities of the health care system are extremely difficult if you're an uninsured patient and don't have that network of a health plan. One of the things we are trying to do in connection with the release of the price transparency report is actually to provide a companion consumer guide to navigating price transparency.

Getting some tools out there to start educating patients and start letting them know this is the information you're going to need to have, these are the questions they're going to need to ask. Whether you're going to your health plan or whether you're going to a provider is critical. Even if the data's out there, I don't think there's necessarily a great understanding among patients as to how that data should be used or how that information should be used.

The referring clinician piece is, I think, very interesting. Because we're starting to hear, certainly anecdotally, that physicians who aren't at financial risk, so aren't in a shared savings plan or an ACO or whatever, are having patients showing up in their office and saying, “Well, you know, you're recommending this test, this procedure, how much is this going to cost me?” And the typical response is, “I have no idea, I haven't really thought about that.” Physicians are really starting to see the need just coming into the office of patients with high deductible health plans to actually be able to provide some of that information when they are ordering a test. Certainly for referring clinicians who are under some sort of financial risk that ability along, certainly, with patient safety, with patient quality data to be able to have price as a factor in those decisions when they're managing a patient population is critical.

STEPHANIE WILKINSON: Thank you. Dr. Ginsburg?

PAUL GINSBURG: Yes, I think a critical area in limited data access is what data that's needed to create a more meaningful measure of price, such as per episode or per patients. This is the issue of most insurers or large employers being limited to the data on physicians and hospitals for their own insured patients and not having access to the rest of the community's experience.

In theory, Medicare could do a lot to help this. Medicare has been very grudging in making access to its physician Part D data available. All-payer claims databases, they're all different. Some of them have the capabilities of providing this data, some of them don't. Some of them with the capabilities don't do it. That's holding the system back in getting more meaningful information at the provider level.

STEPHANIE WILKINSON: Thank you. Dr. Courneya?

PATRICK COURNEYA: Probably the best way to address this is just to describe what's unfolding in our marketplace right now. Dr. Ginsburg's point about the challenge associated with cost information for HealthPartners, as a health plan, for instance, reflecting only those patients that we have with that provider can be an issue. Although we've done validity testing as a part of that NQF endorsement process to look to see what population size for a given diagnosis was necessary to create a statistically reliable result.

However, what is happening, through our Minnesota Community Measurement Collaborative, is that all of that data is actually being brought together. So multi-payer data is being brought together. We've tested it with the three largest payers in the marketplace collected together. It's working. Worked out the kind of data variation problems there. And the other payers in our market will be joining in that in this first quarter. What that does do is it gives providers the ability to understand their performance on total cost of care for their entire population, which for them is a lot more credible. It also makes it easier for the leaders in those groups who do intend to work effectively at managing those total costs to get their organizations to consider taking the risks necessary to make those operational changes real at the front line. That also, of course, has to align with the general direction in the way payment models are rolled out into the marketplace so that doing that, in terms of better resource use and more competitive pricing, is actually a good business model for them. We're seeing that unfold right now.

The data we have right now is claims data. We are collecting it together so that we're sure that it reflects overall performance. We're also beginning to experiment with the inclusion of medical records information to help more effectively risk adjust. The model itself risk adjusts in a way that is credible to the providers and gives us meaningful information about what's going on and comparability. We know that we can refine that more effectively and we're beginning to use clinical records information to do that.

STEPHANIE WILKINSON: Thank you. I see that we --

PAUL GINSBURG: When Dr. Courneya raised this point I thought of something else I wanted to say before, which is I think Health Partners has been able to do more because it's

large. And that given that we're at the FTC workshop, this is probably a competitive issue in the health insurance market. The access to data because of having a larger share is a real advantage to larger insurers in the market over the smaller ones in a particular market. Having an all payer approach to data can really make that marketplace more of a level playing field and more competitive.

PATRICK COURNEYA: Yes, just a quick response. I agree having enough data for the story that you tell about individual providers to be credible to them or about individual providers to patients is really important. That's a part of that engagement process, so that other payers and other providers looking to see themselves represented accurately can do so at a scale where the size of the medical group that can participate in that gets smaller and smaller all the time.

STEPHANIE WILKINSON: Thank you. I'd like to give Bob Berenson and Mark McClellan an opportunity to respond to my question about the types of data and information that are necessary to achieve price transparency. I will also pose another question that I know both of them are maybe interested in speaking on. What are some of the challenges to achieving price transparency? I will throw that question out for the panelists to be thinking about as well.

ROBERT BERENSON: Just briefly, I will touch on your second one. Almost a year ago, The Times had a story about the growth of price transparency and I got quoted as basically saying "this assumes an MRI is an MRI is an MRI." Sort of your point about it's perhaps one of the closest things to a commodity that we have in medical care. But I was suggesting that I am not necessarily ready to accept that an MRI is just a commodity. I was then approached by a person who runs a company in New York whose business is evaluating MRIs and CT and PET scans. He convinced me that "an MRI is not an MRI is not an MRI," -- in the CT context, he says in his area there are still using 2-slice CT machines. You have 64-slice CT machines, 128. They're completely different and maybe we don't need the fancier ones to do it. But to simply say you're going to go get an MRI, he said that in Japan they have five or six different categories in their fee schedules based on the specifics of what machine we're talking about.

There is pretty good literature, as well as anecdotes, that even something like an MRI, some of them are indecipherable. They come in on referral and to some extent the place that

gets it wants to generate revenue so wants to do its own. In some cases, it's that we don't know how to interpret this one.

To move in the direction of price transparency and to get even a price for what seems to be one of the simplest services like an MRI requires the payer to actually bring some sophistication to it. Especially -- and later we'll get into the discussion of the relationship between quality and price -- when you move towards reference pricing and you want to be able to tell your patient population, your membership, that here are the places that you can go get your joint replacement, your colonoscopy, your MRI done for this amount. It's at that point that the payer has an obligation to assure certain levels of things happening to put that price into context. I think that's some of the challenge. We can get the data, but I think sophistication even on the price side, harder on the quality side, but even on the price side bringing some nuance.

The final example I would give, because hip replacement has become a very prominent example of a service that you can provide total cost of care information for. It's part of reference pricing. There are a number of components in the hip replacement that -- here was the point I wanted to make specifically -- that a hip replacement for degenerative joint disease may not be the same as the hip replacement for a patient with osteomyelitis and an infection and requires six weeks more of antibiotics. That has been a criticism of CMS's approach to bundled payment for a hip replacement. You need to get into that level of nuance. Are you going to have exclusions? Are you going to include the diagnosis and the cost for diagnosis? The referral centers are all going to then say, “We get the sicker patients.” You need to be able to do that. I am not saying you cannot do that, and I'd be interested in how they do that in Minnesota. I am just saying it's a commitment, is what I am saying.

STEPHANIE WILKINSON: Mark McClellan?

MARK MCLELLAN: I agree with Bob that the vast majority of health care is not a commodity. But Patrick may have a point specifically on this that would probably save me a little bit of time too in terms of how you get to -- it is hard, but that doesn't mean we shouldn't be trying to get there.

PATRICK COURNEYA: Right. In fact, I would say the fact that price transparency forces that question is probably one of its most powerful impacts. It's not something that is forced just on the payer. It's actually forced on the provider of the service. If somebody says, “Well, I get sicker patients and we have data on that,” it implies that they handle those sicker patients better -- and we need to explore that. And our experience has been that the more data and information you have, the easier it is to differentiate that and the easier it is to answer those questions. In fact the transparent conversation about price and the related value you're bringing to the patient is forcing a lot deeper analysis and communication about whether or not they are indeed different in quality.

MARK MCLELLAN: I wanted to go back to as well, in terms of other challenges, to price transparency is I am not so sanguine that the data are really available. We've talked about a lot of examples of that. But Minnesota and Massachusetts are not representative.

There have been a number of Medicare initiatives. We talked about some of those. On the private side I think there are some real obstacles -- in many cases created by so-called “gag clauses.” involving providers and plans where the plans are prohibited from discharging information. As I understand it, for a number of the large employers and other employer efforts that are trying to work with pooling insurance claims data. Sometimes they run into issues of the insurers regarding their individual claims data as receipts that are under their control that are not part of the information that should be shared back with the employer. There'll be some individual privacy reasons and so forth for doing it. But it does effectively stymie employer efforts to get at the larger picture of the cost of care, the prices of care for their beneficiaries. Those issues are not yet resolved.

Paul mentioned on the Medicare side that there have been some steps to make Medicare data available but they've been, what was your word? It wasn't halfhearted.

PAUL GINSBURG: Grudging.

MARK MCLELLAN: Grudging, right. There are some real concerns that CMS has as well. And partly they are just sort of the burden of having to deal with lots of different requests for a sense of information. But there also are real concerns about beneficiary privacy and

confidentiality. Look, if you're getting out enough information that you can answer questions like not just what's the Medicare price for the specific service, which we all know. I mean, that's been released now for years, it's just not very relevant. But what kinds of utilization and what's the overall spending associated with things like the more meaningful bundles that Patrick's been talking about? Well, to construct those, you have to know a lot of potentially identifiable information about an individual. There are rules that Medicare has set up to assure that that happens. I don't know of any big data breaches. Hopefully there won't be any. But it is definitely something that CMS worries about. This is very sensitive data for a large number of Medicare beneficiaries.

Now, CMS is using a so-called "qualified entity" approach for nonprofit groups and multi-stakeholder collaborators to get access to this kind of information under conditions that preserve individual confidentiality. But those efforts have been limited and I think have not yet produced broad insights in these more meaningful measures of price and utilization on transparency. Ways that that could happen, well, maybe CMS could consider broadening out the program since it seems to be working so well so far from its incremental start. That might include giving more entities access to the data. I know there are concerns about, say, for-profit entities or companies working together, getting access to it. Maybe there are good reasons for not allowing unrestricted use of those data. But if CMS were clearer about things that could usefully be done with this information, maybe limit some of the uses, at least initial uses, to those measures. If there are 250 good bundles out there where we'd like to have good price information, maybe that's what a broader use of qualified entity data could be restricted to at the beginning.

It is still a contained incremental expansion of the program, but one that would enable a much better fit with some of these private sector and state efforts. This may be a case where there's something -- not to bring back too close to home -- but where there's something that the FTC could do. If there are real issues about price and utilization that are of importance in evaluating large concentration mergers or other consolidations, having kind of a standard list of what should be produced from Medicare and from private plans that, for evaluating them, would help drive some more meaningful transparency around price and utilization.

STEPHANIE WILKINSON: Okay, thank you. Andréa?

ANDRÉA CABALLERO: I want to build off of some comments that Mark made about the potential contractual barriers that exist. That's to set a really practical level. The work that we've done in talking with health plans is that the “gag clause” issue is-- while it still may be contractually in place -- there seem to be work-arounds so that that data can be released for price transparency tools. On the opposite side of that, you talk to hospitals in large systems who will say, oh no, that's not really the case. I don't think we really know the extent to which these “gag clauses” still exist but there are workarounds, or if they are really in place and being enforced. There are certain parts of the country, clearly, where the provider market power has wielded the effect of absolutely not allowing price or quality information on institutions to be released.

It's that lack of competition where there's no incentive to have to release this information. On the “gag clauses” issue, contractually there's also “anti-tiering,” so limitations on being able to tier products based on quality or price. In a “take it or leave it” contract, you have to have all of our hospitals in your system. There are a variety of contractual issues that really underlie and undermine the ability to get price and quality information into these tools.

STEPHANIE WILKINSON: Thank you. Jim Landman?

JAMES LANDMAN: Yes, I just had one comment to follow up on this discussion of commodity or commodity-like services. Certainly it is both a trend and a challenge. Certainly we would expect the most competition to start emerging around these lower priced procedures and services. You're already seeing there are lower barriers of entry, they're within a high deductible plan range or an out-of-pocket maximum range.

As we get more competition on those services, there's also through certain tension that emerges with providers who are being paid to manage the care of a population. If you have a group of providers over at an ACO who are trying to manage the cost of care for a population but you have members of your population drifting off into services that really aren't part of that network, that becomes a real challenge. We certainly expect to see more competition there.

The question is whether that competition is at odds with emerging care delivery and payment models as well.

STEPHANIE WILKINSON: Thank you. We have several questions from the audience, and I am going to try to incorporate some of those as we go. But one question specifically about the challenges to achieving price transparency. Somebody's made the point that there's no uniform billing in state Medicaid programs. The question is, how close are we to resolving that issue? If anybody would like to speak to that issue. I will pose that.

ÁRON BOROS: This isn't my area of expertise, but there was a Massachusetts panel on local billing codes and my understanding is that they met for several years in order to standardize local billing codes and succeeded to a large extent. But even after several years of work, there was still half a percent of local billing code use. It's just one symptom of the enormous complexity of the health care system.

I was speaking to a hospital CEO recently who said, if you look in Massachusetts, "We have a medical loss ratio of about 10%." That's the administrative cost for plans of the premium dollar is about 10%. But, he said, "Being on the hospital side, I spend another 10% or more on billing and following up on billing and all the other things that are associated with managing multiple insurance carriers and all of the variable rules and billing procedures and denials and all of that." When you're looking at maybe 25% of the premium dollar going just to the complexity of the system, it does seem like that is an area there for standardization. But the work of standardization is extremely hard and requires the full commitment of multiple parties.

STEPHANIE WILKINSON: Thank you. We've also received a question, several people have mentioned focusing on the price for an episode of care. If people could just elaborate, how do we define episode of care? How do you determine what costs should be included in that? Dr. Courneya?

PATRICK COURNEYA: Well, that really varies depending on the type of care we're talking about. For surgical episodes it's easier to do. For pregnancies it's easier to do. For chronic diseases like diabetes, it's more difficult to do. Actually, it's not that much more difficult. You just approach it in a different way. What's the total cost of care performance for a medical

group, for instance, on a diabetic? Especially when correlated with their performance on clinical quality.

Now that may give a patient with diabetes guidance as to which groups have the best combination of total cost for taking care of their population of diabetic patients. It is a reflection of overall style and approach to managing those populations. Our experience has been that patients are sophisticated enough in understanding that their own circumstances may not exactly match the outcomes. But they can still make a judgment about what environment they want to be in when it comes to getting the care that they're looking for their diabetes.

The same thing is true when you look at things rolled up together. There's rarely a diabetic patient who is purely a diabetic patient. Seeing those things rolled up together -- which is one of the ways that we represent the overall total cost of care for complex medical patients in the way we report this-- is another way of helping to at least give insights to patients, to providers, to employers about how care delivery system approaches care of those populations.

STEPHANIE WILKINSON: Okay. Dr. Ginsburg?

PAUL GINSBURG: Yes, well episodes of care of course are dependent on sorting out claims, to see which services are related to that episode of care and which ones are related to other care issues. We're certainly dependent on algorithms to do that. But the overall concept for episode of care these days is going beyond what the physician does, to include hospital, the post-acute care, the prescription drugs used. There's a striking parallelism between the movements in provider payment reform, which are providing often in a shared savings context, incentives for keeping down the cost of bundled episodes. The same information that is used for the provider payment forms becomes relevant for the price transparency aspect.

Now, the big barrier is risk adjustment. You know that diabetes is a particularly challenging episode of care because of the other conditions that often accompany it. So far, CMS, through the Innovation Center, is focused on some acute conditions which involve an inpatient stay such as joint replacement, which are relatively easy, or easier, to deal with the patient variation. I think there are some opportunities in chronic disease, although they have to

be chosen very carefully. My colleagues in the ophthalmology profession believe there's potential with respect to glaucoma to manage that because of the strong ability to do the necessary risk adjustment.

STEPHANIE WILKINSON: We have time for brief remarks from the remaining panelists before we move on to the next series of questions. Andréa?

ANDRÉA CABALLERO: Just very quickly, I think in terms -- I am sorry. I will put my card down.

CHRISTINE WHITE: Well, I will take advantage of those extra minutes, then. Oh, I guess I won't. Jim Landman?

JAMES LANDMAN: Yes. The HCFM Price Transparency Task Force had extended conversations around whenever we use terms like “unit of care,” “episode of care,” to promote precisely what we were talking about. And this is in flux. There are emerging payment models and bundled payments, total cost of care population management models that are going to affect how an episode of care or unit of care is defined pragmatically. Today, the key thing is to make sure that if you're providing comparative price information to a patient, you're including the same thing. So the “apples-to-apples” comparison.

