# "Transparency" in Principle and in Practice: Health Insurance Plan Perspectives

**By**

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## I. Introduction

Good morning. My name is Stephanie Kanwit and I am Special Counsel for America's Health Insurance Plans (AHIP). I would like to thank the Federal Trade Commission for the opportunity to share AHIP's perspectives on Quality and Price Information Transparency. AHIP is the national association representing nearly 1,300 health insurance plans providing coverage to more than 200 million Americans. Our members offer a broad range of products in the commercial marketplace including health, long-term care, dental, vision, disability, and supplemental coverage. Our members also have a strong track record of participation in Medicare, Medicaid, TRICARE, and other public programs.

The topic of transparency is an important one, given the spectrum of quality challenges faced by our health care system. Studies by the Institute of Medicine (IOM) as well as RAND and the *Dartmouth Atlas of Health Care* are well-known, all pointing to wide variations in care across the country, unacceptably high numbers of medical errors, and medical practice that is often not based on scientific evidence. The latest edition of the *Dartmouth Atlas*, released just this month, finds Medicare to be paying hugely disparate sums for care delivered at top teaching hospitals to patients during the last two years of life. That finding confirms yet again that more services – including more time in the ICU and more visits to specialists – do not necessarily mean better quality care for patients, just more expensive care.

The IOM, in its landmark 2001 report, *Crossing the Quality Chasm*, stressed transparency as the key to improving clinical quality as well as achieving better value in the health care system.

AHIP's health insurance plan members are committed to that concept, and have been diligently working for years to further that goal. My testimony today focuses on both:

- the critical *principles* that guide AHIP's health insurance plan members as they work to assure transparency, namely that consumers have reliable and useful data to help them choose physicians and hospitals that deliver value-based care; and
- concrete *examples of initiatives* health insurance plans have taken – working with physician groups, hospitals, consumers, employers, and government representatives – to address gaps in quality and to promote transparency of results to aid consumer decisions and improve physician performance.

Before addressing specifics, however, I note upfront some competitive concerns that arise when government bodies and regulators incorrectly believe "more transparency must be better" and create transparency initiatives, without regard to *first*, their actual utility to consumers, and *second*, their possibly adverse impact on the competitive marketplace. To be clear, many types of government involvement in the transparency process can have quite beneficial effects for both competition as well as consumers. All transparency initiatives, however, must be carefully designed to assure that they truly provide consumers with useful, understandable information relevant to their health care decisions, while not resulting in public disclosures – especially of sensitive, proprietary data such as pricing and payment terms – that undermine the competitive process and ultimately result in higher costs for consumers. We commend and applaud the FTC's opposition to these types of transparency initiatives and its efforts to educate government bodies at all levels about the unintended consequences of such initiatives.

The key is that transparency must not be deemed to be an end in itself, but rather a means of providing consumers with relevant, useful information that adds value to their health care decision-making processes. Just as transparency initiatives have the goal of moving consumers towards "20/20 vision" with respect to their health care decisions, those launching transparency initiatives must not be myopic with respect to the likely consequences of their proposals. Thus, it is incumbent on us to ask the following key questions of every transparency initiative: (1) *how will making information more transparent benefit consumers*; and (2) *will that transparency effort have countervailing, anticompetitive effects, such as higher prices for consumers?*

## II. Health Insurance Plans' Efforts to Promote Quality and Transparency

Consistent with the goals set out in the 2004 Federal Trade Commission and Department of Justice report on health care,[1] our members are committed to working on a number of initiatives and strategies that improve physician and hospital performance measurement as well as provide consumers with information that helps them make informed, value-based decisions.

