The Future of Price Transparency in California

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IHA Organization

- Statewide multi-stakeholder leadership group that promotes quality improvement, accountability, and affordability of health care in California.
- Actively convenes all health care parties for cross-sector collaboration on health care topics; administers regional and statewide programs; and serves as an “incubator” for pilot programs and projects.
- Organized as a 501(c)(6) nonprofit association; does not operate as a trade association.
- Mission: To create breakthrough improvements in health care services for Californians through collaboration among key stakeholders.

Overview

- Consumer audience
  - Consumer priorities
  - Available information
  - Effect of information, incentives on behavior

- Purchaser/Provider audience
  - Total cost of care (TCC)
  - Measuring, reporting, rewarding TCC
  - Data uses

Consumer Audience

What Do Consumers Want?

- Consumer priorities for *content*
  - Quality: Physician-level patient experience
  - Cost: Out-of pocket
  - Integration of Q&C information

- Principles of effective *presentation* inconsistently applied
  - Visual display, labeling, context

Source: Yegian J, Dardess P, Shannon M, Carman K. "Engaged Patients Will Need Comparative Physician-Level Quality Data and Information About Their Out-of-Pocket Costs," *Health Affairs*, February 2013.

EXHIBIT 1

Emerging Models For Delivering Consumer-Oriented Quality And Cost Information

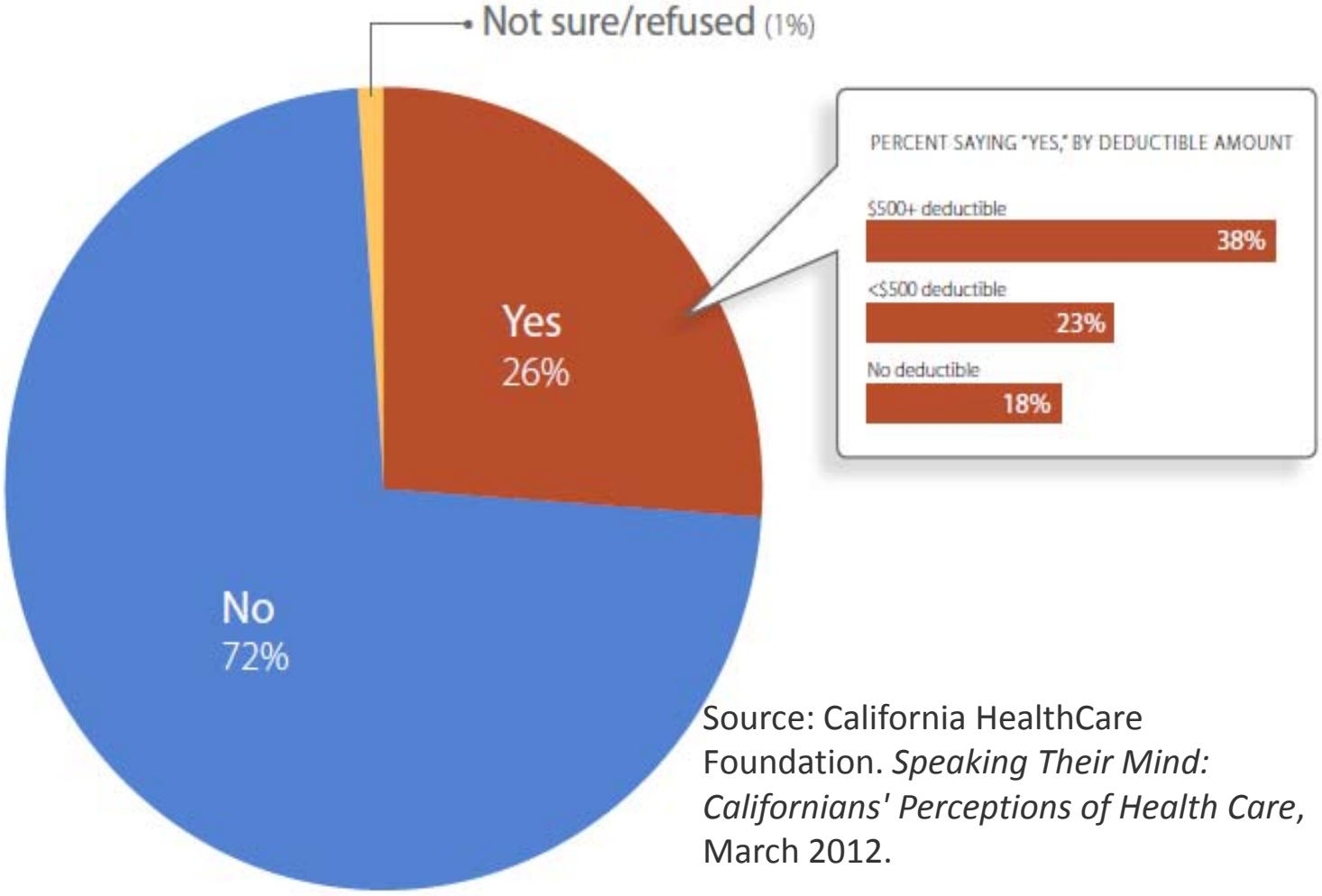
	Transparency for the greater good	One-stop shopping
Goals	Improve quality and efficiency, engage consumers, increase awareness of variations in quality and cost	Provide personalized, integrated information on cost and quality to support consumers' decision making regarding care providers and services
Organization type	Multistakeholder coalitions, state agencies; usually nonprofit	Third-party vendors, health plans; usually for-profit
Cost data	Most often average charges but may feature negotiated rates; data sources include multipayer claims data and statewide discharge databases	Negotiated provider rates overlaid with individuals' benefit designs based on claims data from health plans or third-party administrators
Quality data, physicians	Partial list of sources: Clinician and Group Consumer Assessment of Healthcare Providers and Systems (patient experience) Ambulatory Care Experience Survey (patient experience) Healthcare Effectiveness Data and Information Set (clinical quality)	Partial list of sources: Vitals (patient experience) State medical boards (sanctions) American Board of Medical Specialties (board certification) HealthGrades (sanctions, malpractice, board certifications)
Quality data, hospitals	Partial list of sources: Centers for Medicare and Medicaid Services (clinical quality and patient experience) Leapfrog Group (patient safety) Statewide discharge databases (clinical quality) Healthcare Facilities Accreditation Program (clinical standards, patient safety) Joint Commission (clinical standards, patient safety)	
Business model	Philanthropic funding Government funding (for example, mandated availability of cost information for consumers) Offering of tools to customers as value-added service	Selling of data and interface to employers (health plans) for use by employees (enrollees) Venture funding Offering of tools to customers as value-added service
Examples	New Hampshire HealthCost, Massachusetts Healthcare Quality Partners, FAIR Health, Chartered Value Exchanges, Aligning Forces for Quality sites	Castlight, Change Healthcare, UnitedHealthcare, Aetna, Anthem