MARK MCLELLAN: The “apples-to-apples” issue is further complicated by the fact that we're trying to get to the goal that Patrick described, and Paul, that you really want to put everything in from the standpoint of, say, a patient with diabetes. It's not just the cost of a particular visit to the office, but the downstream cost, any specialty referrals, and so forth. That all matters.

Patients are making a choice, but with fragmented payment systems and fragmented care delivery systems, for most people even if you put that number together, that's not necessarily a meaningful thing to choose. They are going to have to go out and sort out getting care from their primary care doctor, maybe from a specialist, maybe from other cardiologists for some of the care as well. That makes this job very challenging to help people dealing with the choices and different ways based on the different levels of coordination and integration of their health care systems.

ANDRÉA CABALLERO: I am not going to comment on how the different episodes or bundles are designed. But I think in terms of the tools that we examined, what you'll find is that some will start with the care path or the episode and then the patient or consumer is able to drill down to the individual components. Some tools will start with the individual components and then build back up and say, well, if you're searching for this, then these are other likely things that would go on. You can sort of zoom in and zoom out in some of the more sophisticated tools that are available.

CHRISTINE WHITE: Very quickly?

ROBERT BERENSON: Very quickly. The point that hasn't been made so far today, all of our discussion has been about price transparency to affect market behavior. But another purpose of price transparency is to bring public attention to a problem. We've all focused on difficulties in the former area. But Minnesota and others are trying to work it through. But I have no doubt that editorials in the Boston Globe and the Attorney General's Report and other publications bringing attention to unreasonable pricing has a positive benefit. For that purpose some of the issues might be different than what you'd need to do in a market environment.

CHRISTINE WHITE: We may come back to talking about the value of "sunshine," as I think Dr. Ginsburg referred to earlier. But right now we want to take a deeper dive into the market implications and the competitive implications of price transparency.

In a number of markets, price transparency has been shown to promote efficiency and competition and lead to lower and more uniform prices. The question for the panelists is, what are we seeing in health care markets today? Dr. Courneya?

PATRICK COURNEYA: Again, I will describe some of the dynamics that we're seeing. First of all, we do have in our marketplace a great deal of large multi-specialty groups. We do have individual, single specialty primary care groups as well. We see experience in that. And we see folks who are in that circumstance responding in really interesting and effective ways.

In our marketplace, we do have provider groups who have very strong, positive brand names, brand images, that are also kind of stepping out and saying, we're going to maintain that brand image for service and quality as represented by the publicly reported measures. We

are going to start to shoot the lights out in terms of total cost. They are using the tools that they have to identify those opportunities and make that difference evident in the marketplace. That is creating some interesting dynamics. It's creating interesting partnerships.

Our own care delivery system at HealthPartners has partnered with one of our other contracted care delivery systems, Allina, up in one sector of our marketplace where the trends were pretty high. We recognized that we could do a better job because we used the same hospital systems and didn't own them or had other areas where effectively cooperating on reducing trend in the context of a payment model that rewarded them served the interests of both of those organizations. They've gone from trends in the 8% or 9% range down to essentially zero for the last two years. We know that there are other market forces that are driving some of that, but Allina was distinctly better, actually, than the others in the marketplace during that period of time. We're seeing folks responding to signals in the marketplace about total cost as a legitimate place to be paying attention and as driving future competitive positioning in the marketplace that will serve them well as businesses going forward as well.

ÁRON BOROS: If I could react to that. That issue of brand power, one of the sort of parables that I like to tell us that when you're an insurer and you're negotiating with hospitals, you face two kinds of hospitals, broadly speaking. On the one hand are these high brand name hospitals who have this very positive reputation and consumers, patients, demand them in their networks. On the other hand, you have generally low brand name community hospitals who have less market power. Not by size, but rather by reputation and brand.

What does price transparency do? Well, it doesn't do anything with the high brand hospitals. Because they're negotiating on the strength of their brand. They're not negotiating, with actually some exceptions that are about public pressure and sort of political pressure, but generally they're negotiating on the strength of their brand. But the low brand name hospitals who are typically paid less are now able to see how much the high brand name hospitals are being paid. The low brand name hospitals actually have a new tool to drive up their payment rates. So you actually have an upward pressure in payment from price transparency. I don't want to suggest that's the only effect. There are lots of different effects going on. But it is

something that we've at least talked about a lot and it's hard to put a number on how big that effect is.

CHRISTINE WHITE: When you say you've “talked about that a lot,” is it something you are observing in Massachusetts?

ÁRON BOROS: There's so much going on in the health care market -- including benefit design and the fact that there's price negotiation, but then in Massachusetts as well there's total cost of care negotiation -- that it's really hard to say that the price transparency is the thing that's having one influence or another. The intersection of these things is really hard to untangle. What I mean when I say we “talked about it” is that we're creating files for different parties to use out of our data. And we have long conversations with multi-stakeholders about what's an appropriate level of specificity that is for this use it for this audience and we have those regularly.

CHRISTINE WHITE: Andréa?

ANDRÉA CABALLERO: It dovetails us very nicely with that. Because just speaking from California, and this is an anecdote, a well-documented one, that all of the panelists and I am sure many of you know about, which is CalPERS and the public employee retiree and their reference pricing for hip and knee replacement. And so this is just an example of price transparency, quality transparency, and how you move the market.

When CalPERS in 2010 did their baseline, they had an average paid amount of $32,000 approximately per service. Although the range was from about $15,000 to $130,000 -- so this speaks to Bob's point about this complete irrationality of the price variation. Obviously, California is very large. You're going to have these variations. But many of those high prices are not showing that level of quality improvement or differentiation.

When they did their one year post implementation of reference pricing, their average paid amount went down to $23 per case. And so -- $23,000. What did I say? I am sorry, $23,000 per case. So the exposure and the loss of volume, impacted those $150,000, $130,000 prices, and you saw price compression. CalPERS uses a very powerful slide that shows the compression of those providers lowering their prices. And darn it, they wanted to get to or under the

reference price because they were losing volume. All of those that were below the reference price clearly then could see what those other hospital were charging. There was some floating up of what those lower cost providers were charging. But it did not offset the gains that were made in the reduction. That is an effect that can happen and there is a cautionary tale there about how much that can happen. But it did not offset the positive gains.

ÁRON BOROS: Just very quickly on that offset, typically the highest price hospitals are very large. So like you said, you could have actually large increases in the small providers. If you have small increases in the large providers, you get exactly the effect you're describing.

CHRISTINE WHITE: That example also pulls us back to Dr. Ginsburg's introductory remarks where he made the point that pricing transparency is often a supporting tool, used in this case in connection with reference pricing. There are more comments --

PAUL GINSBURG: Yes, actually the comment, and I am glad that others spoke before I did, because I thought that the problem with the question you posed about price transparency leading to competition was that -- now, what you heard is about reference pricing, about total cost of contracting to payment reform -- those were the things that potentially lead to lower prices. Price transparency, as you said, was supportive of them.

This issue of what about if you just put prices out there, say for “sunshine” reasons, what kind of risks do you run that prices could go up? The interesting thing is that, strictly from an economic theory point of view, I’d be most concerned with the higher priced providers basically being discouraged from experimenting with cutting their prices because they wouldn't gain as much market share if their competitors knew about it.

But the anecdotes seem to be more about the low priced hospitals’ ignorance about how their prices compared with others. These are risks and hence the reason for using the transparency cautiously. Particularly if you think through how the transparency is going to lead to lower prices, that's probably a really good guide to how you should use it. Although the “sunshine” uses are important, that they have influenced policymakers in many areas and they have influenced employers in many areas -- and later we’ll speak to the New Hampshire experience.

CHRISTINE WHITE: Mark?

MARK MCLELLAN: Just emphasize the point that has been made earlier about prices for things that aren't commodities don't necessarily lead to comparability and they can complicate actions. In the kinds of examples, especially the reference pricing examples that we've talked about, the price information is either explicitly accompanied by some meaningful quality information or it's something that people, for the most part, view as interchangeable or commodity products.

The evidence when price information is just provided alone without good comparable and good associated information on quality or a context that gives people confidence that the price information is meaningful for comparable kinds of services. If you don't have that, then I think the effect can be quite adverse. We haven't seen as much, I think, empirical evidence on price information as you have on quality.

But there are a number of studies on when quality information became more transparent, but did not fully account for risk and other factors, it could have adverse effects on access. Not just because of competitive reasons of people choosing the wrong places or going to someplace that was just more expensive because they thought it was better and not worse, but because of provider responses to avoid kind of higher risk cases. I would have some of the same concerns given the limited empirical evidence here about some effects like that potentially happening with pricing if you don't pay careful attention to quality at the same time.

CHRISTINE WHITE: Jim?

JAMES LANDMAN: Yes, our task force had fairly extensive conversations around the question of the business to business marketplace between health plans and provider organizations and public disclosure of negotiated rates. And there are some clear current antitrust concerns about public disclosure of those rates. What we are trying to figure out, obviously there are procompetitive effects and a potential for procompetitive effects and having an insured patient understand price variation. That does not require, at the same time, full public disclosure. A lot of that information is actually currently out there right now in explanations of benefits.

Looking at the sharing of that information with insured patient but in a way that's limited communications between the plan and the patient, for example, that doesn't require full public disclosure. We do think, and a lot of this analysis is based on, for example, observations of the Danish concrete industry. We do think this is probably an issue that merits further study with respect to the U.S. health care market.

CHRISTINE WHITE: I take it that you see that there are different ways of providing pricing transparency. Some which may create greater opportunities for collusion and some which may help restrict those opportunities?

JAMES LANDMAN: It's really about trying to negotiate that line right now.

PAUL GINSBURG: If you choose that price transparency as what a tool needs for the patients to make choice, that usually can solve that problem.

CHRISTINE WHITE: Any other comments on the collusion concern or observations?

PATRICK COURNEYA: Just one, I guess, observation. When we talk about the potential downsides, in my mind all we're talking about is the things we need to anticipate and plan for. We're not talking about stepping away from greater transparency. Because if we talk ourselves out of greater transparency, what we're doing is surrendering all of the advantages that transparency would bring because of concerns about a manageable set of possible downsides that are more a result of the behavior of individuals and organizations and not the validity of price transparency as an important market dynamic that needs to come to this market.

CHRISTINE WHITE: Áron, based on your earlier comments, it sounds like this is a concern that Massachusetts is very cognizant of and really focused on when you're looking at how you distribute your data?

ÁRON BOROS: Yes, but I would 100% agree with what Pat just said. It's something that we think about. It's something that we plan for. But it doesn't get in the way of the clear trend, the clear progress, the clear commitment to price transparency.

It is interesting. We've been doing this relative price publications now for several years. At the beginning the planners were very nervous about this, about exposing sort of some of

these differences. Now they live with it. They don't talk about it at all anymore. We are talking about publishing more price transparency at a bundle level or at a service level and they're very nervous again.

But we remember the experience, right? Which is that there is a lot of nervousness about this. But there are all these unanticipated positive consequences that have to do with economic theory about transparency being an important tool for a well-functioning market that we hang our hat on at the end of the day.

CHRISTINE WHITE: Jim, your card is up. Do you have a comment?

JAMES LANDMAN: Sorry, no.

CHRISTINE WHITE: Okay. Just checking.

JAMES LANDMAN: I keep forgetting.

CHRISTINE WHITE: Dr. Ginsburg, in your earlier comments you referenced the impact of market concentration -- and Dr. Courneya, you did as well. I'll pose the question of how market concentration appears to effect the adoption, use, or impact of price transparency measures?

PAUL GINSBURG: I've got to think about that one. You want to go first?

PATRICK COURNEYA: Again, I will speak to the experience that we have with regards to market concentration. It's interesting, actually. Our state has population concentration centers. The vast majority of that population concentration is in the Twin Cities metropolitan market. We do have large, good brand name, highly competitive groups in that marketplace, large multi-specialty groups. We also have other markets that are more rural, in greater Minnesota, where there are actually dominant players where there is much less of that potential need to respond to the market.

However, at least in Minnesota, the transparency seems to be having its effect across even those marketplaces where the choices are limited. Because the brand and identity associated with those large brands in the greater Minnesota marketplace do associate themselves with the performance across the state. The metrics that we use are based on the indices across the state rather than in those individual markets. In those markets that have

been identified as clearly higher in total cost, and those markets who have as a consequence significantly higher premiums as a result, have been needing to respond to that market pressure. Actually in some cases there are best partners in that conversation as we work with them to help them to identify opportunities to reduce resource use where they have that chance.

ROBERT BERENSON: Does that response include Rochester, Minnesota?

PATRICK COURNEYA: Well yes, as a matter of fact, at least in ways that call the question. Representing performance based on saying that --

ÁRON BOROS: In case everybody doesn't know, can you explain the context that he's referencing?

PATRICK COURNEYA: Yes. Rochester, Minnesota is where Mayo Clinic is headquartered. Recently the state exchange information showed that the costs there were much higher. They were much higher for the whole population, which at least calls the question about whether or not the prices are justified by reduced overall total cost. That's an important conversation and an important dynamic. It hasn't unfolded, but it at least produced in a marketplace where Mayo has a justifiably strong and proud brand that the public did ask some pointed questions about the implications of that for the populations. The person who's serving tables in a restaurant in Rochester may not be enjoying all of the benefit that is implied by the higher price.

PAUL GINSBURG: Sure. In the work I've done about market consolidation in health care, it continues to strike me that some of the organizations that have the greatest power to charge the highest prices are not necessarily in very consolidated markets. They don't necessarily have an enormous market share. It's their reputation. It's their must have status.

Again, I could rephrase the question, not about how price transparency can work in these markets, say, with very strong brands. It's really how the tools can work. How the tiered designs can work, how the reference pricing can work. A key thing in the ability to use those tools is the regulatory environment. Whereas we see high performance networks, which is what insurers call tiered networks for physicians. Tiered hospital networks are pretty unusual.

When we talk to people about why, it's really because of the power of those organizations to refuse to contract unless they're guaranteed they'll be placed in the preferred tier.

When Massachusetts in 2010 basically outlawed that process through legislation, that seemed to open a door to a rush of tiered hospital network products from Blue Cross Blue Shield of Massachusetts, and the other major carriers, that proved to be very popular. So in a sense, I think that the tools have the potential in these markets that have very powerful "must-have" providers. But often the legal framework needs to be supportive.

MARK MCLELLAN: Just to go back to a little bit of economic theory -- just having a large market share in and of itself is not necessarily a bad thing. If you are there because you are better, and I think at least part of the reason a lot of our friends in places like Rochester and Boston are at institutions that are having these higher prices and large market shares may be because of better quality. I take the fact that we haven't seen market tiers for hospitals yet not as just an indication that hospitals have market power. Because they do tend to use market power to avoid the tiers and also to avoid data release and transparency and so forth.

But maybe an indicator that our tools aren't working that well yet. That if despite the information that we're putting out there, people are still insisting on going to and having access to these institutions, maybe they either are better in some ways we're not measuring yet, and or we haven't yet "gotten there" in terms of the transparency tools around not just price, but also quality being convincing enough to change people's decisions.

Let me to go back to that prescription drug example. Very few people in this country believe that a brand name drug just because it's a brand name is better than a generic version of the drug, at least when their money is on the table. They've shown that they will switch and quickly change prescribing patterns in the United States when consumers get price information and an ability to gain financially from using it. This is different. It's harder to sort out the quality comparisons.

I just turn this around a little bit. The question was about does market concentration affect the use of price transparency initiatives. How about doing more to use price transparency initiatives to affect market concentration? These very high share organizations should be

expected to be able to produce more in terms of documenting better results as well as the better performance on price. At least properly understood. Not for specific services, but for meaningful episodes of care.

We had a report last year from our Bending The Curve group at Brookings, a big bipartisan effort, that strongly urged some steps that Medicare could take and that the antitrust enforcement agencies we thought could take to get to a much higher expectation about the release of meaningful price and quality information from high market share organizations. That would really help sort out this problem of are they on those better tiers for a good reason? Better quality? Or is it something that's an issue of market power and protecting higher prices?

CHRISTINE WHITE: Any further observations?