There is a major push by both public and private stakeholders to promote greater transparency and value-based competition throughout the U.S. health care system, through empowering

[1] In the report, the agencies touted "increased transparency" as the key means "to implement strategies that encourage providers to lower costs and consumers to evaluate prices." Federal Trade Commission and Department of Justice, *Improving Health Care: A Dose of Competition*, Executive Summary at 21 (2004), available at http://www.usdoj.gov/atr/public/health_care/204694.htm. (henceforth, "*FTC/DOJ Report*"). They specifically recommended that private payors, governments, and providers "should furnish more information on prices and quality to consumers in ways that they find useful and relevant." *Id.*

consumers to be more actively engaged in making decisions – based on reliable, user-friendly data – about their medical treatments and how their health care dollars are spent.[2]

Public and private stakeholders have responded to the call. The Centers for Medicare & Medicaid Services (CMS) has posted quality information related to hospitals, nursing homes, and home health agencies, as well as Medicare payment information for common elective procedures and other common admissions by county.[3] More recently, CMS created a voluntary physician quality reporting program.[4]

### A. AHIP's Principles of Transparency

AHIP and our members have spoken compellingly over the course of the last several years on the need for transparency in our health care system. These five principles issued by our Board of Directors in 2006 are the cornerstones for AHIP's policies:

- ***Supporting a uniform approach for the disclosure of relevant, useful, actionable and understandable information to facilitate consumer decision-making and choice.*** Information should be made available to enrollees to permit accurate comparisons of physicians, hospitals and other practitioners. Additionally, information should be disclosed and displayed in a format that is easily accessible and understandable; consumers should be educated on how to use the information as appropriate.

- ***Supporting efforts that advance transparency while preserving competition and basing analyses on objective, agreed-upon measures.*** Consumers and purchasers need accurate information to make more informed health care decisions. At the same time, the disclosure of this information should comport with antitrust guidelines to ensure that

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[2] *See, e.g.*, http://www.whitehouse.gov/news/releases/2006/08/20060822-2.html (containing Executive Order No. 13410, *Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs*) and http://www.hhs.gov/valuedriven/ (discussing the Department of Health and Human Service's *Value-Driven Health Care Initiative*).

[3] For more information about CMS's transparency initiatives, *see* http://www.cms.hhs.gov/QualityInitiativesGenInfo/.

[4] For more information about CMS's physician quality reporting program (PQRI), *see* http://www.cms.hhs.gov/pqri/.

vigorous competition continues to thrive in the marketplace. To achieve this objective, ranges – such as the 25th percentile and 75th percentile of payments to hospitals which are disclosed by Medicare – should be the model for disclosing price information.

- ***Recognizing the importance of linking quality and cost of care.*** Disclosure of information about the quality of care which physicians and hospitals provide and costs of services is important to enable consumers and purchasers to evaluate their health care options, and to enable practitioners to learn how their practices compare to their colleagues' practices in terms of effectiveness and efficiency. At the same time, consumers need assistance in interpreting this information and using these data to make informed decisions.

- ***Developing the tools to analyze high-utilization, high-cost services or conditions where variation exists.*** The nation needs to build the capacity to analyze certain agreed-upon episodes of care as well as certain services or procedures. Presenting data on episodes of care (e.g., pregnancy) – rather than merely on services (e.g., labor and delivery) – will allow consumers to make more comprehensive and informed assessments. The episodes of care selected should align with conditions which address areas where practice variation exists, have high utilization rates and are known to be cost drivers.

- ***Supporting the disclosure of information for physician as well as hospital services.*** To promote continuity of care and prevent the proliferation of silos within the health care system, stakeholders should advocate for the disclosure of physician performance information as well as the disclosure of hospital performance information. Disclosure of information for other providers – such as nursing homes and home health agencies – also should be considered.

### B. "Transparency" in Practice:

AHIP's transparency principles can be seen in action through our involvement in the AQA Alliance, the member-focused transparency efforts of AHIP's members, and the leadership of AHIP's members in developing initiatives to reward quality performance.

### 1. AQA Alliance

AHIP and several prominent physician leaders began a vitally important collaboration four years ago with physician groups and other key stakeholders to establish the AQA Alliance.[5] The coalition, which includes private groups like the American Academy of Family Physicians and the American College of Physicians, as well as the Federal Agency for Healthcare Research and Quality (AHRQ), has as its goal the development of uniform processes for performance measurement and reporting – a fundamental building block needed for consumer health information systems. Its processes would: (1) allow patients and purchasers to evaluate the cost, quality and efficiency of care delivered, and (2) enable practitioners to determine how their performance compares with their peers in similar specialties. This effort now encompasses more than 135 organizations, including consumer groups, physician groups, hospitals, accrediting organizations, private sector employers and business coalitions, health insurance plans and government representatives.