Source: Yegian J, Dardess P, Shannon M, Carman K. "Engaged Patients Will Need Comparative Physician-Level Quality Data and Information About Their Out-of-Pocket Costs," *Health Affairs*, February 2013.

Searched for Cost Information Prior to Getting Care,
Overall and by Deductible Amount, California, 2011

Have you ever looked for information about the cost of a test, treatment, or other type of health care you needed, before you actually got the care?

BASE: ALL ADULTS (n = 1,528)



Source: California HealthCare Foundation. *Speaking Their Mind: Californians' Perceptions of Health Care*, March 2012.

About one in four Californians (26%) say they have looked for information about cost before receiving care.

Those with a relatively high deductible ($500 or more) are twice as likely as those without a deductible to look for cost information before getting care.

A Sampling of Recent Research

- Effect of high deductibles on shopping
  - RAND's research on price shopping in "consumer-directed" health plans
- Effect of reference pricing on consumer choice
  - UC Berkeley evaluation of the CalPERS reference pricing initiative
- Consumer use of all-payer claims database
  - Center for Studying Health System Change study of the New Hampshire HealthCost website

Incentives Without Information: Effect of Deductibles on Price Shopping

- Examined health insurance claims data from 63 large employers, comparing high-deductible health plans to traditional
- Nine common outpatient services examined to estimate extent of price shopping
- Consumers did not engage in more price shopping before reaching deductible
- Even with incentives to shop, consumers often do not have adequate access to information on price

Source: Neeraj Sood, Zach Wagner, Peter J. Huckfeldt, and Amelia M. Haviland. "Price-shopping in Consumer Directed Health Plans," *Forum for Health Economics and Policy*, March 2013.