ROBERT BERENSON: Mark has brought up a very interesting point, of which I think there may be some later discussion in the day, but I want to just throw it out. If you are a high priced organization because you have a reputation, perhaps deserved, and not because have 70% of the providers in the market. Market theory would suggest you should be rewarded, and if we had no barriers to entry and real competition, the market would do something about it.

My point would be is that doesn't create a competition problem or an antitrust problem but it may create a policy problem of having hospitals with the ability or ACOs -- which we'll be talking about later -- to get high prices. It suggests different policy approaches other than sort of an antitrust approach. In many ways they should be rewarded. But it doesn't mean that we should be paying high prices to them. That is a discussion that we should be hearing today at some point.

ÁRON BOROS: That's actually a perfect segue for my comment, which is a slightly different angle on this exact conversation -- which is these high brand hospitals, high reputation hospitals tend to be politically powerful as well. I can only largely speak for Massachusetts, but the hospital chain that's responsible for $0.28 out of every dollar that goes to hospitals and physicians in Massachusetts goes to one chain. It's also the largest private employer in

Massachusetts. There is a real political question about how do you work within that system given those realities?

CHRISTINE WHITE: Does anybody have any comments on how you work within that system?

MARK MCLELLAN: I will reiterate that is a good reason for pushing for more transparency, more meaningful transparency, not just around lists of prices but around prices provided at a level that goes along well with quality and gets at that these reasonable concerns The public has about lower prices not necessarily being better quality.

CHRISTINE WHITE: It does bring us full circle back to the value of "sunshine," as we referred to it earlier.

PAUL GINSBURG: Yes, precisely. This is where the "sunshine" function can work. And this might be time to bring up the experience in New Hampshire. The Center for Studying Health System Change is publishing a study of New Hampshire.

In New Hampshire, the insurance department, five years ago, started publishing prices. We did a qualitative study recently. One of the results of the studies is that when there was a dispute between the most expensive hospital in New Hampshire, Exeter Hospital and Anthem Health Plan, the wide public knowledge, the civic knowledge about Exeter's high prices led most respondents we talked to to believe that affected the outcome of the showdown between the plan. That rather than just getting a limit on price increases, Anthem succeeded in actually getting the prices reduced at Exeter. Respondents believed it was because of the "sunshine" and the scrutiny of the high prices.

While I am at the other major effect of the transparency in New Hampshire -- by the way, not much consumer use of the information -- was that it led employers to adopt tiered benefit designs. They focused on outpatient services, on lab tests, and on ambulatory surgery. The point now is that apparently 70% of the large employers in New Hampshire have tiered designs for these outpatient services. The state of New Hampshire employees just adopted it for this year.

CHRISTINE WHITE: Jim?

JAMES LANDMAN: Yes. HFMA's been working on an initiative we call the Value Project, since 2010, and we're working with hospitals and health systems around the country on this question of how they are going to demonstrate value. We've been on site visits, like I said, to organizations around the country. No one's strategic plan is looking at significantly higher rates in the future. They're all very much focused right now on getting the business intelligence and performance improvement initiatives into place that will enable them to demonstrate to quantify the value of the services. They understand that that's something that they're facing. We are seeing movement on the provider side.

CHRISTINE WHITE: Dr. Courneya?

PATRICK COURNEYA: Just a point. We've been talking a lot about the kind of intramarket or intrastate dynamics around this. One of the things that we've wondered about, and the dynamic in our state is how does the differential in performance on total cost impact those businesses in those regions that don't directly benefit from the economic activity that's driven by the health care delivery system? They make decisions about where they locate, where they expand, and what they can afford to do based on all of their costs. When their costs, 20% of which or more can be related to health care costs, and they can see between markets where that performance is better in terms of the three parts of the triple aim.

I am interested as time goes on about whether or not employers will be making decisions about where they locate, where they expand based on the health care delivery system performance on those kinds of parameters. Greater transparency on that will also have policy implications for the states in markets where they see an imbalance that creates a relatively high cost compared to other markets that have demonstrated value, demonstrated quality that makes the decision makers about those locations and expansions comfortable with the idea of doing it in those different markets.

CHRISTINE WHITE: I am going to come back to the panelists in just a moment and ask each of you for some concluding remarks. Before I do that, I wanted to go back to something that, Andréa, you alluded to in your comments earlier. That you see that there is a rush or some

competition between health plans to get price transparency tools out to patients even though they're not necessarily finding that the patients are actually using them. Do you want to comment a bit on that dynamic and where you see the pressure coming from and where you see it going?

ANDRÉA CABALLERO: There are a lot of variables as to why the patients aren't using these tools. They can range from the tools are hard to find, in any given health plan website trying to find the cost estimate. You have to your login, your username and password, and we have thousands of them in our brains right now. Using them, and then finding and getting to the tool, which then can give you your personalized information, is hard. In some instances, the tools are not available if you have a benefit design that doesn't require it. If you're in an HMO and you have a co-payment only, you don't have a high deductible, in some cases, the health plan will just say you don't need that tool even though it really limits them the sensitivity from a consumer point of view and the employer actually would like that to be available to them.

Some of these tools are, while the information is there, they're hard to navigate and clunky. Can you compare provider next to provider and quality next to quality? Sometimes they have to navigate between different pages. Some of them, I think, give up. You might have an initial registration which could lead to why some vendors or plans will say they have higher utilization of the tools. You can have a registration, but then ongoing use of the tool just kind of falls off because of probably the first experience.

Education, from a health plan and an employer standpoint, is important. The benefit designs and the education and the really engaging the consumer -- that's kind of an overused word -- but engaging them through this processes over and over and over again. And the easier these tools are to use, hopefully the more they will be used.

CHRISTINE WHITE: This brings us back to the benefit design question. Does the consumer have the economic incentive? Also, is the pricing transparency tool effective? Is it actually reducing the search burden on the consumer and making it easy for them to go get that information?

ANDRÉA CABALLERO: Right. What we've learned from some employers who have high deductible plans that their utilization of some of these tools can be very significant while the employee is in the deductible phase of their plan. Then as soon as the employee hits the deductible, and it goes to different a different level of benefit, then their engagement about what things cost drops off. That's another problem that we have to solve for, which is how do you maintain that?

Some employers that we work with have gotten quite creative in terms of identifying that you still need to be concerned about what is spent above and beyond that deductible -- because that is associated with your compensation and it's associated with our overall performance as a business. There are other strategies that employers are trying to use to keep that engagement past a deductible. But it's still a barrier.

CHRISTINE WHITE: Dr. Ginsburg?

PAUL GINSBURG: Yes. What I get from what Andréa told us, is that if someone has a high deductible health plan, giving them a good price transparency tool may not be enough. There's a wide-open sphere. What about reference pricing? What about a tiered network? These tools are easier for consumers to handle than being given a lot of prices with a price tool. The implication is that we should not put all our eggs in that one basket.

CHRISTINE WHITE: As we move to the concluding remarks, we also do want to welcome any suggestions for further research that would help us grapple with these questions and find good answers. Of course, this is an area where we welcome public comments as well. We are accepting the public comments through April 30 and you can access the workshop portal to provide those. Would you like to start us off with concluding remarks?

ROBERT BERENSON: I won't give you research ideas yet, but I have all day to think about it. Just two quick ones. One is I am more convinced about the usefulness of the public attention, the “sunshine” part of all of this. Although even there I am much happier with the Attorney General of Massachusetts approach -- which looks at whether teaching is an explanation, or disproportionate share hospital payments, low income, or higher quality. It

wasn't a perfect study but it went through the discipline of trying to see if there were explanations for different prices.

I am happier with that kind of approach in a number of states -- that sounds like what Minnesota is doing -- than simply publishing a lot of chargemaster information. In the beginning, I think that's what you have to do. Steven Brill got a lot of attention, and that was probably useful. But we now need to be, in the public attention area, more sophisticated. I am using it for consumer choice. I basically agree we need to be proceeding, but there are technical problems we need to work through in making that useful. I agree with what Paul has been emphasizing. Just dumping a bunch of prices is not as useful as combining it with the payment policy and benefit design. That is where this afternoon I will have some things to say about what I think are the obligations in benefit design payment policy to get transparency to be more useful.

CHRISTINE WHITE: Áron?

ÁRON BOROS: I will adopt something that we heard from this morning about pathways and simply say that when you look at all the pathways to better value, most of them require transparency. There are some pathways to higher cost that are affected by transparency, but most of the pathways to better value require transparency.

CHRISTINE WHITE: Andréa?

ANDRÉA CABALLERO: I would just say that I am more encouraged than ever that employers are sort of onto this and onto the “sunshine” of this, and that there's probably more willingness than ever to move toward benefit design structures that can change markets and can change competition dynamics within a market. They can only do so with transparency. But I think tiered networks, narrow networks, reference pricing, there's more courage and appetite to move forward on those once they have the tools to be able to do it.

PATRICK COURNEYA: I was particularly encouraged by an aspect of the conversation around the issue of whether or not price transparency was legitimate. I didn't get a sense of that. What I got from everybody's comments was a series of experiences that hint at the possibilities. Positive possibilities associated with price transparency.

A recognition that the list of tools that will take advantage of price transparencies are at their earliest stages of development, which is of course no great surprise, because we haven't been called upon to take advantage or even develop those tools because we haven't had the price transparency to respond to. I am encouraged by the idea that the general thrust of today's conversation was almost identifying the design characteristics of the responses that we need in the context of more effective transparency.

PAUL GINSBURG: I just want to reflect about how productive I thought the discussion was and compare it to how a discussion might have gone five years ago. That there was so much more focus on really supporting tools, what's useful for “sunshine”, what is not. I am leaving encouraged.

MARK MCLELLAN: Well if Paul's feeling optimistic, then I am happy. It does seem like there has been progress. It's been a virtuous cycle, albeit a slow or maybe sometimes seemingly half-hearted cycle, towards better information on price, on meaningful price, and quality along with it, I want to emphasize, and the reasons why people would care.

So we've seen a lot of progress in the tiered benefit designs and in other steps to engage consumers more. You are not going to get one without the other. We are not there yet. People are understandably not comfortable with going to tiered networks for many types of hospital services and other services. We will come back to this more in the afternoon. But clearly putting some pressure on there drives more availability of price and quality information, as Jim was just emphasizing from the providers. That in turn makes further progress possible.

The other thing I'd take away is that this is not easy for many health care organizations. But we actually are at a stage now where we can do a pretty good job of meaningful, comprehensive price and quality information together, at least in some circumstances. Getting back to FTC, if there's one priority area where that should be done and where it is technically possible to do it, it's in cases where health care organizations have real market power. There are concerns about quality on the one hand and pricing power on the other. So if there's one group that ought to be leading the way in producing this information, it's those high

concentration organizations which are comprehensive, that have the ability to put these kinds of data together, and should be expected to produce it now.

JAMES LANDMAN: I certainly share the sense of optimism among the group. We've seen a widespread agreement among a range of very diverse stakeholders around the need for greater price transparency. I am also glad that the price transparency panel and the quality panel are coming together after lunch.

Because one of the points of the HFMA Price Transparency Task Force, was to focus on price transparency, but again and again it was commented that price transparency has to be presented in the context of relevant quality and safety information, as well as experience information.

In terms of further study, as a number of the panelists have pointed out, yes, early days price transparency is one thing there's a massive education effort that has to go into ways that patients actually understand how to use this information, how to access this information. We don't know yet exactly what tools and what methods of presenting information are the best. So we really need a study on that. Then the whole question of incentives as well.

STEPHANIE WILKINSON: That concludes our panel. We are out of time now. I'd just like to thank our panelists for participating. I thought it was an excellent discussion. We will be back at 1:45 for the quality and price transparency roundtable discussion.

[LUNCH BREAK]

PANEL: INTERPLAY BETWEEN QUALITY AND PRICE TRANSPARENCY

Moderators:

- **Thomas R. Iosso, Economist, Antitrust I, Bureau of Economics, Federal Trade Commission**
- **Erika Wodinsky, Attorney, Western Regional Office, Federal Trade Commission**

Panelists:

- **Andrew Baskin, MD, National Medical Director for Quality Performance, Aetna**
- **Robert A. Berenson, MD, Institute Fellow, The Urban Institute**
- **Áron Boros, Executive Director, Commonwealth of Massachusetts Center for Health Information and Analysis**
- **Andréa Caballero, Program Director, Catalyst for Payment Reform**
- **Lawrence Casalino, MD, PhD, Livingston Farrand Professor of Public Health & Chief of the Division of Health Policy and Economics in the Department of Healthcare Policy and Research, Weill Cornell Medical College**
- **Patrick Courneya, MD, Medical Director, HealthPartners Health Plan**
- **Paul Ginsburg, PhD, Norman Topping Chair in Medicine and Public Policy, University of Southern California, formerly, President, Center for Studying Health System Change**
- **James Landman, JD, PhD, Director, Healthcare Finance Policy, Perspectives and Analysis, Healthcare Financial Management Association**
- **Mark B. McClellan, MD, PhD, Senior Fellow in Economic Studies & Director of The Health Care Innovation and Value Initiative, The Brookings Institution**
- **Patrick S. Romano, MD, MPH, FACP, FAAP, Professor of Medicine and Pediatrics, Center for Healthcare Policy and Research, UC Davis School of Medicine**
- **Shoshanna Sofaer, DrPH, Robert P. Luciano Professor of Health Care Policy at the School of Public Affairs, Baruch College, City University of New York**

THOMAS IOSSO: Welcome. We welcome you to the afternoon session of our health care workshop. Now we're going to have a roundtable on both quality and price transparency and how they intersect. Is everybody here?

OK, so this morning we learned a lot about quality measurement, and we learned a lot about price transparency. And we've learned that more and more information is getting out to patients and other people who can use the information. And we want to make sure we don't wind up in a world where we know the price of everything but the value of nothing, with apologies to Oscar Wilde.

So we're going to have a good chance to talk about how the two can intersect, how we get those types of information out in such a way that it can be helpful to various patients and

various other agents. And so we're bringing back most of the people from the morning to talk about these issues. And I turn over to Erika Wodinsky, who's going to help co-moderate this panel with me, and I'm Tom Iosso, an economist with the FTC Bureau of Economics.

ERIKA WODINSKY: Thank you very much. What we would like to do because we have so much to cover, we have a lot of questions, and we also want to make sure that all our panelists have the chance, that the people who spoke on quality this morning will have a chance to talk about price transparency issues and vice versa. First, what I'ld like to do is just, I assume most people saw the panels this morning but if not just have the panelists go through and just introduce themselves and just who they're with. We don't need long introductions, and then we will turn to Dr. Courneya, who will give us a brief overview. So why don't we start.

ANDREW BASKIN: Sure. Andrew Baskin, I'm from Aetna. The National Medical Director for Quality of Aetna.

ROBERT BERENSON: The B caucus is speaking over here. This is Bob Berenson. I'm a Urban-Institute Institute Fellow.

ÁRON BOROS: I'm Áron Boros. I'm the Executive Director of the Massachusetts Center for Health Information and Analysis.

ANDRÉA CABALLERO: I'm Andréa Caballero. And I'm the Program Director at Catalyst for Payment Reform.

LAWRENCE CASALINO: Larry Casalino. I'm the Chief of Division of -- what is it, we've changed our name -- Health Policy and Economics at Cornell Medical College.

PATRICK COURNEYA: Pat Courneya. I'm a family physician and the Medical Director for HealthPartners Health Plan .

MARK McCLELLAN: I'm Mark McClellan. I'm a Senior Fellow and the Director of the Health Care Innovation and Value Initiatives at The Brookings Institution.

JIM LANDMAN: I'm Jim Landman. I'm a Healthcare Finance Policy Director at the Healthcare Financial Management Association

PATRICK ROMANO: Patrick Romano. I'm a General Internist on faculty at UC Davis School of Medicine, Sacramento, California, and I do health services research on quality measurement.

SHOSHANNA SOFAER: Shoshana Sofaer. I'm a professor of Health Care Policy at the School of Public Affairs at Baruch College, part of the City University of New York. And just in time,

PAUL GINSBERG: Paul Ginsberg. Professor at the School of Public Policy, University of Southern California, until recently President of the Center for Studying Health System Change.

ERIKA WODINSKY: Dr. Courneya.

THOMAS IOSSO: And let me say, while the doctor is getting ready to present, if we could have the comment cards circulated. Since everybody's heard from the various panelists this morning, potentially this may give you an opportunity to ask some questions of them that haven't gotten the chance to be answered so far this morning. And hopefully maybe we can get a few of the questions from the audience in.