To date, the AQA has approved 218 *quality* clinical performance measures in 32 different ambulatory care setting areas, many of which are being incorporated into health plan provider contracts. These measures represent an important step in establishing a broad range of quality measurement. The AQA has also approved a prioritized list of conditions for which *cost of care measures* should be developed, and the group continues to make further progress towards that goal.

In addition to its work in the area of performance measurement, the AQA has implemented a pilot program in six sites across the country, with support from CMS and AHRQ. These pilots,

[5] For more information about the AQA Alliance, *see* http://www.aqaalliance.org/.

now known as the Better Quality Information or BQI sites, combine public and private sector quality data on physician performance. This program is testing various approaches to aggregating and reporting data on physician performance, while also testing the most effective methods for providing consumers with meaningful information they can use to make choices about which physicians best meet their needs. Ultimately, we anticipate that the results of this pilot program will inform a *national framework* for measurement and public reporting of physician performance, which is an important step toward advancing transparency and providing reliable information for consumer decision-making.

### 2. Health Insurance Plan Member-Focused Transparency Efforts

Many AHIP member plans have individually implemented their own initiatives to empower their members by supplying them with price as well as quality information designed to support consumer decision making. While they use a variety of approaches, these plan initiatives – often in the form of easy-to-use tools that allow consumers to access secure websites – encompass providing such resources as the following:

- **Access to price data on specific physicians**: A member of many health insurance plans can type in a particular physician's name, specialty, or office address and view a menu of common procedures, and determine the cost of procedures, such as routine office visits or x-rays.
- **Access to quality data on physicians**: Members of some health insurance plans can access information on either plan-specific or regional collaboratives' websites regarding clinical quality delivered by a specific physician, including indicators based on adverse events, clinical processes, use of health information technology such as electronic medical records, as well as overall efficiency in use of medical services.
- **Access to hospital price and quality information**: Members in many plans may have access to cost ranges for common procedures at hospitals and surgery centers, in some

instances separating out doctor fees from facility costs, as well as tools to ascertain the comparable value of those facilities.

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

### 3. Promoting Quality and Transparency through Rewarding Quality Performance

As the AQA initiative demonstrates, AHIP's members are committed to working with stakeholders across the health care community, particularly health care professionals who work on the frontlines every day, to *measure* as well as *reward* physicians, hospitals, and other health care practitioners for high quality performance. Those efforts are consistent with another recommendation of the *FTC/DOJ Report*, calling for private payors, governments, and providers to "experiment further with payment methods for aligning providers' incentives with consumers' interests in lower prices, quality improvements, and innovation."[6] Critically, those efforts are "win-win" for both consumers, who benefit from public disclosure and the opportunity to select the best practitioners, as well as clinicians, who will receive valuable feedback on how their performance compares to their peers.

[6] *FTC/DOJ Report*, Executive Summary at 21.

AHIP and our members currently are working to advance quality-based payment systems that are based on transparency with respect to framework, processes, and rules. The AHIP Board of Directors has issued principles for such systems, including: (1) assuring that measures, data specifications and methodologies, such as attribution, risk adjustment and the relative importance given to different types of performance measures, are clear and transparent; (2) involving physicians, hospitals and other health care professionals, as well as consumers and other appropriate stakeholders, in the development of provider performance reporting programs; (3) giving clinicians and hospitals an opportunity to review and comment on the results before performance information is made public; (4) assuring the "linkage" of quality and value of care so consumers have information about the relative significance of each factor included in the evaluation; and (5) assuring that physicians are notified in a timely manner of significant changes in evaluation methodology, data sources, or network structure.[7]

Just a few weeks ago, on April 1, 2008, AHIP joined other stakeholders, including major physician, consumer, employer, labor, and quality groups, in supporting a standard set of guiding principles, developed by the Consumer-Purchaser Disclosure Project, on physician performance measurement and reporting.[8] The principles are embodied in a "Patient Charter," which parallels the AHIP Board of Directors' policy statement just discussed.

