February 24, 2015 Workshop Transcript: Examining Healthcare Competition

Hosted by the Federal Trade Commission and
U.S. Department of Justice, Antitrust Division

February 24, 2015

Constitution Center Auditorium
400 7th St SW
Washington, DC 20024

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[START OF WORKSHOP, DAY 1]

WELCOMING REMARKS AND ANNOUNCEMENTS

- **Tara Koslov, Deputy Director, Office of Policy Planning, Federal Trade Commission**

TARA KOSLOV: Good morning, everyone. On behalf of my colleagues at both the Federal Trade Commission and the Department of Justice Antitrust Division, I am delighted to welcome you to our workshop examining health care competition. My name is Tara Koslov, and I'm the deputy director of the FTC's Office of Policy Planning. As many of you know, this workshop is the second in this series following two workshop days organized by the FTC last March. This year, staff from the DOJ Antitrust Division and throughout the FTC have joined forces to assemble a number of expert panels. We will use these two days to study recent developments related to health care provider organization and provider models, and payment models, with an emphasis on how they may affect competition in the provision of health care services.

We are excited by the high level of interest in this workshop. We believe we have put together a robust agenda of top-notch speakers, and it looks like our audience agrees. We're very happy to see you all here and we appreciate that so many of you have joined us in person. We're also glad to be able to provide a live webcast to make the program more accessible to a wider audience. So hello to everyone who is watching via webcast. All of the workshop materials will be made available online as well, to create a lasting resource for everyone interested in these important issues. And a huge thanks to our tech team for making the webcast happen and also for enabling a few of our panelists to participate via video over the course of the two days. We have a couple of remote speakers who are going to be participating from some of the FTC regional office sites.

I would like to extend an extra and very sincere thanks in advance to all of our speakers, without whom we could not put together a program of this quality and depth. We are very grateful for your time and your efforts and we look forward to hearing from all of you over the next two days.

I would also like to remind everyone that the public record for this proceeding will remain open through April 30th of this year. We encourage interested parties to continue to submit public comments, especially if the workshop discussion sparks new ideas or reactions.

Before we get started today with our substantive program, I have the pleasure of being the one who gets to make all of the very exciting security announcements. But please do pay attention to them. So first, we ask you silence all mobile phones and other electronic devices. If you must use them during the workshop, please be respectful of the speakers and your fellow audience members. Please be aware that if you leave the Constitution Center building for any reason during the workshop, you will have to go back through security screening again. So please bear this in mind and plan ahead, especially if you are participating on a panel, so we can do our best to remain on schedule.

Most of you received a lanyard with a plastic FTC event security badge. We do reuse those for multiple events so when you leave for the day, please return your badge to event staff.

If an emergency occurs that requires you to leave the conference center but remain in the building, please follow the instructions that will be provided over the building's PA system. If an emergency occurs that requires the evacuation of the building- which would be particularly unfortunate on such a cold day, so we'll hope that doesn't happen- an alarm will sound. Everyone should leave the building in an orderly manner through the main 7th Street exit. After leaving the building, turn left and proceed down 7th Street and across E Street to the FTC emergency assembly area. Remain in the assembly area until instructed to return to the building.

If you notice any suspicious activity, other than people trying to smuggle coffee into the auditorium, please alert building security.

Please be advised that this event may be photographed webcast, or recorded. By participating in this event, you are agreeing that your image and anything you say or submit may be posted indefinitely at FTC.gov or one of the Commission's publicly available social media sites.

We've provided a table outside where speakers and attendees are able to leave copies of handouts or other materials that might be of interest. To be clear, the FTC and DOJ do not endorse any of those materials. We are providing the table space as a courtesy.

Restrooms are located in the hallway just outside the auditorium.

As a reminder, lunch is on your own both days. The Plaza East cafeteria is located inside this building. It is open until 3:00 PM, although it is closed from 11 to 11:30 AM. Unfortunately, we do have a limited ability to provide refreshments but you are welcome to visit the cafeteria. No food or beverages are allowed inside the auditorium, so please plan accordingly.

For those of you who do stay with us throughout the entire day, FTC and DOJ staff are hosting a networking reception immediately following the conclusion of today's last panel at 4:30. And that will be held in the adjacent room where the coffee was set up. We hope you will be able to join us for light refreshments, as well as the opportunity to mingle with other workshop attendees and agency staff.

And I also want to say a quick note about our use of webcasting, social media, and the Q&A process for this event. We've done our best to get all the speaker materials loaded ahead of time so they should be available to webcast viewers. If any materials are not accessible during the webcast, we will post them as soon as possible following the workshop. For those of you who are on Twitter, FTC staff will be live-Tweeting the workshop at #FTChealthcare.