PATRICK COURNEYA: I only have two slides, and the intention behind these two slides is not to have anybody see really the detail. It's more to help me keep a little bit organized on some of the points that I want to make. This first slide really is just a visual representation of many years' worth of work that we've been doing at HealthPartners and in our community to put together the necessary building blocks for creating an environment where total cost of care information actually produces the kinds of results that we would like to see. I'd like to say that 20 years ago, when we started this work, we had this grand plan that would unfold over the next 20 years and result in this. It's really just a series of activities and learnings that have gone over time and built one on the other that brought us to the point where we have any story to tell it all.

One point about quality. I first began getting really involved in the quality work back in the early '90s. That transparency hadn't yet reached the market except for transparency about our performance relative to others that was reported to us without really any significant transparency to the public. But in a single specialty, primary care small group, we began to

tackle that. And in our marketplace, which is dominated by large, multi-specialty, well-organized groups that have been around for a long time, our competitive drive was that we needed to be able to demonstrate to ourselves, and ultimately to the public, that as a small group, on those quality measures that the community had agreed were important, we could do just as well as those big groups. We knew that that was going to be a competitive requirement for us to do well.

In that time, we began reporting publicly, as an example, a comprehensive measure on diabetes, where it wasn't just measuring the important parameters. It was actually getting the patient to target, and you didn't get credit in the numerator unless they were at target for all five of the parameters. Now community-wide performance for that measure was less than 10% when we started, and it ranged anywhere from about 10-11% down to 2% or 3%. In that time community performance is now up around 30%, which means that 30% of our diabetic patients are now on target on all five measures. And we have high-performing clinics that are running in the 60% range.

And the thing to remember about that is that those high-performing clinics, because of the transparent nature of the reporting, are identified to the public. And they're also identified to the providers within groups. So they actually attract the more difficult patients. They're not picking the easier ones, because they get referred over there because they know that they get the job done.

So we have seen substantial improvements. In fact, one of the things we did to try to illustrate the benefit of that, was to calculate, based on what the evidence showed, how many heart attacks were avoided, how many patients didn't suffer vision loss, kidney failure, and other things. And so every year we produce a report as a health plan for our member population, calculating that number. And that's pretty compelling, and it translates those clinically relevant measures into patient-relevant outcomes. And it does so in terms of things that were avoided.

Another issue that I wanted to touch on too, with regards to quality, had to do with disparities. We have a pretty strong feeling that we don't think that, for quality improvement

purposes, adjusting for socioeconomic or race and ethnicity should be done. In fact, one of the reasons we feel that so strongly is that we began gathering race and ethnicity data on our patient population in the early 2000s. We identified those disparities and have actually been able to close those disparities gaps significantly. For instance, for colorectal cancer screening, the disparities were at about 18%, and they're now down to 12%. In that time frame, both the general population performance has gone up to the 90th percentile. And the performance for the populations of color is now at near the 90th percentile, based on a national standards.

So we have been able to close disparities and improve performance for those populations, really by identifying them and owning those populations because they were our patients. And those are two really pretty compelling examples to me about the value of transparency, both internally and externally.

What you see here is actually a series of steps, including tiering that we've been doing for 15 years now, quality metrics being kind of the barrier to entry to get into the tiering. You can't get tier one unless you've got quality metrics going. And then also the evolution of our total cost of care measure, used first internally to help us to understand our performance on total cost of care, so that our group, which at that time was not really competitive in total cost, both because our fee schedule was too high and because our resource use wasn't where we needed it to be. We've driven our total cost of care down to where we're 9% better than the average in Minnesota. And that is creating signals in the marketplace that others are responding to.

I've been talking a lot about the total cost of care measure and there are some details that I want to highlight. The total cost of care, of course, is a pretty simple formula. Total cost is resource use times price, and we've developed some very rich analytics to help support provider groups in their efforts to identify opportunities to reduce total cost of care, both in terms of resource use and in terms of price. And we've created shared savings payment agreements with them that mean that about 85% of our membership are going to clinics that have shared savings payment agreements with us, so that's driving engagement. And one of the things we've found very important is, if we're going to go into a total cost of care agreement with the providers, these analytics, this support, the work we do with them, is a clear signal

that we want them to succeed as much as they want to succeed. And that creates the kind of partnership that actually drives good attention.

The other thing that's been important about that trajectory that I showed you before, is we built relationship with provider groups that made it clear to us which were the best first partners in going into the total cost of care agreements. The ones that we knew that could execute effectively were the ones that we wanted to partner with first because, if we got early successes with total cost of care performance, we could draw in the other provider groups much more easily.

The other thing that's important to note on this is that we have gotten the NQF endorsement for this measure. We make it available on the website. And we also include the analytics packages, including the software, so that people can use those. We license them, but only so that we can show how much it's being used. And right now we have 80 different licenses, 24 or 25 different states where those metrics are being used in experimental fashion, or at least to apply them to the claims data that they have to see what's going on.

Also, as I mentioned earlier today, our care delivery system through Minnesota Community Measurements, have decided that this total cost of care metric is going to be the foundation of the way their performance on total cost of care will be represented publicly. And because that's our quality reporting mechanism, the two will be side by side in the public reporting mechanism that we have in Minnesota. So we are bringing these together.

The other thing that's important in our experience is that we have seen groups at all points along the spectrum, some of our highest performing groups are actually the smallest. They have agility and just enough information about their patient population to drive better performance. And they're actually among the most cost-efficient groups that we use as well. Those smaller groups actually have greater flexibility in identifying high-cost hospitals or even high-cost behaviors within emergency rooms and other things, and can go to those referral providers and actually talk to them about what the problem is.

So for instance, we have one hospital system where the ER use of high-tech imaging is significantly higher than in other hospitals. And because the community knows those other

hospitals, or at least based on their reputation, are doing a good job, it gave one primary care clinic the opportunity to go to that hospital, ask them about that, and ask them whether or not they should continue to use that ER for their patients. Now, they continue to use the ER, but they got a response from the hospital system. And the hospital system is now using a much more rigorous approach to the use of high-tech imaging in the ER and reducing that signal. It's a great way that that individual group has created a response and resource use that was exactly the direction that we had hoped it would go with this greater transparency.

The other thing is that we have identified groups, and actually feature them, who are hitting the lights out in terms of the clinical quality reports that we do publicly, as well as total cost of care and patient experience. So by featuring those groups that are working best and most effectively on Triple AIM performance, we can highlight the fact that it's possible, sort of demonstrate to the marketplace what they should come to expect, and it does create significant response -- competitive response -- among the other medical groups in our community.

So that's our experience. And I do believe, we do believe pretty strongly that we can effectively marry a reasonably credible story about total cost of care with a credible story about clinical quality that the provider groups buy into, that the public response to, and that's driving the kind of competitive norms and changes the we would hope for.

ERIKA WODINSKY: Thank you.

THOMAS IOSSO: Do any of the other panelists have any specific examples of the marriage of quality and price information, and its use, that they'd like to bring forward now?

LAWRENCE CASALINO: May I just ask Patrick one very specific question. Patrick, when you say some of your smallest groups are some of your best performers, what size are you talking about?

PATRICK COURNEYA: Well there's one, actually, who is a solo provider, and I would say I was pretty skeptical about whether or not his particular practice performance was more of a random consequence of, sometimes that happens. But in spending time with them at their clinic, it was pretty clear that this was a result of their specific attention to those things.

There was another group that we featured in our awards ceremony this year that is three clinic sites, 10 primary care physicians, with, I believe, three or four nurse practitioners and very much the same thing, well-led, focused on quality, attentive to cost, practice styles that tend to be more conservative, but now supported by better information from us about identifying additional opportunities where they could reduce overall cost.

LAWRENCE CASALINO: It's interesting, and just in two sentences, we've done an analysis with about 1,000 practices nationally, of 19 physicians or fewer, and using Medicare data, and we find that the one- and two-physician practices are the best performers on the main analysis and on re-admissions and ambulatory care-sensitive measures. No one believes it. We've analyzed the data every way. One- and two-physician practice. McWilliams in a paper recently also found smaller practices do better. So everyone assumes that bigger is better, and there are reasons to make that assumption, but it is mostly an assumption so far.

PATRICK COURNEYA: It is, and that's a really important thing to me, because when we started the work that I described when I was early in my career, it was small, and at that time our group was nine FDEs, and we originally sort of lamented the lack of resources that we had compared to the big multi-specialty groups. But then we also recognize that we as a group can make a decision at a physician's meeting on Thursday and have it in implemented by Monday, which is not true for the bigger organizations, and we can respond to the things that are going on with our patient populations with greater agility. So in the same way that the Minnesota market may have certain advantages about the way it can approach these things, it really is a matter of recognizing what different organizations, different marketplaces, are capable of and actually taking advantages of those things, as opposed to focusing on the things that are standing in the way of getting the job done.

ERIKA WODINSKY: I'd like to remind panelists that if you'd like to speak, if you'd turn your placard. Andy, go ahead.

ANDREW BASKIN: It's actually a comment in the form of a question for Patrick. So a wonderful example of high-tech radiology use and a provider response. And I guess my question is would that provider response or interaction be the same had that provider group

been employed by the hospital? Which is, by the way, of course, all too common nowadays, and more and more common. So the dynamic conversation changes, I guess is my comment.

PATRICK COURNEYA: Actually we've seen similar responses. I described this morning a collaboration between our own medical group and one of our competitor medical groups, in a sector of the Twin Cities marketplace, where they actually do own some of the facilities. And they also have made decisions that reduced use of the hospital. And it was quite clear that that was going to happen, but did so because the metrics drove them to those identified opportunities as the only ones that they could see to perform better in the total cost of care agreement. And because they could effectively implement the processes, the operational details at the front line, so that they could reliably do those things. So yeah we've seen examples in both directions.

Another example where we've seen the medical group hospital system respond to the metrics on total cost of care has been in greater Minnesota, with a good partner that we have, Essentia, where they've identified over-use of the ER because they don't have available after-hours access to convenience care. And they're implementing alternatives in the marketplace that produce that, and will intentionally reduce their ER use.

ANDREW BASKIN: I just might add that we have seen some positive results in that, but more so in a shared savings type of example -- is when it occurs.

PATRICK COURNEYA: Yeah, the other thing that we're transparent about with our provider partners is we recognize that shared savings is ultimately a transitional strategy. Because the better a group is at realizing those savings, the shorter the timeline before they reach the theoretical limit to what they can do. We have to work with them to redesign the nature of the payment models that replace that once that point arrives.

LAWRENCE CASALINO: What then, Patrick?

PATRICK COURNEYA: We actually have folks who are much more interested now in accepting a larger share of the total dollar. And we're comfortable with the idea of doing that. We're also very sensitive to the lessons that we learned back in the '90s, where provider groups accepted risk that they had no way of managing effectively. And so we intend, as a health plan,

to make those transitions thoughtfully, and with the kind of organizations that we know, as I said before, have the highest chance of succeeding in the early phases of learning.

ERIKA WODINSKY: Did anyone else want to comment on the things that were said in the other panels this morning. We had some specific questions which may prompt some other answers, but I don't want to cut anyone off.

THOMAS IOSSO: We might want to start at that end. Professor Sofaer, if you want to comment on the price panel, anything that was interesting.

SHOSHANNA SOFAER: From my perspective, I think that we can't forget that sometimes the devil is in the details. And I think there's been a general recognition of the fact that it is probably counterproductive to provide people with price information without also providing them with quality information. So what I am concerned about -- I'm concerned about multiple things. I'm concerned about what's the nature of the price information, how accurate is it. Is it about the cost to the consumer, or is it only the overall cost, which the consumer generally does not, at this moment in time, care about because we haven't really sensitized our population to how expensive medical care is for the country, let alone for themselves. So I worry about those things.

The other thing I think we're going to have to be careful about, is that if we're going to provide price and quality information together, we have to have the price information and the quality information refer to the same entity. So there has to be very careful mapping. So, for example, we have right now no measures of the quality of different facilities that provide MRI's or other kinds of radiological examinations. We may very well have information on the prices of different facilities, and my concern is that people are, in fact, going to rush to provide that price information because we have it and because, as was earlier discussed, that's a more commodity-like, or appears to be a commodity-like, kind of a structure, kind of service. But if we don't have the quality information to go with it, what are we going to do? And I would have to say that I think that the folks who were working on the development of quality measures, and the folks who are trying to do price transparency, are really going to need to put their heads together in order to make sure that we're really not going off in two different directions.

And I see NQF being, to some extent, in a position to do that. But I think even NQF is really going to have to engage with a much broader range of both experts and stakeholders in order to really pull that off and pull it off effectively.

PAUL GINSBERG: Yes. During the price panel, both Bob Berenson and I brought up the important aspect of price transparency as far as giving referring clinicians information about prices. We should probably bring that into the quality discussion as well. And I could think of a personal experience where being referred to getting an MRI, where I had a list of a subset of MRI providers in the area, which I presumed that these are the ones that the orthopedist has been able to read their images better. And in a sense, I don't know what it was based on, but it helped me make a choice based on price. And I think there's opportunity for a lot more of that. And again, maybe patients choosing carefully primary care physicians, and having those primary care physicians do a lot of the work in screening the quality data on the referral, physicians and facilities.

THOMAS IOSSO: Dr. Romano.

PATRICK ROMANO: A couple of thoughts came to me through that discussion. I think where we are with price transparency is probably several years even behind where we are with quality transparency. And I was reminded looking at the back door of my hotel room last night, where it said that the price of the hotel room was $1,200 a night. And I can guarantee you that I'm not paying $1,200 a night. But that's what we see in a lot of the transparency initiatives, is either there's a list price, which is what our state government in California is publishing. Or there's some kind of average price, or average cost of care, which really doesn't pertain to any individual patient or any individual payer.

So I think it's really important just as we're trying to tailor quality measures more to patient-specific circumstances, their geography, their health conditions, their comorbidities, their age and demographic characteristics, so too the price measures need to be tailored. So if it's for a consumer, it's what price is the consumer going to pay. If it's for a health plan, it's what price is the health plan going to pay. So that means different measures for different audiences, tailored in different ways.

The other thing I've seen that bothers me is some interest in putting price and quality together, into a single composite, which I think is a bad idea because it obscures both and it confuses the signal. We know that there's no relationship overall between price and quality, and the emphasis should be on getting value, getting the best quality for the lowest price, which I think is obscured by a composite. So there are just a few thoughts.

THOMAS IOSSO: Professor Sofaer.

SHOSHANNA SOFAER: Yeah, just a comment on Dr. Ginsberg's point. Here we have the irony. We don't have any quality information about MRI facilities, so in your example, there wouldn't have been any quality information to provide you. You're assuming that -- and patients do this all the time, they assume -- the doctor gave me these three names, they must all be good. And then they would maybe make a decision based on price if they believe that. But on the tools that were so discussed earlier, we did some exploration in qualitative work about both reference pricing and the tiered networks. And just as patients were unwilling to believe that a lower-price provider could be as good or better than a higher-price provider, they also had a very hard time believing that the people who were putting providers into tiers were putting them into those tiers on the basis of something other than the price to them.

And so, if you're going to use tiered pricing, reference pricing, you have to be transparent about how you made those decisions. Otherwise, they will be viewed very cynically by many in the consumer world. And I think it is just for the sunshine reasons. I think it's good to make those methodologies very, very clear. You don't have to use fancy language, but you can very clearly say what you took into consideration in this reference price. And was this reference price a price at which you could get a safe and high-quality service? And are these high-tier providers, are they high-quality providers, or not, or just cheap providers?

THOMAS IOSSO: Dr. Berenson.

ROBERT BERENSON: Yeah, I wanted to join the fray a little bit. I see a real potential for marrying quality and price transparency, but the point I would emphasize is that it's actually quality and not necessarily based around measurement of quality. I am much more skeptical

about our ability to fill all the measurement gaps, to have valid and reliable data where we need it. So let me give you a very concrete example of what I'm trying to say here.

Reference pricing, let's say for hip replacement. I think it's CalPERS that has some pretty impressive data. Here I'm going to sort of give kudos to the Catalyst for Payment Reform, which has a detailed set of provider roles and duties that should go along with being included on the list that the payer, the purchaser, provides to the beneficiary and to the member to be able to say, here are the places that you can go with your reference price and be assured of a certain level of quality. It's not all based on quality metrics.