These principles are crucial to gaining practitioner support in programs designed to reward quality and efficient use of resources. Indeed, one recent study found that fully sixty percent of the organizations surveyed provide incentives related to network physician services. Such

[7] A copy of the full Nov. 2007 Board of Directors Statement is attached hereto as App. A.

[8] *See* http://www.ahip.org/content/pressrelease.aspx?docid=22829.

incentives can include financial and non-financial rewards. On the government side, where our members are integrally involved in administering the Medicare program, CMS has made value-based payments for services to Medicare beneficiaries an integral part of its Strategic Action Plan for 2006-2009[9] and has launched the Premier Hospital Quality Incentive Demonstration Program to recognize and provide financial awards to hospitals that demonstrate high-quality performance.[10]

We expect that you will continue to see, in the months and years to come, an impressive range of efforts, from individual health insurance plans and from multi-stakeholder collaborations that advance these principles and bring increased value to consumers.[11]

## III. Harmful "Transparency" Initiatives

As noted, AHIP works closely with many government agencies toward the goal of greater price and quality transparency with respect to health care services. Much of what governments have done in this area has been to the benefit of consumers, such as the over two dozen states which currently mandate provider "report cards" or other reporting of quality measures.[12] When

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[9] *See* CMS Strategic Action Plan 2006-2009, *available at* http://www.cms.hhs.gov/MissionVisionGoals/Downloads/CMSStrategicActionPlan06-09_061023a.pdf.

[10] For more information on CMS's Premier Hospital Quality Incentive Demonstration Program, s*ee* http://www.cms.hhs.gov/hospitalqualityinits/35_hospitalpremier.asp.

[11] Among the private sector collaborative efforts that have already emerged is a hospital rewards program launched by the Leapfrog Group, which is made up of private- and public-sector health care purchasers and suppliers of health-related products and services. The Leapfrog Hospital Rewards Program ties hospital payments to nationally accepted and endorsed performance measures. *See* http://www.leapfroggroup.org/for_hospitals/fh-incentives_and_rewards/hosp_rewards_prog.

[12] *See, e.g.*, http://www.floridahealthfinder.gov/ and http://mhcc.maryland.gov/consumerinfo/hospitalguide/index.htm.

governments become involved in transparency initiatives, however, they need to tread carefully to ensure that they are furthering, rather than hindering, the interests of consumers. Such regulation raises two primary concerns:

- First, inappropriate government regulation of, or interference with, transparency initiatives can stifle the flowering of various private transparency initiatives before such initiatives have had the chance to benefit consumers.[13]

- Second, some government-initiated transparency initiatives can lead to the disclosure of the "wrong" types of information, which not only ultimately may prove useless to consumers, but can harm competition, resulting in higher prices.

The critical question, again, is *how will the transparency effort benefit consumers*? As the FTC has recognized, to benefit consumers, the information made transparent must be information that customers or consumers *can actually use*. Yet some so-called transparency initiatives continue to mandate the revelation of information that not only fails to help consumers make informed purchasing decisions, but, once disclosed, can lead to higher prices and other market harms.

The FTC has played a leading role in helping state legislators and regulators distinguish between "good" and "bad" transparency initiatives. Specifically, in a number of letters this agency has opposed recent proposed state regulations intended to mandate greater transparency of

[13] The FTC and Department of Justice have noted that "vigorous competition…is more likely to arrive at an optimal level of transparency than regulation of those terms." *FTC/DOJ Report*, Chapter 7 at 17. Inherent in allowing such competition is innovation and flexibility. As AHIP's Board indicated in its November 2007 statement, "[w]e recognize the importance of achieving consensus standards to validate methodologies used for these programs as well as the value of *flexibility to design innovative tools and approaches that recognize and report performance.*" (emphasis added).

contractual data from pharmacy benefit managers (PBMs). Those letters explain that disclosure of *proprietary contractual terms* can have the unintended effect of limiting competition and raising the cost of prescription drugs to consumers. Those letters find no empirical reason that PBMs' customers, health insurance plans, need to know the details of the PBMs' bargains with pharmaceutical manufacturers to achieve a competitive price.[14]