We have comment cards available here in the conference room, and audience members will have the opportunity to submit questions or comments throughout the panels. During each session, workshop staff will be going up and down the aisles and will collect the cards and bring them up to the moderators. And we will also be monitoring Twitter and the workshop email account periodically during the day for additional questions that may be submitted. Time permitting,

moderators will try to select some of those questions for the panelists, but given that each of the panels already has a pretty crammed timeline and lots of topics to cover, it's unlikely we'll get to all of those questions during the workshop. But I do want to assure everyone that we will be reviewing all of those questions that are submitted as we continue our research and our inquiry, and so we really do encourage you to submit them anyway, because they will be very useful to us.

If anyone has any questions throughout the day, please feel free to ask any of the conference staff, including our wonderful team of paralegal helpers at the registration desks.

That's the end of my administrative remarks. And, now it is my pleasure to officially open the workshop by introducing FTC Chairwoman Edith Ramirez. Chairwoman Ramirez was sworn in as a commissioner of the Federal Trade Commission on April 5, 2010, to a term that expires on September 25, 2015. President Obama designated her to serve as chairwoman effective March 4, 2013. I had the privilege of serving as Edith's attorney advisor for the first year that she was the commissioner, and I've had the opportunity to introduce her at a few events, and I always say it's been both an honor and a pleasure to work with her as we've both moved on to our new roles. So I'm glad to once again have the opportunity to introduce you here.

Chairwoman Ramirez has embraced the agency's longstanding commitment to promote health care competition, and she's been a very strong supporter of our efforts to organize both of these workshops over the last couple of year. Please join me in welcoming Chairwoman Ramirez.

[APPLAUSE]

OPENING REMARKS

- **Edith Ramirez, Chairwoman, Federal Trade Commission**

EDITH RAMIREZ: Thank you very much, Tara, and good morning to everybody. Thank you for joining us here today. I'm really delighted to be welcoming all of you to this event. We have an incredibly ambitious agenda and a stellar lineup of panelists, and I know that it's going to be a thought-provoking couple of days. So I'm very pleased to see the turnout, and I know that many people are joining us via webcast.

I'm especially delighted that we're continuing our examining health care competition series by co-hosting this workshop with the Department of Justice. You're going to hear from Assistant Attorney General Bill Baer tomorrow morning, but I know that I speak for the both of us when I say that we thought it was important that the FTC and DOJ conduct this inquiry together. Both agencies have a strong record of success in promoting competition in health care markets, and our staffs have spent many months jointly planning this workshop. I'm really delighted that it provides a terrific opportunity for our two agencies to collaborate and to bring our shared expertise to bear in one of the most important segments of the US economy.

Health care is certainly one of my top priorities for the FTC's competition agenda. As everyone in this audience knows very well, health care accounts for over 17 percent of GDP, and arguably no other industry affects the quality of our lives more profoundly.

The FTC has long argued that consumers benefit from health care competition, just as they benefit from competition in other product and service markets. Numerous studies confirm that vigorous competition in health care markets help to reduce costs, improve quality, and expand access to care for consumers. And, for these reasons, the FTC has held firmly to our longstanding belief that the goals of antitrust and competition law are entirely consistent with, and complementary to, the goals of health care reform. That's the key principle that drives our health care agenda across the entire range of the Commission's enforcement and policy tools, including workshops like this one.

A recent enforcement success underscores this point. Two weeks ago, the Court of Appeals for the Ninth Circuit affirmed the District Court's decision in the FTC's challenge in the St. Luke's case, holding that St. Luke's health systems acquisition of Salzer Medical Group in Nampa, Idaho, violated Section 7 of the Clayton Act. If left unchallenged, that acquisition would have created a dominant provider of adult primary care services, which we were convinced would have led to higher costs. We also believed that any benefits the acquisition might have provided to consumers could have been achieved in ways other than this anti-competitive merger. The District Court and the Circuit Court agreed. And, most importantly, both courts affirmed the FTC's challenge with language that perfectly captured the theme that we've been emphasizing for years.

The goals of health care reform are consistent with, but do not supplant, the goals of competition law and policy. The FTC recognizes that more coordinated and integrated care can help transform health care delivery and payment toward a risk-based financially and clinically integrated system that will improve and reward patient outcomes. But we determined, and the courts agreed, that these goals could be achieved by aligning incentives in other ways, rather than allowing an acquisition that would substantially lessen competition and create a risk of significantly higher prices.