Let me read a few. Creating and maintaining a list of indications and contraindications for acceptance of patients to the program. Assuring all providers of care that are part of this care bundle, or reference price, whatever you want to call it, comply with the plan's credentialing standards. Providing summary of intake and workflows and communication to the plan. Demonstrating compliance with quality metrics to the extent that there are some. What I guess I'm describing is something akin to conditions of participation.

This is not easy to measure everything that we want to be able to assure patients that they're going to have appropriate attention to quality and safety in the places we're holding out to them as being a -- you can get good quality at this price. I think we've overdone the -- well I'll call it the tyranny of measurement. I actually don't believe you can improve what you don't measure. I mean I know that has become sort of standard aphorism. I don't think that's true in life, and so I think we just have to be much more realistic about where we are with measurement. We need to make a commitment to make the measurement that we are able to do related concretely to the prices and a reference pricing kind of an environment.

Let me give you one other example here, and then I know my time is running out. Colonoscopy is another example which sounds like it should be a service that people should shop on. We have outrageous prices in some places. There's been recent evidence, through clinical journals, that the withdrawal time of a colonoscopy, if the operator spends six minutes or more, they have a much higher yield of findings, polyps, et cetera. It's surprising that, in fact, withdrawal times have traditionally been less than six minutes for many services.

Well as the condition of participation, to be in the reference pricing program, the colonoscopy center, the endoscopy center, makes a commitment that they're going to follow the standards, the guidelines that have now been promulgated by the College of Gastroenterology. Does that mean you're going to have a measure of that and ask people to self-report that they took more than six minutes? I don't think so. I think you're just going to occasionally audit, make sure that the entities that you're, short of saying, we're working with these, we're going to say you can get high enough quality at a good price. They're meeting some standards.

And so I just think we've overdone the measurement piece of it. Where you have measures, use them, but otherwise, it doesn't mean that you're impotent. And I think payers have great opportunity, as well as medical groups, to set the quality standards that go along the price transparency.

PATRICK COURNEYA: At first, when you first started with your comments, I was almost ready to disagree, but I think maybe there's more agreement there than I had thought initially. One of things that's always puzzled me about this conversation is, if indeed we don't know how to measure the quality of something, how do you know that the price you're asking is justified?

And so there's kind of a two-direction conversation that would need to go on there, because the value is, to a certain extent, conveyed by what you're willing to charge for the service you provide. And it seems to me to be a difficult protestation to say, well I charge more because I'm doing a higher quality work, when I have no way of actually demonstrating that. And that's why I think price transparency is important here, because it calls that question in a way that's more direct than it has been in the past.

Having said that, doing the work for a decade or more in our marketplace, where we built credibility around the process and results being reported publicly on clinical quality -- was an important way of engaging physicians in the idea first of all, that it was appropriate to be measured. But in the course of that decade, for them to be able to see that they were able to take something like comprehensive diabetes measure, where the initial impression was that they had no control over what patients did once they left the office. And to see their

performance go from less than 10% of patients at target, to a community norm where it's in the 30% range, gave them a much stronger sense that they could have more influence than they thought they could, and that's translated over into a whole bunch of other different initiatives that we've worked on to improve quality.

The other thing that it did is it proved to us which clinics were better at operationalizing the kind of detail that was actually necessary to be able to reliably deliver the evidence-based care that was going to drive improved performance.

ÁRON BOROS: I'm trying to figure out how to be as constructive as possible. Let me caveat what I'm about to say by saying I probably don't believe what I'm about to say, but I'm trying to be provocative.

So I think that there is an underlying sentiment that we don't trust patients to evaluate quality, that is probably overstated. And you could go so far, and this is the part that I'm not sure I believe, to say let's publish price. Let's let the patients see the price and then make their own evaluation of quality. And if they want to go look at measures, and there are lots of measures out there. And if they want to figure out if they want patient experience measures, or clinical outcome measures, or whatever they care about. Fine, but maybe we don't need it for patients -- and I think that's separate from the issue about for providers. But for patients maybe we don't need to put price and quality right next to each other.

And one thing we hear a lot about is the Neiman Marcus effect, that if you only put out a price measure that patients, in the absence of any quality measure, will assume higher price is higher quality. But that's really only true if the patient has no financial incentive to choose the lower-price provider. And if the patient really has a choice of figuring out, should I spend more to get more out of my own money, not the premium dollars, but my own money, then I think that we could empower patients more to say, “Here's the price difference, you go figure out whether the brand name is giving you value for your dollar versus somebody else,” -- and maybe trust patients more.

UNIDENTIFIED SPEAKER: But you don't believe that.

ÁRON BOROS: I don't know what I believe, to be honest. I really don't.

ERIKA WODINSKY: We will follow up with the other -- I see that we have a lot of people who would like to address these and some other questions. I want to remind the audience, if you have any questions you'd like us to pose, we will try as we have in the past, but it's helpful for us to have your questions and your cards anyway. And people will come around and collect those. So with that in mind, Andréa, why don't you jump in.

ANDRÉA CABALLERO: Yeah, I think I'm sort of where Áron is a little bit on this. What's difficult from the purchaser and employer point of view is that they feel they're in a position where they must provide the quality information. And so regardless of whether we trust the consumer to use it, or how they use it, the employer is in a position -- and you can use the reference pricing example, that without that, the employer is only going to be accused of signing up with only the cheapest providers and not look at quality. And so that's the dilemma that the employer is in.

And I wanted to react to some comments this morning on the quality panel and echo Shoshanna's point, is that the employers are just massively confused. And there are lots of experts in this room on quality measurement and can speak to it all day long. Employers cede this expertise to their health plan or to other people and they get hundreds of metrics back that don't mean anything to them or to their employees. And so we are in this quandary.

And some of the work that CPR is trying to do is really -- what are the metrics that matter to the employer and matter to the consumer? And they are things about safety. They are about adverse events. They are about, will I die. And those more simple, very tangible, easy to understand metrics. Other than things that certainly should be measured, and work very well in the provider context and give very good feedback, but they don't translate well into the consumer world.

So trying to find that parsimonious set of metrics that speak well to that audience is a real challenge, because everybody has an interest. But that's where marrying the two together -- right now in the tools there are quality, you can hover over your quality metrics, or the provider there's a star next to it. They've been designated by the health plan as being a top-tier quality efficiency provider or whatever. And you can hover over it, and you can see what those

quality metrics are. Nine times out of ten the consumer really isn't going to understand how those metrics were derived.

ERIKA WODINSKY: Jim, you haven't had a chance yet. Why don't you.

JIM LANDMAN: So I mentioned this morning that HFMA, since about 2010, has actually been working on something we called the Value Project. And just to begin with we needed a working definition of value for our membership. So we had value is quality in relation to payment. We used payment instead of cost because cost immediately confuses. Our members are wondering whose cost. So we used the term payment or price to really focus on, we're looking at value from the perspective of the purchaser.

Now HFMA, both sides of that equation, the quality side and the payment or price side, are in flux. We talked this morning on the price transparency panel about some of the issues around what exactly, what sort of unit of care, episodic care are we measuring. On the quality side, obviously HFMA, we are finance people. We're not going to take up the question of what are the appropriate quality metrics, but we did very early on in the Value Project work with the patient advocate to really define a working definition of quality that we could use with our members.

And we just came up with four attributes that could be linked to four simple patient statements. So the first, access. Let me get the care I need. The second, safety. Don't hurt me. The third, experience. Respect me as an individual. And the fourth, outcomes. Help make me better. So that's our working definition of quality, as a composite. And again a shifting composite, depending on what's being measured. But a composite of those things.

Now what are we seeing on the ground when we talk to provider organizations? We've done a number of both surveys of the membership, and on-site interviews. And the greater the exposure to value-based contracting, at the provider-organization level, the greater the problem with a proliferation and inconsistency of metrics becomes. And that does have some particular practical effects. It dilutes the organizational focus. It can increase administrative costs, and it is ultimately confusing to the patients.

Now we've worked with health plans as well. And I very much support Andy's point from earlier this morning. The health plans we're talking to do not want to be in the business really of defining all these quality metrics either. There's a real craving on the payer side for some consensus and some way to measure quality across the system. And I do think that as we start focusing in on the IHI triple Aim, and building a national quality strategy off of that. And keeping everybody's eyes on the same target and coming up with that consistency of measurement, that would be a really helpful thing for the industry. But also again keeping in mind those patient questions and those patient concerns about the care they receive.

THOMAS IOSSO: Professor Sofaer.

SHOSHANNA SOFAER: We've been talking some about value, and I thought it would be interesting to share the response of exactly 100 consumers to being asked to speak to how they would define value. And we gave them about a dozen statements that they could either really like a lot or really hate a lot. And what's very interesting is that the statements they really liked a lot had almost nothing about cost or price in them. They were almost all about quality. And the statements that they hated were the statements that were exclusively about cost.

So I just want to emphasize that this reflects to me, this is why, to me, Andréa's saying that only 2% of the consumers are using all these nifty price transparency tools that their health plans are providing. They don't care yet. They don't care yet. They aren't hurting. Others in the system are hurting.

So what I am asking of us goes back to some extent, Paul talking about all the multiplicity of audiences that there conceivably could be for both price transparency and quality information. And I believe in the transparency of this information for its own sake, for the sake of transparency in a democracy, for the sunshine side. But I think we have to be very careful about overestimating how consumers can really move this market, which is such a bizarre market, from an economic perspective, from a sociological perspective. I think we have to be very careful that we not inflate our expectations to beyond what people can do.

On the other hand, in Maine they are tiering hospitals. They do have hospital tiered networks, and when they did that they actually shifted market share. There is a fairly large

hospital in the state that was not in the top tier, and so their deductible was not waived. And they lost a lot of business. And as a consequence, they responded. So what I'm saying to you is that in the middle of this kind of sea of non-response to this kind of information, we may find, all of a sudden, something where it looks exactly like what the theory tells us is supposed to happen. OK. That's it.

ERIKA WODINSKY: Dr. Casalino.

LAWRENCE CASALINO: I'd like to talk a little bit about bundled payments or episode-based payments, or whatever you want to call them. I don't think they've had sufficient attention today. They've been mentioned a few times in purely positive terms, but I think bundled- or episode-based payments are really a place where the rubber hits the road in terms of doing both quality and price at the same time. And then the CalPERS reference pricing is a kind of example of that. So a bundle for joint replacement surgery or hip replacement surgery, that gives price information and for the episode and also gives some form of quality information although limited probably.

I think that this is so obviously, to me at least, a good thing. I think to most people, bundles for discrete surgical episodes like that are so obviously a good thing that people tend to think that bundles or episode-based care are just good things period (a), and (b) don't make a distinction between the bundles or episodes as a unit of measurement, OK, for public reporting. And bundles or episodes as a unit of payment to the provider, right.

So let's take these two contrasting things, bundle payment for hip surgery. And now I'm talking about payment to the provider. And bundled payment for a year's episode of diabetic care. The first makes a lot of sense to me. Patrick may have some comments on this. I suspect Bob Berenson may as well.

Paying for a unit of surgery makes sense to me. Paying for a year of diabetic care, especially within the framework which some have urged, which is, we're going to make everything into a bundle. We're going to have a year of diabetic care, and a year of asthma care, and a year of preventive care. And a year of this, and pretty soon everything will be

bundled. And since bundled payments are good, all our problems will be solved. This is a huge mistake.

Patrick mentioned this morning -- I'm almost done -- measuring the average cost for medical group, say, care of their diabetics, risk-adjusted for a year. And if you have a big enough group, and it might have to be fairly big, I think that's a good measure. But if I'm the physician, and you're saying you're going to pay me on the basis of these episodes, then I think that's crazy.

Because I think this diabetic has asthma, they have congestive heart failure, they have hypertension, they have a sprained ankle, they have dermatologic problems. And they need all kinds of things. They're depressed. And what exactly goes into the bundle and what does not? And how are you paying me for this exactly? I can't figure this out. There's a prominent payment model out there that wants to bundle everything this way. And I just want to make sure that we realize that there are bundles and bundles, and some may be great, and others may really not make sense as a way to put a pricing and quality together.

ERIKA WODINSKY: Dr. Berenson.

ROBERT BERENSON: I'll pick up on that one. I'm not even convinced that the bundle of surgical care make sense if you haven't dealt with appropriateness. So people are just looking at, yes it's more efficient. The doctors agree they're going to use one appliance. Or if it's heart surgery, stents, they're going to agree that we can get together and exert some pressure to get a better deal because we're all going to agree on one stent. Absolutely they can have a more efficient episode. They can also have lots of episodes.

And so that's what I liked about the CPR approach. It's saying, we're not going to assume we're saving money just on the episode. We're going to ask the entities that are part of this program to tell us what appropriateness guidelines they're using, and that we're going to come in occasionally and make sure they're following those guidelines. And plus I think for operational reasons it's tough, is what I'm understanding, to manage the claims and all that, to actually pay based on bundles.

I wanted to just give two other examples of where I think we fool ourselves to some extent with all the measures. And the recommendation that if we only -- we now have 1,000 measures -- we need thousands of measures. There are some areas that we cannot fill the gaps, I would argue. And the best example I know about, because I'm now going to be part of an Institute of Medicine panel looking at the issue, is diagnostic errors.

Everywhere you look, 10 to 15%, and where you look means in research projects, because we don't routinely record diagnostic errors. A lot of people go to their grave with a diagnostic error. And in fact that's a source of information is autopsy reports, which show that 5 to 15% of the time people who die had an undiagnosed serious life-threatening illness that may have actually caused their death. How do you measure that? I don't think we know. Certainly routinely, it's not on NQF's list of gaps.

And yet do I want some assurance around safety? To me, it's the leading cause of malpractice claims, or it's one of the leading cause of malpractice claims, is misdiagnosis. We're not doing anything in the measurement area, but there's plenty I believe that could be done in this area, outside of the measurement area.

And the other quick example I would give, and there was agreement this morning that process measures aren't the greatest. But a couple of studies, mostly out of Harlan Krumholz and others at Yale Outcomes, basically found that the process measures used to look at heart-attacks outcomes predict a couple of percent of difference in the outcomes. And what really is the difference across hospitals are things like culture, leadership, management. This is qualitative analysis. That's what they concluded. How are we measuring culture again? I don't think I know that measure.

I think there are some areas that measures are terrific, and we can improve diabetic care. But I think we are so measure-oriented that I think we are fooling ourselves to think that something as complex as health care delivery is measurable. Some aspects of it are. Others, no, and we shouldn't be oblivious to the important quality and safety problems because we don't have a measure for them.

ERIKA WODINSKY: We are running short on time. We have about five minutes, and I'm going to see if we can have first Dr. Ginsberg, Dr. McClellan, and then Dr. Romano. I apologize for giving you so little time, but have at it.

PAUL GINSBERG: I had a couple of quick comments. One was about the consolidation of price and quality into value. I think one of the panelists, I think it might have been Jim, said he was against that. I am against it also. I think basically combining price and quality into a composite has to be a personal thing because people are going to be different. That some expert can do it for all of us is just not going to happen.

On the other hand, I have to realize that it's one thing if we're going to give people a lot of price information and quality information, they do it for themselves. But if we're going to get to the more practical approaches of doing tiers, of doing reference pricing, it does mean that someone who is creating those tiers, or establishing the reference price, is in a sense going to be using both quality and price to make these judgments.

This is going to have to be more of a question, as to how we get through that and basically giving patients some of the confidence that it's being done well.

ERIKA WODINSKY: Dr. McClellan.

MARK McCLELLAN: I just briefly would like to highlight two things. First of all is we've heard just during this panel, not to mention the rest of the day, there are many uses of both quality and price information, many different dimensions, many different settings, ranging from internal quality improvement efforts, to reporting and trying to improve choices, to actually tying into payment systems. And it's important to keep in mind that we're not going to get to three or four, just a small number of quality measures to solve all those problems -- when in some ways proliferation of better data is not a bad thing.

Along with that, I think it is important to keep the focus on what it is that patients really want, and these points about safety, better outcomes, better functional status, better experience of care, and avoiding costs are all very key for that. And even though we can't measure a lot of those well doesn't mean we can continue to try to make progress on them. There are no perfect measures of diagnostic errors, but there are measures of the

consequences of diagnostic errors in populations. There are no perfect measures of leadership in culture, but there are some pretty good correlates that have been observed, and I think are increasingly going to be observed in the future.