Incentives and Information: CalPERS Reference Pricing Initiative

- Cost for hip and knee replacement ranged from $15,000 to $115,000 in California hospitals
  - PERS worked with Anthem Blue Cross to develop benefit limit in PPO product; implemented in 2011
- To address this price variation:
  - Identified 63 hospitals in California that performed more than 10 hip or knee replacements for PERS members in last year
  - 47 had total hospital charges of $30,000 or less; set as ***reference price***
  - 16 hospitals had medical costs above the reference price—patients exposed to the cost difference

Source: Jeff Kamil, presentation at Aligning Forces For Quality National Meeting, November 9–11, 2011.

CalPERS Reference Pricing: Results

- Number choosing low-price hospitals increased by 21% in the year after implementation
- Number choosing high-price hospitals declined by 34.3%
- Reference pricing caused a 28.5% increase in volume for low-price hospitals
- Reference pricing resulted in 20% decrease ($7,028 per case) in hospital prices in 2011
- Estimated savings of $3.1 million (447 patients) in the first year

Source: J.C. Robinson and T.T. Brown, "Increases in Consumer Cost Sharing Redirect Patient Volumes and Reduce Hospital Prices for Orthopedic Surgery," *Health Affairs*, August 2013.

Information Without Incentives: Low Consumer Use of State Database

- The New Hampshire HealthCost website features:
  - Provider-specific, insurer-specific median cost estimates
  - 30 common conditions
- HealthCost has had *low* usage by consumers
- Website's effects instead seen in market dynamics:
  - Evidence suggests providers are reducing prices in response to increased transparency
  - Introduction of tiered networks for lab services and outpatient surgeries with strong consumer steering incentives, especially in small group market

Source: Ha Tu and Rebecca Gourvitch, "Progress Report – Updated Analysis of the Effect of Price Transparency on Markets in New Hampshire," Health System Change, 2013.

Purchaser/Provider Audience

Total Cost of Care

- Shift away from unit price toward total cost
  - Fee-for-service model focuses on unit price, maximizing revenue, shifting cost around within system
  - New models (such as ACO) align financial incentives across providers to jointly reduce cost
- The key – and challenge – is capturing full cost picture
- IHA now collects data on total cost of care for HMO/POS enrollees in California

IHA P4P Program Evolution to Value-based Performance Payment

2003:

First Measurement Year –

Quality only

2007:

Payment for Improvement Added –

Quality only

2009:

Appropriate Resource Use added/Episode Measures tested

2011:

Total Cost of Care Measure added

2013:

Value Based P4P – Quality and Resource Use integrated into single incentive program

Program Participants

Eight CA Health Plans:

- Aetna
- Anthem Blue Cross
- Blue Shield of CA
- CIGNA
- Health Net
- Kaiser Permanente*
- PacifiCare/United
- Western Health Advantage

Medical Groups and IPAs:

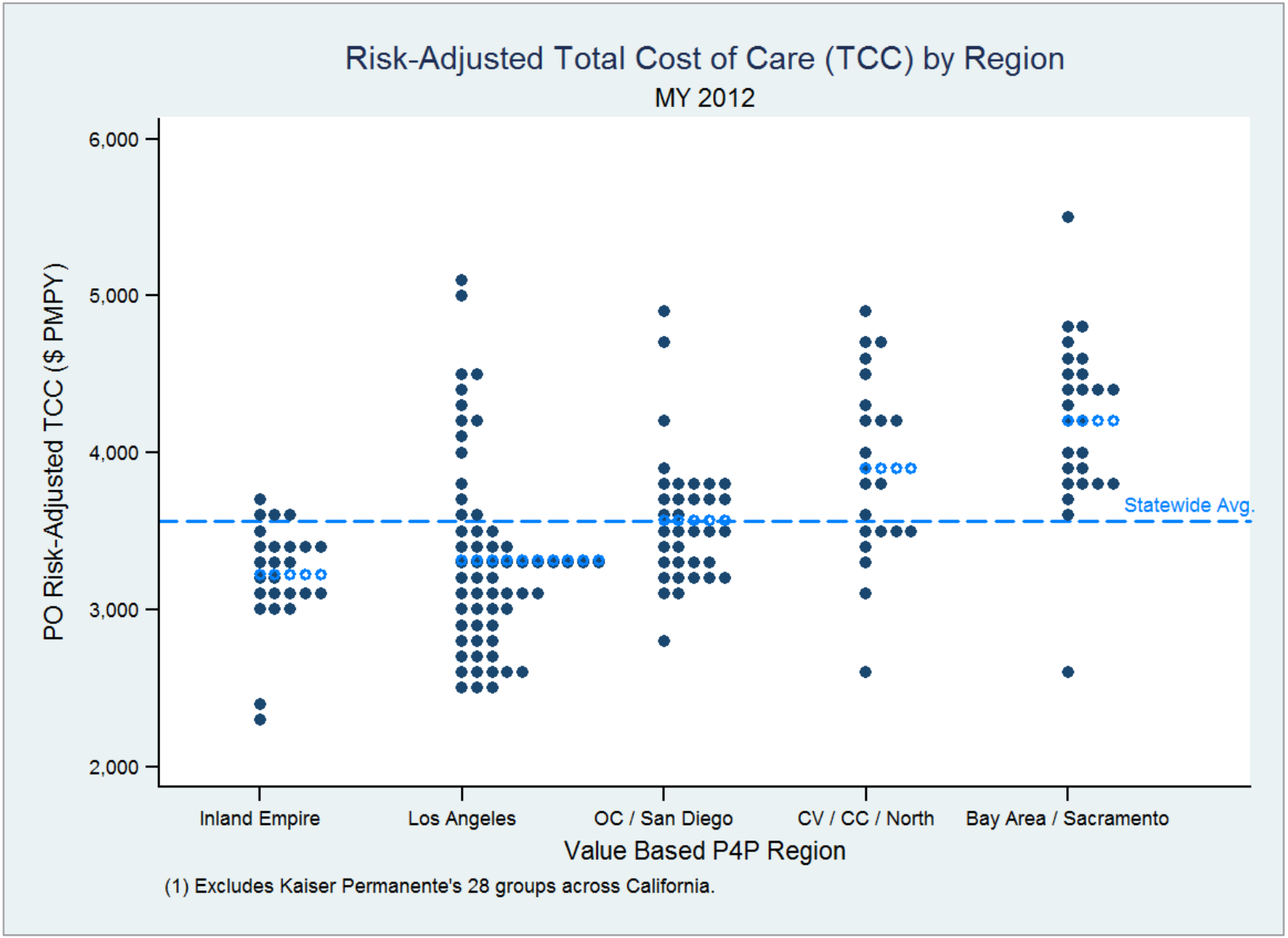
- 200 Physician Organizations
- 35,000 Physicians
- 10 million commercial HMO/POS members

* Kaiser Permanente medical groups participate in public reporting only, starting 2005.