But, while we're very gratified by our win in St. Luke's, we recognize the complexity of the issues that are at stake here. To say that the health care industry has been changing significantly and rapidly would be a vast understatement. We appreciate that health care companies and policymakers throughout the country are scrambling to react to a new business and regulatory environment. And their awareness of antitrust law is often in the background. Every day, they're making choices about how to implement the goals of health care reform. Our desire is to better understand those choices and their competitive implications, as well as the underlying economic incentives of various industry stakeholders. And that's what ultimately motivated us to craft the agenda that we're going to be pursuing over the course of the next two days.

Beyond enforcement, we rely heavily on our broad set of policy tools to pursue our health care competition agenda. At our health care workshop last March, I emphasized the FTC's efforts to engage in continual study to ensure that our agency has the most up-to-date understanding of health care markets and practices. Industry participants are constantly reacting to market

changes, and we're seeing continued innovation in how to deliver and pay for health care services. I think it's vital for us to invest resources to stay on top of these developments and to anticipate likely competitive effects.

This year we've identified important trends and practices that will have both near and long-term impact. Specifically, staff has organized two days of panels to study recent developments related to health care provider organization and payment models, with a particular emphasis on how these trends and activities may affect competition. And I want to highlight just a few of the issues that we're going to be examining over the course of the next two days.

One panel is devoted to ACOs, a central component of ongoing health care reform efforts, while another focuses on alternative payment models. By increasing the coordination of care and shifting incentives to a more outcome-based approach, they hold substantial promise for improving the quality of care and for lowering costs. As antitrust enforcers, we often grapple with both the promise of these new models as well as their impact on competition. The agency has provided substantial guidance on prospective ACOs through a detailed policy statement to ensure that their potential is not undermined by diminished competition. Learning more about the early experiences with ACOs and alternative payment models, as well as their impact on competition, will help inform our understanding going forward.

Another panel examines network design. The FTC has long recognized the potential cost savings associated with the use, or the threatened use, of limited or restricted networks. In fact, that thinking informs much of our provider enforcement efforts. Potential impediments to limited networks, both contractual or structural, can raise significant competitive concerns. And it's important for us to examine the latest trends in the creation of limited networks, their impact on cost containment, and potential barriers to their creation.

Yet another panel is going to review the latest developments in provider consolidation. While we focused our enforcement efforts on horizontal mergers between competing health care providers- and with good reason, given the mounting evidence of competitive harm from these deals- we now also hear growing concern that provider consolidation in non-overlapping product or geographic markets may also lead to higher prices. Examples of these combinations might include center city hospitals acquiring smaller hospitals in outlying areas, or vertical acquisitions of physician groups by hospitals.

We need to learn more about the competitive impact of these types of transactions. And to ensure that we continue to explore these and other important topics, staff has designed the specific panels with tremendous care, seeking a balance of speakers and perspectives. In addition to a star-studded list of notable health care academics and policymakers, we also seek to obtain a real-world perspective from a number of industry participants.

Now, in particular, I want to express my appreciation to our colleagues from the Centers for Medicare and Medicaid Services at HHS, who are serving as panelists and adding their unique expertise to our inquiry. We really value our close working relationship with HHS and many of its components, including CMS, the FDA, the Office of the National Coordinator for Health Information Technology, and numerous others.

I also want to highlight the final panel, our summation roundtable, which will take place tomorrow afternoon. We're bringing together an expert antitrust panel of lawyers and economists to offer perspectives from private practice, government, and academia. They're going to discuss and debate some of the core competition issues that we expect will be raised over the course of the next two days. And they're going to help us synthesize and process the workshop proceedings, which will be crucial as we look ahead and examine these critical issues.

Let me emphasize that while at the FTC we embrace our role as advocates for sound competition policy, our credibility depends heavily on our industry knowledge. And by engaging in workshops like this one, we create a learning opportunity that ultimately will support all of the Commission's efforts in health care, whether it's enforcement, advocacy, or consumer and business education. The more that we learn, the better we can do our job protecting competition and promoting the interests of American consumers.

I also just want to remind, as Tara did, that the inquiry is not going to be closing at the conclusion of the panel. We are accepting comments through April 30, and I encourage all of you to submit comments to aid in our analysis of these critical issues.

And finally, I'd like to take this opportunity to thank the many FTC and DOJ staff members that are responsible for organizing this workshop. There are too many involved for me to name all of them, but I do want to note that at the FTC, the Office of Policy Planning took the lead, but the effort was truly agency-wide, involving the Office of General Counsel, the Bureau of Competition, the Bureau of Economics, and several of our regional offices, as well.