And with respect to linkages to payments, remember that in just about every payment application we've seen so far, no one has said they have anything like perfect quality, or even price measures, going along with it. Rather this is, in some sense, a policy effort to try to solve a fundamental dilemma which is on the one hand, trying to make sure that there is enough support for providers and patients to get the care that they need, and on the other hand, there's not unlimited use of the resources.

In the old days, when there were less concerns about cost, and most everything could fit into a standard fee-for-service system, that worked fairly well. These days, for many people, the alternative to going to a partially bundled payment, at least, is not unlimited fee-for-service. It squeezes down on prices across the board, and it's no payment at all for the many increasingly important aspects of what should be medical care that aren't in traditional fee-for-service systems. Like telemedicine, and wireless technologies, and spending time with patients as part of a team, and other things that just aren't covered at all.

So these are imperfect solutions to challenging problems, and what we're likely to see, hopefully, is some more incremental steps to doing public reporting better, to doing richer systems with better analytic tools for internal quality improvement efforts better, that can link to the things that patients really care about. But it's going to be an ongoing process.

ERIKA WODINSKY: Go ahead Dr. Romano. We've run out of time, but please.

PATRICK ROMANO: Just a couple quick things. I guess I have to speak a bit in defense of measurement. And Dr. Berenson and I have served on a number of panels together. But first of all, there are reliable and valid measures of patient safety culture in organizations. I think that just because something is measured, doesn't necessarily mean that it has to be on a public website, like Medicare Hospital Compare. We can be selective and respond to consumer demand, in terms of how measures are reported to the public and how measures are used in value-based purchasing programs.

We also have learned two important things from Shoshanna's work and Judy Hebert's work and others. One is that if we create composites of measures, that makes sense to consumers. It's like the grades and the GPA's that we got when we were going through school. It make sense to combine multiple measures of safety together, and multiple measures of performance. And we also know that we can construct reporting platforms to allow tailoring of measures, to allow drill-down, so if all a consumer cares about is pregnancy, then they can go right into pregnancy and look what the pregnancy-related outcomes are.

So there are ways of designing our reporting templates, our frameworks, so that we don't overwhelm people with information but deliver only information that's needed at the right time. The challenge is getting what we know into practice, but it's an ongoing process.

So the final point is just that with this measurement enterprise, again, ideally, more of these measures would be embedded within the continuous operations. Just like our cars all have computers now that monitor all the functions, and how the engine is performing, transmission, so forth. Our health systems should be embedding the same kind of performance platform, and we're starting to see that in high-performing health care organizations, but not as widespread as it should be.

THOMAS IOSSO: My electron telescope tells me there's a comment down here.

ANDREW BASKIN: I guess I just want to make something clear to folks, and that when we're measuring quality, in most instances, relative quality is something that people think is there that is really not there in the science, OK. So you see a lot of scores out there of 60% and 72% and 81%. In reality, quality in many instances is either pass/fail, or it's above average, average, or below average, and that's about as far as you can go. And frankly that's not so bad in situations like tiered programs where someone is either in the higher tier, the higher quality tier or not. But you shouldn't be comparing within the tier, let's put it that way.

And also with bundled payments or reference-based pricing, the way these programs really work is not, who does the best hip replacement. It's can I get a quality hip replacement or not a quality hip replacement. It's a yes or no. And if it's yes, then you're eligible to be in the system, if you charge the right price. And I think that actually makes sense, and it is one of the

other reasons why value is not necessarily quality divided by price. In those instances, it's really meet the quality threshold and then prices is the decision point after that. Thank you.

ERIKA WODINSKY: I want to thank all the panelists, the amazing panelists. I know we could talk about this another three or four hours, but we do have another panel. So I want to thank you all, both for being here this morning and also for joining us now. Also very briefly I wanted to thank, in the process as we were planning this, we interviewed many, many other people, and they gave us ideas and helped us plan. So if they are watching my video conference, we want to thank them as well. But again, a round of applause for this amazing panel.

[SHORT BREAK]

PANEL: SUMMATION ROUNDTABLE

Moderator:

- **Martin Gaynor, Director, Bureau of Economics, Federal Trade Commission**

Panelists:

- **Robert A. Berenson, MD, Institute Fellow, The Urban Institute**
- **Mark B. McClellan, MD, PhD, Senior Fellow in Economic Studies & Director of The Health Care Innovation and Value Initiative, The Brookings Institution**
- **Ateev Mehrotra, MD, MPH, Associate Professor, Department of Health Care Policy, Harvard Medical School**
- **Farzad Mostashari, MD, Visiting Fellow, Engelberg Center for Health Care Reform, The Brookings Institution**

MARTIN GAYNOR: I would appreciate it if people could take their seats. First, let me introduce myself. I am Marty Gaynor. I am the Director of the Bureau of Economics, here at the Federal Trade Commission. And we have had an absolutely fabulous couple days here, and I just want to thank my colleagues at the FTC who have worked so hard to organize this fantastic series of panels. And we are very fortunate in that we have four very distinguished guests here -- Bob Berenson to my far right, from The Urban Institute; Mark McClellan from Brookings; then to my immediate left, Ateev Mehrotra from Harvard, my former colleague from the University of Pittsburgh and Rand, but what can we do against Harvard; and Farzad Mostashari from Brookings.

And what we are going to do here in this final roundtable -- we are not going to try and summarize all the important and wonderful points and issues that have been brought up over the past couple days. But really what I've asked people to do is think about some of the things we've heard, and start thinking forward about what are some of the key issues; what are some of the key challenges that we at the FTC are likely to be facing with regard to these rapidly changing, dynamic health care markets. And particularly, again, on the role of the Federal Trade Commission, protecting competition and protecting consumers.

So everybody has a relatively short amount of time, five minutes or so, to give some brief prepared remarks. And then we're going to have open discussion among the members of the panel. And of course we want to hear from folks in the audience, questions and thoughts

about this, as a way, again of helping us to think forward about the kinds of challenges that we're going to face.

So I'll start with Bob and then we'll just keep going.

ROBERT BERENSON: I keep going first -- these guys have had a chance, so let’s start there.

MARK McCLELLAN: You’ve got to change your name.

ROBERT BERENSON: All right. I'll be happy to go first. Marty gave us a list of things we could talk about. I generally like talking about payment policy, and we will make a few remarks about payment policy in relationship to ACO development. And I guess the major point, in trying to keep things sort of efficient, is that I don't think that clinical integration and financial risk bearing, by themselves, protect against the exercise of market power, by ACOs or ACO-like organizations. They are desirable in and of themselves. I think they might produce higher quality and a lower unit cost, but I don't see any reason that an organization with market power would pass back those savings to the payers and on behalf of consumers.

I am impressed, with the idea of total cost of care, but I just think price often dominates. The best we know initially from the Dartmouth studies and then some refinements of their findings, is that an efficient organization can reduce health care utilization by 20%, compared to the norm, something like that.

There are price differences in the market. I've heard as much as 1,000% price differences. Doctors in Miami, based on health system change interviews, often accept 70% of Medicare in a small practice. And I've heard about one group that was being looked at, which was something like -- this was a physician group -- at about 900% of Medicare. Paul Ginsberg has published stuff showing some hospitals at 500% of Medicare.

And then most concretely in relationship to the ACO situation, when we published our study, Paul Ginsberg and I did a Health Affairs article about what was going on in California. And I became friends with a lot of health plan executives, because we were talking about hospitals using their market power to raise prices. I kept hearing that some of the most prominent

organizations that are held out as the prototypes of what we want a good integrated delivery system to be, were the ones who were able easily to get 250% of Medicare. And you can't go to market without these organizations.

The policy approach du jour -- not the policy approach, but what payers are doing now as the responses within the health exchanges, where you have people who are very price-sensitive -- is moving back towards narrow networks, or tiered networks. There are various varieties. That seems to be about the only strategy that they have. I'm not sure that's great public policy, to be moving towards narrow networks, which for all the aspirations that they're going to be picked, that the providers are going to be picked for high performance, high value, it's largely about price concessions, I think.

And so we're going to have narrow networks, but we're not, I don't believe, going to be able to assure members in those qualified health plans that those narrow networks provide necessarily the highest value. They are the ones who that particular payer is working with. The point here is that plans can't go to market without dominant ACOs. The ideal policy approach here would be, in my view, competitive ACOs. I just think in a lot of places it's not going to happen. Either the markets can't support multiple ACOs, or for historic reasons or other reasons, the horizontal and vertical integration has occurred.

So to me, one of the major issues to deal with is how do you deal with the cow that has left the barn, the organization that's already out there. Are you going to break it up? Are you going to have some other requirements on it and how it does business that doesn't involve their exercise of pricing power? I think that's what we have to address because I think it is a desirable move in health care that we would move towards clinically integrated, risk-bearing provider organizations. I think what we need to grapple with is, how do we deal with the prices that they then want to ask for their opportunity.

The final point I'd say, to put it on the table, there are some very smart policy people who think that the new payment models by themselves will have a depressing effect on the exercise of pricing power, that if we move away from the current volume-based payment approaches into forms of risk bearing, which doesn't reward volume generation, that that by

itself will have a moderating effect on price demands. I would like to believe that, but I'm not so sure that's the case. But I think that's an area where research I think would be very helpful. So those are my initial remarks.

MARTIN GAYNOR: Thanks, Bob. Mark.

MARK McCLELLAN: I'd just like to start by asking Bob whether that last comment was meant as an introduction for my remarks.

ROBERT BERENSON: I'd be happy to.

MARK McCLELLAN: No. I am not a believer that somehow magically payment reforms are going to change things. But I would like to start by talking about the big picture on the fact that things do need to change, in terms of cost of care and quality. And I do think that payment reforms and benefit reforms, as well as new kinds of information to go along with it, is going to be a big part of it.

We've heard a lot today about how much progress is happening, on the one hand, in terms of data and measures based on data becoming available for supporting quality improvement, choices, payment reforms. Also heard about how long of a way there is to go. But I do think we're going to keep moving down this road. The approaches before of just trying to control costs, mainly by limiting fee-for-service prices, I think haven't worked. I talked a little bit about that briefly in the last session.

And it's not just probably an ineffective mechanism of controlling overall cost, it's also just an increasingly bad fit with more personalized and prevention-oriented health care, that should increasingly include a lot of stuff that just isn't part of traditional health care payment systems and can't become part of it very easily in old fee-for-service models without breaking the bank. So we are going to keep seeing reforms in the direction of bundled payments or accountable care, as well as the benefits side of that where patients or consumers get more opportunities to save when they meet their care needs at a lower cost. And that all depends on better and better information. So we can talk more about that.

But I do want to get to this very central issue for FTC that Bob raised around market power coming with coordination of care and consolidation. And I want to put myself squarely, I think, in Bob's camp. You don't get anything for free in life, and you certainly don't get big, large-scale coordination that has a meaningful impact on market power without real concerns, and a lot of evidence of higher overall prices and perhaps other anti-competitive effects as a result. And so the challenge, as it long has been in antitrust policy, is not how do we get one or the other, but how do we get the best balance or the most competitive benefits from things like economies of scale, economies of scope, which are real, versus avoiding the downsides of more market power and higher prices and other adverse consequences that can come along with that.

Marty, you're the chief FTC economist here, and I'm just a health economist kind of guy, so I'm going to do great damage to the history of FTC and economics by saying that if you look at a lot of the industrial organization literature, much of it has been founded on issues related to market structure and how that affects market performance. So higher market shares, higher HHIs are associated in some cases, it varies across markets and products and so forth, with worse market outcomes. And that's been a mainstay of many aspects of policy analysis and law.

I think where we're headed, certainly in health care and probably in other areas as well, is having a much better capacity to actually look at the direct consequences of different kinds of mergers, not in theory but in actual practice and in terms of things like the total cost of care measures that we talked about earlier today. And in terms of things like meaningful measures of outcomes and other consequences for patients.

Here's where I'd really like to make a call for a sort of reinforcing relationship between steps towards transparency and better information on quality and meaningful price information -- not just list prices, but stuff that actually matters for patients and policymakers -- and antitrust policy. The organizations in health care that are large enough to be of concern for market power, the ones that Bob was talking about, either do or should have the capacity to produce some awfully good measures of performance, in terms of outcomes and with at least some limited cooperation from payers around things like meaningful total cost of care measures.

As Patrick talked about earlier, some really meaningful measures of cost as well. And I would think we're at a point now where that ought to be a prerequisite for evaluating a merger, if not for taking actions to undo mergers and other consolidations that were undertaken in the name of improved coordination and better quality of care, but just aren't delivering on it. And I mentioned before some work that we've done in this area, our "Bending the Curve" report last year, which was supported by broad range of health economists and other economists, people like Mark Pauly, David Cutler, others across the spectrum, that called for something just like this.

I get there are some challenges -- and who has the authority to do it, and how to accomplish it? If you look at what Medicare has done in the past, they actually do have, we think, under current law good ability to get these kinds of measures produced certainly for participation in programs like ACOs or other alternative payment arrangements. And if you look at some of the FTC's recent actions, this isn't necessarily something that can just be done on a prospective basis.

The Saint Vincent's merger case which was undone. Sorry, Saint Luke's. Sorry, I'm getting my saints mixed up today. St. Luke's Idaho physician and hospital merger, which was undone, certainly is a precedent for that. And if we are getting in this era of greater transparency in health care, what better place to start than with these very large organizations that should be capable of producing this evidence, and that are of the greatest concern in terms of antitrust adverse effects. So maybe as Bob said, the cow has left the barn, but fortunately cows don't move very fast. That's better than the horse leaving the barn. So maybe we can catch up with some of these mergers by taking account of the fact that we are entering an area where we ought to be able to expect very explicit and meaningful measures of both outcomes and cost impacts of large-scale consolidations.

MARTIN GAYNOR: Actually I'll preempt Ateev a little bit. And, of course, the man from Texas should know from cows, so we'll go with your word. Just very briefly, certainly there have been a lot of advances in antitrust analysis over the years, and while things like market shares and measures of concentration are still germane, in some cases we've moved well beyond that,

both in terms of the analysis we do, and in part due to better data and greater availability of data.

With regard to efficiencies, specifically, there I think again as a lot of things we've heard about better quality measurement, better data availability, I think those will be tremendous helps to us and our analyses of matters. In general, everything is fact-based, the more facts we have the better, the more evidence we have the better. And so as things evolve, and as we have better data, there will be a lot more evidence on whether efficiencies are achieved from certain arrangements or not, the nature of those efficiencies.

To be clear, a key question for us -- let's take a merger as an example. On the efficiencies side, are there efficiencies? But not just whether there are efficiencies, but whether the merger is necessary to achieve those efficiencies or whether they could be achieved through some other arrangement that would not have a damaging impact on competition. So again, one thing that's tremendously heartening to me is hearing about all the efforts that are going on in so many domains here, both in terms of better data and organizational innovations. And I think they're going to add to our evidence base and be tremendously useful to us going forward.

So I apologize for preempting Ateev.

ATEEV MEHROTRA: Not at all. I think I will focus my comments mostly on the innovations aspect, something I was engaged with yesterday. And specifically some ideas and things that didn't come up in our conversation yesterday, and specifically about what is impediments to good competition for these new innovations and delivery. And I'm not sure I exactly understand the FTC's tools, but it potentially could come under the FTC's purview.

The first place I want to start with is one impediment to these innovations, which is just the pricing of how we price our visits, and the big issue among in terms of health plans. And let me give you the story of retail clinics, which is something I've studied quite a bit. Retail clinics have emerged on the market. They have a good value proposition. Lower cost, good quality, great access. And you could argue that they've really had a strong, amazing success story. More than 20 million visits a year, about 4 million visits a year. You can also flip that around and say,

why isn't that higher? There are about 100 million visits in the United States that could occur at a retail clinic. They're still a teeny sliver of that market, and why haven't they really gained more of that market share.

Maybe not surprisingly, I think a lot of that response is because of the provider -- the existing provider/incumbent response. The emergency department doctors are up in arms, the pediatricians hate these things and put up policy statements, arguing that no child in the United States should ever visit one of these clinics because this would be bad. And you might argue, well that's not surprising, that's just competition. They're competing there.