We commend the FTC's efforts in this area, and note that more such guidance may be necessary as states pursue expanded, and sometimes misguided, transparency initiatives, under the theory that "more information is better." But when the mandated information to be made "transparent" is (for example) *proprietary and confidential information*, such as pricing data, it undermines vigorous competition. The best example is a recent rule enacted by New Hampshire requiring the release of insurer-by-insurer/provider-by-provider pricing information. That means that a doctor in Hanover, New Hampshire will be entitled to learn how much a particular health insurance plan is paying other doctors in the same area for a particular service—although the doctor has negotiated a contract with the plan specifying reimbursement. If the physicians themselves attempted to collect and disseminate such information, they likely would face an

[14] With respect to the absence of pro-competitive benefits, the FTC has indicated that requiring disclosure of factors that determine ultimate pricing is "analogous to requirements that firms reveal aspects of their cost structures to customers. There is no theoretical or empirical reason to assume that customers require sellers' underlying cost information for markets to achieve competitive outcomes." FTC, *Letter to New Jersey General Assemblywoman Nellie Pou* (Apr. 17, 2007) at 12, *available at* http://www.ftc.gov/be/V060019.pdf .

With respect to the harm that such disclosure can cause, the FTC has noted that "[p]ublic disclosure of proprietary information can foster tacit collusion or otherwise undercut vigorous competition on . . . pricing." FTC, *Letter to Virginia House of Delegates Member Terry G. Kilgore* (Oct. 2, 2006) at 13, *available at* http://www.ftc.gov/be/V060018.pdf; *see also* FTC, *Letter to New Jersey General Assemblywoman Nellie Pou* at 10 (noting that requiring "disclosures [of sensitive financial information] may facilitate collusion, raise price, and harm the patients the bill is supposed to protect"); FTC, *Letter to California Assembly Member Greg Aghazarian* (Sept. 7, 2004) at 2, *available at* http://www.ftc.gov/be/V040027.pdf (noting that requiring such disclosures by PBMs would have the "unintended consequences of limiting competition, thus increasing the cost of pharmaceuticals and ultimately decreasing the number of Americans with insurance coverage for pharmaceuticals.").

antitrust investigation. More critically, dissemination of that information is not useful to assure genuine "transparency" and, in fact, is counterproductive for two reasons:

- That information may not be useful or relevant to a New Hampshire consumer seeking to make choices among physicians or to ascertain how much he or she must pay out of pocket. An individual consumer needs to know what the deductible and co-pay are, if the service is provided in-network, or needs to know what he or she might be responsible for paying, if the service is provided out-of-network, but has no need of knowledge regarding general reimbursement scales to all physicians state-wide.

- Dissemination of that information will lead to increased prices for consumers, as it is likely to allow the physicians in a given area to insist that the higher reimbursements become a "floor" for all reimbursements. As the FTC has lucidly pointed out, under the antitrust laws, firms are not entitled to information about what their competitors have agreed to accept in payment for goods or services.

While such state initiatives may be pursued in good faith, usually with the stated goal of lowering health care costs for their citizens, the inevitable economic result is *higher costs* as a result of softening of competition. This does not mean that states (and other regulators) can never engage in such transparency efforts. Rather, this means simply that such initiatives should follow the guidance that the FTC has provided above, as well as the guidance that the FTC and Department of Justice have provided with respect to the use of aggregation, maintenance of confidentiality, and other protections that will reduce the risk of anticompetitive effects arising from proposals to compile price and cost information. We urge the FTC to continue to monitor,

and, when appropriate, comment on, such health care transparency initiatives to ensure that they truly serve consumers rather than leading to reduced competition and increased prices.

## IV. Conclusion

AHIP and our members strongly support both competition and appropriate cooperation among all the participants in the health care delivery system. We commend the Federal Trade Commission for its comprehensive and landmark 2004 report with the Department of Justice, as well as its law enforcement initiatives, competition advocacy, and policy work.

Thank you for this opportunity to discuss this topic with you, and we look forward to continuing to work with the Federal Trade Commission to promote and preserve consumer-friendly, competition-enhancing transparency initiatives.