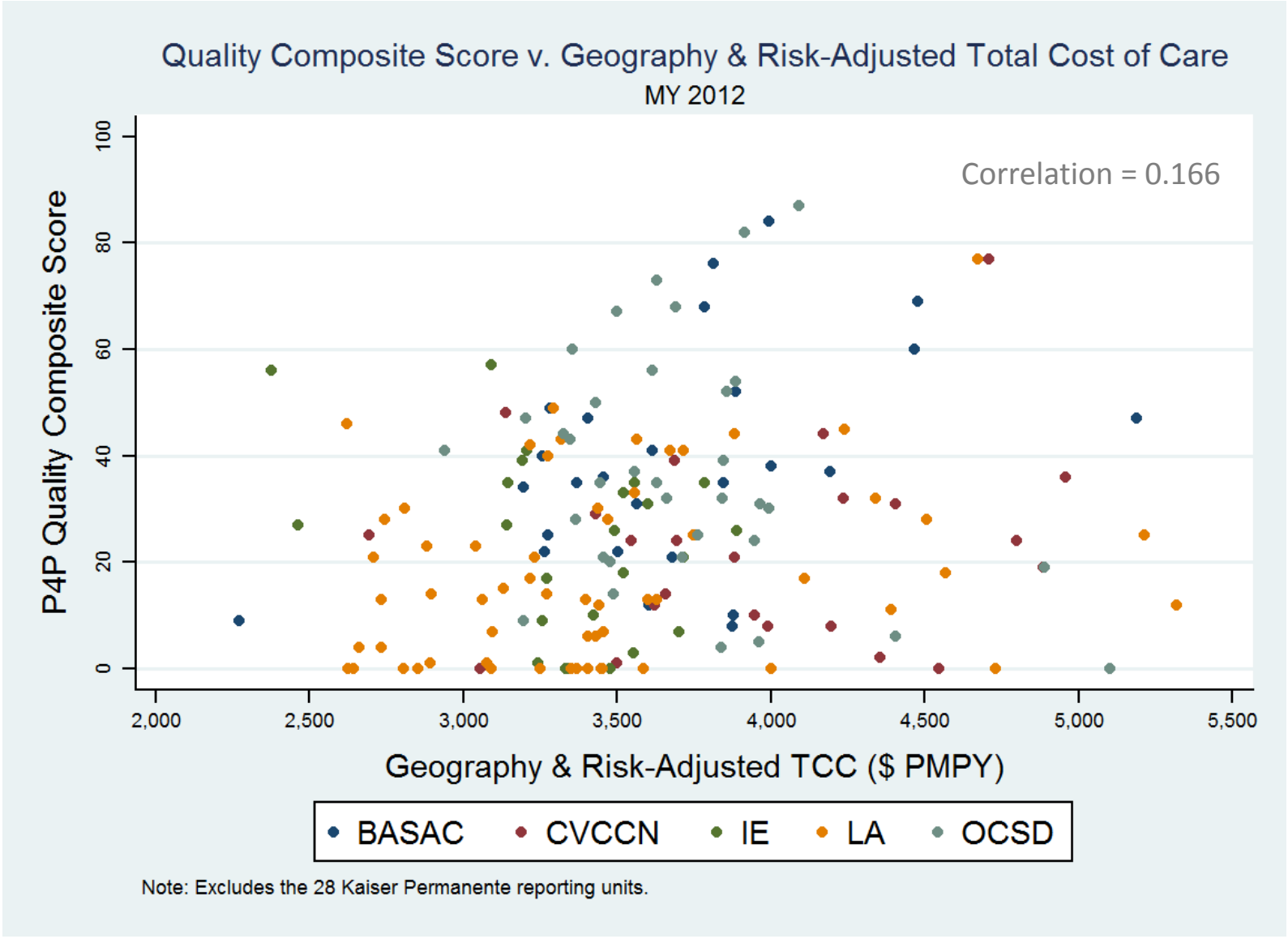
Total Cost of Care Measurement

- Description: Total amount **paid** (versus standardized costs) to a physician group to care for a population for one year:
  - Professional, facility (inpatient and outpatient), pharmacy, and ancillary costs
  - Capitation, fee-for-service, member cost share, admin. adjustments
- Risk adjustment: Concurrent DCG Relative Risk Score with $100K truncation adjusts for age, gender, and health status
- Other adjustment: CMS Hospital Wage Index derived Geographic Adjustment Factor for geographic pricing differences
- Exclusions:
  - Mental health and chemical dependency services
  - Acupuncture and chiropractic services; dental and vision services
  - P4P quality incentive payments