But if you really think about that, is that really the case? Because these providers have plenty of demand, patient demand, and these should be services that they'd be happy to get rid of. Why should an emergency department be managing a cold or a sinusitis? That's a low-margin issue. And they'd probably like to focus on the stuff that's more lucrative for them.

And the reason they're up in arms, I would argue, is probably because of the pricing perversions that we have. That these kind of visits -- the colds, the sinusitis -- that's the high-revenue, high-value business for an ED. That's where they make their money to compensate for the gunshot wounds. And that's how a pediatrician makes some money so they can compensate for the more complicated child who has ADHD. As we think about impediments to these innovators coming into the market, and what's holding them back, I think this pricing issue is something we didn't discuss enough as a major barrier.

A second thing I might focus on as another barrier to competition that I don't think gets enough attention, is the role of the health plans -- and specifically as I think we discussed this a teeny bit yesterday -- as the de facto regulator in many states or de facto regulator for certain areas. I had a really interesting conversation with an organization that helped run nurse-managed health centers. As scope of practice for nurse practitioners has grown, there are a number of new primary care practices where there is no physician there. It's all nurse practitioners, or as they're newly minted, doctors of nursing practice. They've changed their name. And you speak to them and say, I expected the conversation to be about something the FTC has focused their attention on previously, which is scope of practice laws. And these are

impediments. And they said, “No, those are fine. It's the health plans.” Because the health plans had a number of regulations that limited their ability, for example, to be listed on an insurance plan as a primary care provider. So they opened up, they put their shingle out, they opened up this practice, but none of their patients could come, even though they were adding significant value in that market because there's a shortage of primary care, because the health plan wouldn't cover them.

And I think about what's going on behind-the-scenes. The health plans, through the pressure of the medical societies, are really limiting how these new innovators can play a role in these markets. Again, I think that’s another impediment to competition that we haven't really focused a lot on.

The last thing -- and I think this builds on some of the comments across the two days -- is the issue of vertical and horizontal consolidation and how that's also an impediment. You have this really interesting trend, I almost see these two trends in conflict potentially. On one hand, you have these innovators coming in who are taking small pieces of the market and providing higher value care. You can go to your retail clinic for your simple sinusitis. You can go for your derm visit to the telederm. Over-the-counter testing, et cetera.

But at the same time, you have this vertical and horizontal consolidation, in these ACOs and other shared savings programs. And in my conversations, in witnessing at the table, they are fighting tooth and nail these new providers that are coming in. Again maybe that's competition, but federal policy is encouraging that consolidation, and they see these new competitors as leakage. And they will use the control of their electronic health record, but also by discouraging their patients from going there, they are actually impeding some of these new competitors, which we could argue are beneficial for the market.

So I think something also we should be thinking about as some federal policy is having the unintended consequence of potentially decreasing innovation and competition in the market. So, a couple of thoughts.

MARTIN GAYNOR: Thanks, Ateev. Farzad?

FARZAD MOSTASHARI: I'm going to focus on ways in which data and information tools can help innovation, but also could be used as weapons in three domains. The first is information asymmetries and power dynamics between hospitals and physicians -- independent physicians or erstwhile independent physicians. The second, around electronic health record vendors and their customers. And third, health plans and the people who they cover. And I'll talk about each in turn.

On the first one, I would agree with Bob and Mark that there is a concern in terms of particular hospital-sponsored dominant accountable care organizations using information and information tools to create less competition. And two examples of this that we've heard. Again, I'm glad the FTC is leaning forward on this because it really does require more in-depth data, as Marty said, more than anecdote. But what we have are some anecdotes and concerns that, for example, hospital-sponsored ACOs, once they get the Medicare claims data, are predominantly using that as a way to identify leakage. In other words, where the primary care physicians that they're engaged with are not referring the high cost procedures and surgeries and things that they want to them. And using that as a way to crack down and monitor whether they are in fact sending things to the home ship or not.

The second was mentioned -- use of the electronic health record and donations of electronic health records from the hospital to independent physicians as a way, again, to make themselves stickier to those providers. And in some cases, even to limit the providers' ability to actually disengage from the ACO should they choose. So not only are there contracts that limit the ability of physicians to "compete" with the hospital and leave the ACO should they choose, but also the information system could be used as a way to limit their ability to ever leave because the EHRs are very sticky. Switching costs are very high once you've made the switch. It's tough to move. So that's on one side, and obviously the FTC and CMS in this instance would need to work closely together. The second is around where it would really be more collaboration between the FTC and a different sister agency, the Office of National Coordinator for Health IT. And what we heard yesterday was that there are concerns about the consolidation among the EHR vendor marketplace. That it's happening in many ways is a natural phenomenon.

When the automobile industry, there were hundreds of car manufacturers, and there's a maturation process where those consolidate down. And that's happening in the EHR field. There are plenty of choice still certainly, compared to most other industries that the FTC looks at. There's plenty of choice. The question though, is whether, once the decision has been made, once a choice has been made -- and we can argue about whether there's enough information to make an informed choice or not. And there are some information asymmetries there -- whether an EHR vendor, because they are now dominant on the desktop of the physician, could use their influence and pricing, in particular, to hinder innovation in the customer's choice of other applications they might choose to use.

So the example that people talk about is around health information exchange. I have an electronic health record vendor. They happen to provide a health information exchange network, and within that network it's very clean, it's very easy, it's very pleasurable to use within that walled garden of the vendor marketplace. But if you want to go outside, it will cost you money. Or you will have to wait. Or it will be less convenient. And the question of whether obviously everyone is tipping rebounds to themselves. But when does that become anti-competitive? And not just doing what everyone does, which is compete.

I think one of the things that we heard yesterday was that the Office of National Coordinator, in many ways, has been very creative at using a variety of different tools at their disposal -- everything from a bully pulpit to create a voluntary vendor code of conduct, to transparency efforts, to actually having regional extension centers who help smaller practices make vendor selection decisions and advocate on their behalf, to very creative use of their certification program to put forward standards and requirements for EHRs. But that certification program, in particular, is a double-edged sword. And we've heard a lot of complaints both from the providers and the vendors, that the more rigorous the certification requirements get -- which is what everyone wants on the interoperability; make them so that you can share information; make the systems interoperable -- the more you push on that, the more on the other side you get complaints about stifling of innovation and all the concerns that people have about too much regulation.

So it appears to me that this is an opportunity for the FTC to take a closer look at the vendor practices and to help educate the field, frankly, in terms of what is and what does not constitute anticompetitive behavior. Because I think our industry, the health IT industry, is not very well versed, or it doesn't really understand what is competition and what is anti-competition.

The third that I want to mention briefly was, we heard about narrow networks and people choosing on exchanges which health plan and which network they want. Many people are going to choose the wrong plan. We know this. And so helping them then switch is something we have to think about. How do we help people make the right decision for them on the exchanges? And a big part of that is for them to have their own information from one plan, to be able to guide their decision-making in terms of which plan has the medications I'm on, the doctors I'm using, the conditions that I will need treated.

We heard this morning from Kate talking about how she was able to take her mom's blue button file from three years of her Medicare claims data, and see that her mom's colonoscopy had cost $10,000. That is not available right now from health plans, even though HIPAA was the Health Insurance Portability Act, I believe -- not Privacy Portability Act. It gives patients the legal right -- and this is an area of collaboration with the Office of Civil Rights -- to get copies of their own health records from covered entities, including health plans, including a designated code set of information that should include the financial information. Right now as a practical matter, the only place I can go to download my own information that includes the prices paid is Medicare. No plan that I'm aware of makes that available online for patients to be able to download. And that, I believe, can be a huge boon for innovation and portability and transparency in the marketplaces, but right now it's being held back on the part of the plans for competitive reasons.

MARK McCLELLAN: Do you mind -- This is the thing about working together with Farzad at Brookings. So one addendum, Farzad is helping to lead our ACO learning network there. We do have an opportunity to interact with the number of ACOs pretty closely, and have seen some interesting results for smaller physicians and ACOs actually being able to take some meaningful steps to improve outcomes and lower cost.

But there is another class, the hospital-led ACOs, and -- as I think Bob mentioned -- the concern that they have two competing incentives that maybe the physician-led groups don't have. One is to get the overall cost down, quality up, and get more shared savings payments. The other is concern about maintaining, if not enhancing, their fee-for-service billing for institutional services. The point about sharing as an ACO, being able to get data on the overall utilization of patients and being able to see, among other things, whether your referring physicians are referring all the patients or not.

The downside of that is something we have heard anecdotally. I don't know that we can say this is at all prevalent. And there certainly are a lot of hospital-led ACOs that are taking some truly meaningful steps to try to improve quality and lower cost. It goes back to the point that we have heard repeatedly today, is that there is a lot of variation out there. And what more transparency around quality and cost information can hopefully do is help us identify which of these organizations really are doing a good job of improving care and lowering costs and which ones are not. Rather than making broad generalizations that we don't need to make any more, we can look more directly at these issues.

MARTIN GAYNOR: Let me say a couple of things briefly. We obviously pay a lot of attention to mergers. That is an area of focus, but it's not the only one. Overall, that is something we will pay a lot of attention to. What is important for people to understand is that once a merger has occurred, it's extremely difficult to undo. That doesn't mean it's absolutely impossible, but it is extremely difficult for a number of reasons. So there are very substantial consequences of letting mergers go through when there is good reason to think they would be harmful.

But I think in a broader sense, one of the key things that the Federal Trade Commission can do, and really our charge, is trying to do what we can to facilitate as much competition in markets as possible and allow new efficient high-quality forms of organization to emerge. And for the good ones to flourish. And for those that don't do what consumers value, those fall by the wayside. So if we can sort of keep things open and available so that markets are dynamic and responsive, that is absolutely critical. And obviously mergers are part of that, but far from the only thing.

So some other things that Ateev was talking about, without rendering any judgment on them one way or another, about concerns over whether certain kinds of developments could have some benefits but could have unintended consequences. Or perhaps intended by some of the participants, of squelching innovation, that is of really deep concern because it affects not just what is happening in markets right now, but where things will be heading in the future. And Farzad's points about information technology and how it gets used, that is already a key component of health care and should grow in importance. In part it's plausible that it may not have attained what we all think it should have because of some of the kinds of impediments that you have discussed.

I think these are all very important areas for our attention. I'd like to pose the following questions to the panel participants. And I don't want to prevent you from discussing other topics that strike you as important. But as people probably know, the Federal Trade Commission has roughly three tools at our disposal. We have law enforcement for antitrust and consumer protection. We have advocacy, where we can comment on legislation or regulations. And we have research. Roughly speaking, these are the tools we have in our tool kit.

So my questions for the folks on the panel are, given these tools, in your views, what are the three most effective and important things that the FTC can be doing, not just now, but going forward, to protect competition and consumers? And, at the same time, what do you see as the three biggest challenges for us? And maybe I'll start from the other side. I'll give Bob a rest and start with Farzad.

FARZAD MOSTASHARI: I don't know if you call this a Westinghouse effect, but --

MARTIN GAYNOR: That's painful in Pittsburgh.

FARZAD MOSTASHARI: I think your research and law enforcement activities can be linked in effectiveness. The fact that the FTC is interested in collecting more information about something might actually have a salutory effect, I believe. And might actually function -- you may not need to have to do enforcement if you are watching, right? And I think the three areas where we have talked about that would be helpful to have the FTC begin to research and look into and collect information and share information.

One area was around specifically not mergers per se, but hospital acquisitions and consolidation of physician practices. What are the conditions of those contracts? What are the requirements that are put in place after those practices have been contracted with, whether it's acquisition or other forms of affiliation associations with those physician practices?

The second is the area that I had identified in terms of electronic health record vendors who impose differentials. I think the most common form of this is barriers, including pricing barriers, to use of other products or services -- “Use ours it's almost free, use someone else's it's $2 per transaction.” At what point does that become anticompetitive and anti-innovation?

And third is this issue of whether the health plans are providing their beneficiaries with portability information in terms of their claims experiences and including pricing information contained within that.

I think your challenges are going to be there is already a sister agency, CMS ONCOCR, who is already very much an expert in this domain. And you are going to be coming into that domain. I think you should, and I know you do this, but you should work closely with them. Resist the temptation to criticize them from a regulatory point of view, because it is hard to do the regulations. And they know a lot more about this, their domain, but what they may not know well are the competition implications of what they do.

MARTIN GAYNOR: Thanks. Ateev?

ATEEV MEHROTRA: I think three things I might point out in terms of areas where looking at the FTC tools and what they can maybe potentially focus on. I don't have a lot of experience in this area but am really struck by, in the innovation space, how when the FTC enters and even makes a comment on an area, it really has a lot of impact in the state legislatures. And just thinking about this area in particular that is really critical, is scope of practice work. And beyond what I think the FTC has commented on, just what can you do. A lot of what is under the regulations the states have implemented, which have really subtle but I think important effects.

For example, yesterday in the conversation it came up where the scope of practice, the nurse practitioner can do everything, but a doctor has to sit around driving a car and visit them once a week. So they have a physician in a car just driving from clinic to clinic around a state,

just because of this regulation. That just doesn't sound right, and I think the FTC entering there, kind of doing “sunshine” as the best disinfectant, can really highlight how we have a lot of these regulations that I don't think have gotten the attention in the states that they definitely should.

I think the other point I might make is just to echo what I said before, which is these health plans -- and I'm a little unsure of the overlap between the FTC and the Department of Justice, when it comes to some of these insurance policies, but obviously working together on some of these issues -- as a de facto regulator. And some of the other things, it's unclear to me and I have concerns about their competition effect, is these fixed payment differentials. So if it's a certain kind of provider, they get x percentage of what the doctor gets. That doesn't strike me as encouraging competition in the market. It just encourages a fixed differential. So those might be some areas that they can do.

And then in terms of the challenges, this might echo what Farzad said, is that how you work with sister agencies on these issues seem to be critical.

MARTIN GAYNOR: Great, thank you. Mark?

MARK McCLELLAN: So I've already hit on one, which is in the combination of the enforcement and what might be called the regulatory advocacy, or maybe constructive regulatory interaction area. Continuing to move in this direction of much better information on meaningful quality and cost and total spending measures being available, particularly for high market share organizations or organizations that would be high market share in the event of some kind of merger or other consolidation.

I know FTC is an enforcement agency, and there are only so many enforcement resources available to go in-depth in particular cases. But there are some good examples of guidance, like the guidance that was developed with CMS and OIG in conjunction with the release of the first version of the ACO regulation. It's not going to be the last, so a good time to reexamine whether perhaps using some of CMS's authority to get quality information and cost information available as a condition of participating in payment reforms, or even in other aspects of Medicare. Might be a good area for furthering this overall goal, and more generally in health care, coordination with CMS is really important.

In terms of legislation, there are some legislative ideas, including in the context of the physician payment reform legislation, to make better data and performance measures available. We talked about some of the obstacles to effective data sharing while protecting patient privacy concerns for purposes of encouraging and supporting better choices, as well as research. And I think that is an important area for legislation. An important area in legislation that often gets overlooked is that it is hard to come up with good ways of measuring quality and cost in health care. What Minnesota and HealthPartners did took a long time and a lot of work.

And if there is one area where some government investment might be worthwhile, it's in supporting the development and effective implementation of these kinds of meaningful performance measures. And understanding how they can be used effectively and just getting that kind of confidence that right now often takes a lot of years and a lot of providers and payers and others working together on a one-off basis around the country to come up with. We ought to be able to do that more efficiently. And in terms of research, I think FTC could have an important role in supporting, for purposes of understanding different kinds of consolidation and alternatives to consolidation, a really first rate effort of bringing together better data systematically.

We have talked a lot today about reasons why it is hard to get large comprehensive data sets together. Some of those are privacy-related, some of them are proprietary or competitive. I can understand why individual health plans would be nervous about turning over entire files of data for unknown purposes to anyone. On the other hand, there are now some good models emerging in the last few years of sharing data on a large scale, on a national level, across organizations for some key purposes.

So just about every major health plan in the country now participates in FDA's Sentinel system, which is a post-market surveillance system that can pretty quickly do analyses of risks on adverse events associated with drug or vaccine exposures for literally hundreds of millions of Americans. It doesn't require data to be pooled. It's got an infrastructure behind it that the plans, together with the FDA, were able to support around answering questions on drug safety. So it doesn't do everything, but it has an important value for these things.

Well I would think there might be a similar opportunity for something along the lines of understanding the effects of consolidation. If there is one issue besides safety, and maybe comparative effectiveness, that's really important to health plans, it's this. And understanding what kind of consolidation really does benefit patients, and reduce costs, and improve quality, and which kinds don't, and what the alternatives might be.

FARZAD MOSTASHARI: Could I take this opportunity before Bob's turn to tweak our hosts here at the FTC? May I Marty?

MARK McCLELLAN: I thought I just did that.

FARZAD MOSTASHARI: So, you know what would be helpful if -- Let me ask you, Marty, does the FTC monitor the degree of hospital consolidation in different hospital referral regions throughout the country?

MARTIN GAYNOR: We play close attention to what's going on, and actually, one thing I can say that is relevant to both your comments and suggestions, is that we have quite a bit of data on the health care industry. And we are in the process of assembling a very significant data center on health care.

FARZAD MOSTASHARI: What I was going to suggest is that, as the FTC advocates for transparency and openness, it might up helpful for the FTC to share. I see no reason why the FTC shouldn't share information about market-by-market analysis of the degree of market consolidation in those markets, for others to use in looking at correlates. And potentially even with that mere awareness that, “hey we know that in our local market, we have an unusually high degree of consolidation,” behaviors could be affected.

But right now, I have tried to look for a public data set of the degree of market consolidation within each of the 308 referral regions, and there is nothing publicly available on that. And you ask the authors of papers who have published on the HHI and 308 referral regions, and they say, we are not allowed to share that information with you from the Hospital Association that gave us the data used to do that. That's the kind of thing that FTC could and should take effect.

MARTIN GAYNOR: Thanks, I appreciate that suggestion, Farzad. You are right. There is some basic information about market structure that, for a variety of reasons, is not available on an ongoing, consistent basis. And an entity like the FTC, a government agency, can certainly do that as part of its role. So finally, Bob?

ROBERT BERENSON: So on that one, I'm not the expert in this area, but isn't an HRR or an MSA too large an area? Because the review of a consolidation, the desirability of a merger, I think is on a much narrower geographic area.

MARTIN GAYNOR: Without getting into the weeds on that, one could imagine putting together statistics on a national and ongoing basis.

ROBERT BERENSON: I actually think it's a problem where the researcher is analyzing these larger areas that are not particularly relevant to the antitrust analysis. I would want to have some attention paid to that. I'm not sure exactly what the FTC's role is, but let me identify three issues that I think are worth taking on. I think the FTC may have a role in this.

One is, increasingly I'm convinced -- even though there may not be economic theory to support it -- that the multi-hospital system, extending over a geographic area, exerts market power and raises prices for plans. I think that whole area needs a relook to see if there is economic theory to address whether or not those entities actually are able to have pricing power, monopoly power. And then what are potential remedies? And to what extent can antitrust law be expanded or doctrine can look at the tying relationships and that the multi-hospital system really can't negotiate on behalf of the entire system?

Now there are some state laws that are attempting to do this. Paul referred to one earlier, I guess, in Massachusetts. So I'd be interested to know, can antitrust take this on? Should state law take this on? Should anybody take this on? Or is this going to happen? It's happening widely. The empirical data I've seen, like from the insurance department in Rhode Island, suggested there's a pretty clear relationship anyway between prices and whether a hospital is part of a system or not. So that would be one specific area that I would want. And then that one leads into the next one.

There are a number of state activities right now, I guess I'd call them pro-market regulatory actions. They mostly have to happen through legislation, but preventing gag clauses, preventing most-favored nation contracting, et cetera, et cetera. I'd be interested in understanding who has jurisdiction. Should the states be doing this? Will that help promote competitive markets, from an antitrust perspective? Or is this good? Is there a role for antitrust here rather than relying on the states to legislate? I'd be interested in that, and hearing from an agency that is all about promoting competition your views of what states can be doing.

And that might include actually a new look at state action immunity, in where, I'll change it, where the horse has left the barn. To what extent should somebody, where you do have a large entity exerting market power, what do we do about it? And is there a role for government at the state level, which seems the logical place given how we do governance in this country, to restrain its exercise of market power in some way? And what do we know from the few examples of Certificate of Public Advantage, like the hospital in North Carolina and some other places. Or is this just subject to capture and. So I understand the general view that that's not competitive, its regulatory, but to what extent is it compensatory where the pro-competition has not worked. Is there a role for that?

And picking up something Mark said, my understanding -- looking from the outside, when CMS was working on ACO payment models, shared savings, pioneer ACOs, et cetera -- of their perspective is that this is good for Medicare and for taxpayers, essentially. Not is it good for the market overall. So they weren't terribly concerned about creating an ACO. The FTC's role was to be worried about whether they were creating ACOs that would develop market power, but CMS wasn't worried about this, per se. And I guess where I'm going is that, and it is in the area of what Mark suggested, we need to know lots more about quality and efficiency. The ultimate measure is really risk-adjusted per member, per month or per person, per month spending for the population of patients that the ACO was caring for, whether they are Medicare patients or not Medicare patients.

Can Medicare, as a condition of its contracting with ACOs, actually be using metrics that go to sort of the overall quality and costs of an ACO outside of Medicare? In that case, if you were actually using some kind of PMPM measure of performance, driving prices up would be

counterproductive. And so it is worth exploring with CMS -- what I'm suggesting is whether CMS can take a broader view. When I worked at HCFA [Health Care Financing Administration, has since become CMS] I remember a couple of cases that came through in which they wanted us to be in amicus to either FTC or Justice, I forget who it was, on what seemed to be a pretty clear hospital merger that shouldn't happen. And I said, “hey we should get involved with this,” but the powers that be said, “this isn't our problem. This is a problem for Justice and FTC, it's not a problem for Medicare.” And I'm just wondering if -- this is obviously not directed -- I mean CMS isn't sitting here, you're sitting here. But I'm just wondering if there is some framework in which CMS can be more attentive to the broader competitive impact of what they are doing, especially in this ACO area, such as having metrics that are relevant to non-Medicare behavior.

MARK McCLELLAN: It's worth mentioning that there are some metrics that Medicare requires now that are market-wide, institution-wide, measures of patient experience, coming from so-called CAP surveys and so forth. The justification there is that it's not possible to reinforce better care and lower cost for some beneficiaries and institutions without considering the impact on others. And I think this is, as I said, a very good area to explore.

MARTIN GAYNOR: These are all great points. And just on the last platform with regard to CMS, I think that's very important. I think all of us here at the agency are very aware of that, and we have been in touch with our colleagues at CMS. And it's apparent to everybody that the agencies need to really be in close communication, working together at a very high level. And thinking broadly about the system, in addition to the kinds of things that have gone on for a long time where we focus on specific initiatives or measures and cooperate on that. So certainly that's, I agree, very, very important.

We have some questions or comments from the audience. We are very close to time, but I do want to give those of you who have stuck it out here, I won't say to the bitter end -- I hope that's not the bitter end -- but the few, the proud who are still here. So do you want me to call on people? Do you want people to write things down?

TARA KOSLOV: [Inaudible -- providing instructions to repeat audience member questions into the microphone]

MARTIN GAYNOR: Okay, so let's see. Please.

AUDIENCE MEMBER: Hi, I'm Lauren Larson from the state of Colorado and every year new professions come to the legislature, demanding to be licensed, and driving up the cost of [inaudible] and there's no one to oppose it, there's no – they say, oh this will protect consumers, and the profession says, oh this will increase our status, but there is no [inaudible] or group to galvanize and say, oh this will create an economic burden. So my suggestion -- and I'm interested if there is already data available -- would be some hard data from the FTC or others that says, if you do this it will add this much cost. In health care, if you license this group you'll add to this much [inaudible] -- in a way that could be easily quantified and understood. [Inaudible] an office visit would be [inaudible]. So that's my suggestion, and I'm trying to keep economic rationality in our states [inaudible].

MARTIN GAYNOR: Lauren Larson from Colorado, and correct me if I'm wrong, but your point was that there are demands for licensure, or increase licensing requirements at state legislatures that happen on an ongoing basis. If the FTC could provide information to the states, when these things come up, about the kinds of costs that would be imposed on the population of the states, it would be very useful and help the legislature in their deliberative process. Okay, I think we have time for a few more questions.

AUDIENCE MEMBER: Just tying in that question. The FTC during the 1970s and '80s had a tremendous research unit looking at these issues of occupational regulation. Is there any chance that that unit could be resurrected to provide some evidence of the kind that would be helpful to people who are boots-on-the-ground dealing with these regulations at the state level.

MARTIN GAYNOR: The Bureau of Economics and the agency generally does research. It's actually part of our original mandate, our enabling legislation, and the topics do shift over time. But I think if you look at -- and again you guys were on the panel concerned with these issues -- that we have become increasingly more active in this area over time. We obviously look at possible research topics and, based on whether we think that we have something to add to the extant research literature, and whether there are resources say, by way of data, or whatever to

support that. And considering the importance of this, we certainly look at these kinds of things on an ongoing basis.

But health care, as the chairwoman said in her opening remarks yesterday, is a huge priority for us. It's one fifth of the economy. As Zeke Emanuel said, it's bigger than the economy in France. Although they gave us fine wine, and cheese, and pastry. And we give them hip replacements and cholecystectomies, but so be it, those are valuable as well.

[Laughter]

MARTIN GAYNOR: So this is a very active area of research for us, and this is something that we are looking at very actively. Yes?

AUDIENCE MEMBER: [Inaudible]

MARTIN GAYNOR: Alicia Savage from United. The question is about whether we studied rules, regulations, and legislation about advertisements. And the answer is yes. This was a very active area in research and enforcement back in the '70s and '80s. Of course they were parts of the codes of ethics of professional societies, not just in health care but in other professions as well. Some of the most important actions the FTC has taken in health care pertain to that precisely. It's not something that I believe is an active area of research at present, but I don't know if there have been critical changes in legislation or regulation. That's something we would have to look into. Other questions? Please.

AUDIENCE MEMBER: [Inaudible]

MARTIN GAYNOR: Paul Cotton from the National Committee on Quality Assurance. The question is, what Paul said is that they've been working very actively on quality measures. They're the folks that have brought us HEDIS, among other measures. But they are asked continually about cost. One of the impediments that they feel is there are restrictions on what information can be provided because the nature of contracts between health plans and providers. So that's a valid question. It not something that I think that we are looking at at present, but we're always open to hearing about areas if it seems like they are problematic. So I don't know if that's useful. Yes?

AUDIENCE MEMBER: I've heard about a different [inaudible] which has to do with the fact that I've been bypassed and I'd like to find out how much CMS pays, per member per month, for different Part D plans. And we've been told that we can't get that information because it's proprietary between CMS and the plan. So just from a transparency perspective, if a public citizen wants to know how their money is being -- I'm sure we can get aggregate numbers -- but we don't know the distribution. We don't know whether or not we have the same phenomenon, for example, for Part D plans, where the prices are way behind Florida and New York City, where I live, but not so far behind Minnesota. Do we have these distribution numbers? Because this is within the federal government, we're talking about and I don't tend to see it as something that the plans have [inaudible]. So I'm just curious, why can't that information be made available?

MARTIN GAYNOR: Well I am not with CMS, so I can't speak to their policies. And I don't think we have anybody here at present. But let me say something briefly. It's really perhaps a more extended response. The questions do have something in common.

In general, when there are private agreements between parties, whether one of them is the federal government or not, unless there's something about that agreement that harms competition, or on the other side, is deceptive to consumers, or unfair to consumers, then it is not a problem in a broad sense for the Federal Trade Commission. There could be other aspects of it that are a policy concern, but those would not generally be within our domain.

MARK McCLELLAN: May I just say, I don't speak for CMS. I'm not sure I ever really did, but I definitely don't now. But the plan bids, at least their risk-adjusted bids for "standard beneficiary," is the basis for the subsidy calculations they get and therefore the premiums the beneficiaries pay. So that information is available.

If what you're talking about is the specific information on actual -- and CMS gets information on MLR equivalents and things like that. If you're asking about the specific information on what's paid on behalf of a particular beneficiary or a particular set of beneficiaries in a plan, there are resource programs to get access to that. I'm not sure it's generally publicly available. One example of a researcher in health economics who's done some

work in this area recently is Mark Duggan at Penn, who looked at some of the effects of things like different risk adjustment mechanisms, and so forth where we really needed to get those kinds of data.

So there are some precedents out there even for the very detailed payment information.

MARTIN GAYNOR: I'll just say one more thing about these kinds of terms. Without judging them one way or another, I think it's important to think through these things very carefully. And in some cases private terms of contracts can actually be pro-competitive and benefit consumers. It can be the sellers of a service or product are more willing to negotiate and offer their products at reduced prices if they know those terms will remain private. And if they become public they may be less willing to do so. I'm not saying that's necessarily the case. And obviously any particular circumstance one has to know exact facts and details. But that's another kind of element that weighs into this, and so while it's not obvious at first blush, just because terms are private that that's necessarily harmful to consumers.

I think we have time maybe for one last question if anyone has enough energy left to raise their arm. All right. Well I really want to thank this -- we've had a rock star cast of panelists here, and actually not just with this panel but throughout the entire session here. It's been tremendously enjoyable and useful for us here at the FTC. We appreciate the active participation of everybody on the panels and in the audience. And we hope that you found this useful as well. As has been said before, we're very interested in comments. There's a public comment period that's open. I don't personally recall the exact date -- April 30. And so you could comment through the website. And we’re quite interested in receiving your comments and thoughts on that.

So let me thank the panelists again and then I'll turn the floor over to Andy Gavil, who is director of the Office of Policy Planning, to wrap things up.

CLOSING REMARKS

- **Andrew I. Gavil, Director, Office of Policy Planning, Federal Trade Commission**

ANDREW GAVIL: Thank you, Marty, and thank all of you for joining us today. I think we've demonstrated that we compare favorably to health care. We've delivered a high-cost low-cost low -- wait a minute, I'll get it right -- high-quality, low-cost, transparent program. So I think I may be editing the webcast on that one.

As all of you know it takes a lot of people to conceive of and organize a workshop like this, and I'd like to single out some of our organizers for their enthusiasm, their dedication, and their creativity in assembling today's program. In addition to Chairwoman Ramirez, who has supported our efforts, and Marty Gaynor, who has guided us throughout, I'd like to acknowledge a group of folks that really put in a lot of hours and a lot of work.

From the Office of Policy Planning: Tara Koslov, Pat Schultheiss, Stephanie Wilkinson, Dan Gilman, Chris Bryan, and Elizabeth Jex. From the Bureau of Competition: Ellen Connelly, Gary Schorr, Rob Canterman, and Karson Mahler. From the Bureau of Economics, in addition to Marty: Tom Iosso. From three of our regional offices, all of whom were able to come and join us: Christine White, Erica Wodinsky, John Wiegand, Danica Noble, and Susan DeSanti. Our paralegals: Andrea Kelly, Erin Flynn, Elena Vera, Anna Murray, Katia Barron, Kristin Mickel, and Alice Bartek. From the Division of Consumer and Business Education, for designing our workshop logo, tags, posters, our web page, our agenda, and all of our other workshop materials: Carrie Gelula, TJ Peeler, Wayne Abramovich, and Chris Hundycz. For making sure that our technology was all up and functioning properly: Bruce Jennings, James Murray, Ted Roach, and Glen Savoy. From the Office of Public Affairs: Cheryl Warner, who is here, Gail Kingsland, and Mitchell Katz. Our event staff: Lara Kittelson. And for help with security: Charles King.

Did I leave out Karen? It's coming, I'm not done. So I'd like to single out several of my OPP colleagues who led the team over many months and who have spent long hours designing the workshop, reaching out to many of you, and skillfully guiding today's discussion. Special thanks go to Pat Schultheiss, Stephanie Wilkinson, Dan Gilman, Karen Goldman, who I left off the longer list, and Tara Koslov. Congratulations to you and thank you. Well done.

Finally I would like to remind you all that, as Marty noted, the public comment period for today's workshop will remain open until April 30. The details of the submission process can be found in the Federal Register Notice on our workshop website. We encourage and look forward to receiving and considering more comments. Thank you all again, and we look forward to continuing the conversation.

[END OF WORKSHOP, DAY 2]