TCC Regional Variation



TCC vs. Quality Composite Score

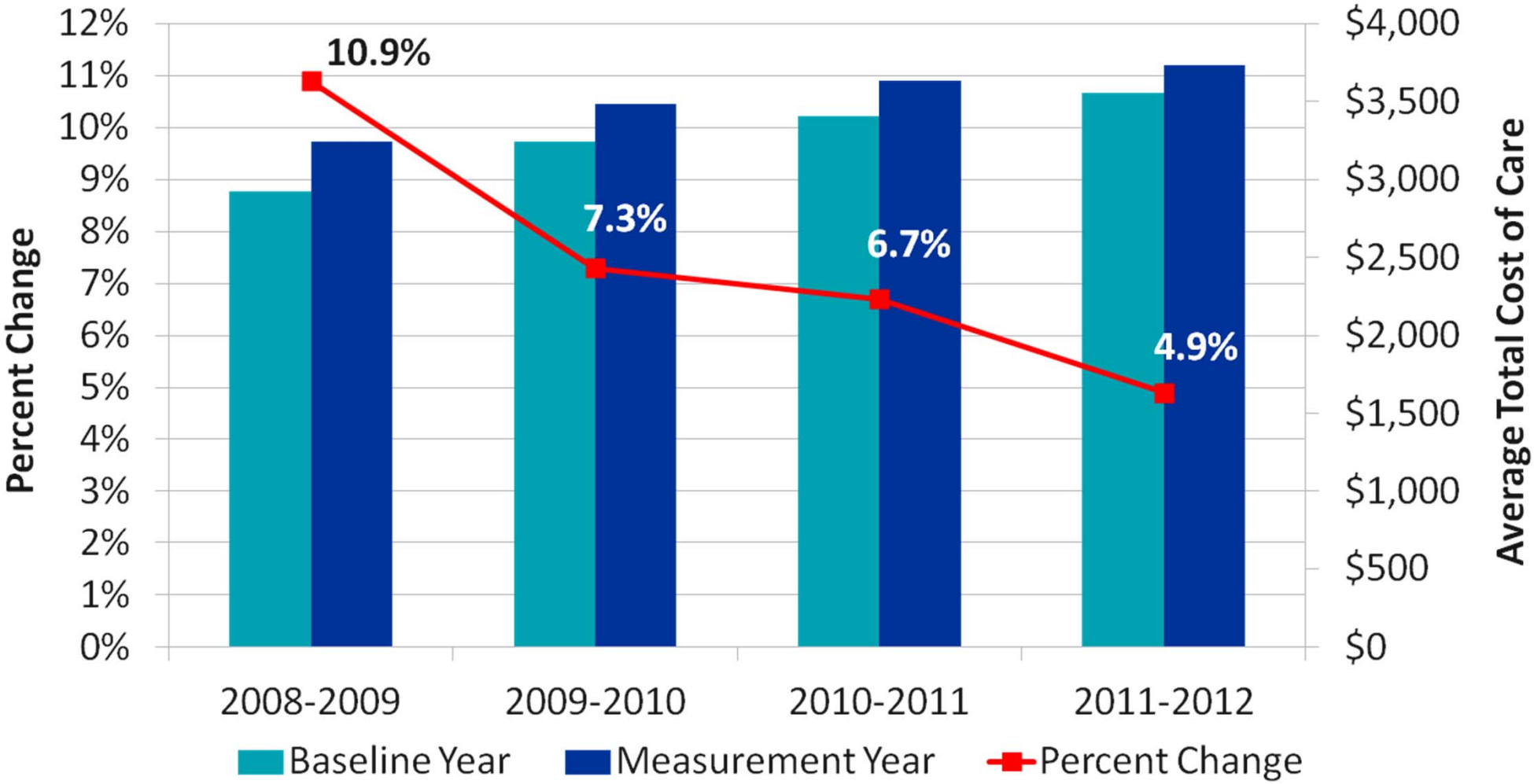


Total Cost of Care by Region

Region	POs*	MY 2012 Member Years	MY 2012 Average TCC	MY 2011 Average TCC	2011-2012 Average TCC Trend
Bay Area, Sacramento	26	586,677	$4,226	$4,042	4.5%
Central Coast, Central Valley, North	22	248,447	$3,871	$3,651	6.0%
Inland Empire	25	334,218	$3,226	$3,139	2.8%
Los Angeles	61	833,704	$ 3,524	$3,225	9.3%
Orange County, San Diego	35	559,050	$3,670	$3,605	1.8%
P4P Population	***169***	***2,562,096***	***$3,711***	***$3,533***	***4.9%***

PO=physician organization

P4P Population TCC Results
Change in Average Costs, 2008 - 2012



Note: Changes to plan data and measure methodologies may affect comparisons across years.

How Can Cost Data Be Used?

- Performance-based payment – Setting targets, shared savings
- Reduce variation, enhance efficiency (identify and address geographic "hot spots" on cost)
- Regulatory oversight – Rate review
- Plan/provider negotiation
- "Steering and tiering" – Benefit and network design, such as reference pricing
- Research – What is the effect of physician organization size and chain ownership on TCC?

Data Use and Reliability

- The use of information dictates both:
  - The *standard of reliability* necessary; and
  - The *legal and practical difficulties*
- The degree of difficulty increases as you move from internal to public reporting

Use	Difficulty
Internal provider reporting	Low/moderate
Determine incentive pay	Moderate
Network tiering	High
Public reporting	Very high

Questions?