And now, finally, it's my great pleasure to introduce our first speaker, who will kick off the workshop with a presentation that will set the stage for our ensuing discussion. He certainly needs no introduction to this audience, but I'm really delighted to welcome Dr. Ezekiel Emanuel to the FTC and to this joint FTC/DOJ workshop. Dr. Emanuel is the vice provost for Global Initiatives, the Diane v.S. Levy and Robert Levy University Professor, and chair of the Department of Medical Ethics and Health Policy at the University of Pennsylvania. He was the founding chair of the Department of Bioethics at the National Institutes of Health, and held that position until August of 2011. Until January of 2011, Dr. Emanuel served as a special adviser on health policy to the director of the Office of Management and Budget and the National Economic Council. He's also a practicing oncologist and a highly respected author. Dr. Emanuel received his MD from Harvard Medical School and holds a PhD in political philosophy from Harvard University. I know that we're going to hear a thought-provoking presentation, and given his track record, I know that it's also going to be provocative, no doubt. Please join me in offering a very warm welcome to Dr. Emanuel.

[APPLAUSE]

FRAMING PRESENTATION

- **Ezekiel J. Emanuel, MD, PhD, Chair, Department of Medical Ethics and Health Policy, Perelman School of Medicine, University of Pennsylvania**

EZEKIEL EMANUEL: Thank you for that kind introduction. And it really is a terrific meeting, and I think perfectly timed, as we go through these transitions to really look at a pivotal issue.

I'm going to cover five points, and I'm not going to use slides to distract you. Let me begin by noting that a lot of what we're doing here and a lot of what the FTC and DOJ have to do is predict the future. And predicting the future is a very risky business. Those of you who have experienced the flu season this year know that we did a pretty bad job of predicting the future there. The flu vaccine is not very effective. Those of you who have experienced the weather and the snow know that we've also done a bad job on that.

One of my colleagues at the Wharton School, Phil Tetlock, may or may not be someone you know, but he is the world's leading expert on forecasting and predictions. And, he's probably most famous for a study he did of hundreds of economists, asking them to make very specific predictions about the future. And he, after having them make over 28,000 predictions, came to three important conclusions. First, economists are better than dart-throwing monkeys, but not by much. Second, they're no better than you and I; they're no better than educated Americans who follow the news about these kind of predictions. And, the last conclusion, which I know will stress out some people, is that the more famous the economist, the worse the predictions. You can think about why that's true. At least one of the explanations is they may not be good at taking in additional conflicting information.

But, I think this issue of predictions- and by the way, IARPA, the intelligence agencies, have been running a competition on forecasting, and Phil is the winner of that competition- but it reminds you that the best models often fail. They tend to be based upon the past, and they tend to be very bad at predicting things in change and especially during significant structural changes. And the fact of the matter is we are going through significant structural changes in the health care system.

The change going on today is more than any change in the American health care system since about 1910. 1910 was the moment in the world medical history where innovations in science- bacteria, x-rays, anesthesia, surgery- began to really explode. It's the moment when hospitals became a place that weren't where you went to die, but actually had some hope, and surgery could be done. It's also the time when we were licensing doctors, and the Flexner Report came out that really dramatically improved the training of doctors and therefore their quality, although dramatically also decreased their quantity, interestingly enough. This moment in time, we have had much less change. It is really this moment in time when we are going through a similar dramatic structural change. I'll talk about the causes of what I think they are going forward. That, I think, makes the past models very uncertain. And, as the mutual fund prospectuses often say, the past is not necessarily predictive of the future. I think we have to keep that in mind when we sort of religiously follow models that we've created based upon the past.

In my comments, I'm going to focus more on providers than insurers and the competition in the insurance market and exchanges. That is very important, and as I've recently written at Fortune, there's a lot of good evidence of competition in the insurance market and in the exchanges that has kept prices down. Fortunately, in the exchanges we've had an increase in the number of players, and those places where we've had more players have definitely kept prices down.

I am, I would say, totally ignorant of antitrust law, but not totally ignorant of the importance of antitrust. In my last six months at the White House, one of the things I did was, because we recognized the importance of the antitrust issue, we actually brought together, under the auspices of the White House- where you can sort of force collaboration where it might not be as willingly or free as it could be- the DOJ, the FTC, and CMS to really try to hash out rules going forward. Unfortunately, by the time I left we hadn't fully concluded them, and sort of have one picture going forward. I do think that it was probably a missed opportunity to conclude those. But, I do think the collaboration between the organizations has increased, and I think that's a good thing.

Second, I want to talk about some truisms about the current system, just so we're all pretty clear about it. Because I think keeping these truisms in mind- we sometimes don't, and I think it doesn't necessarily help us when we're trying to think about what the system's trying to accomplish. So let me go through a few of them.

As was mentioned, and as I think we cannot keep in our minds enough, health care is the single largest industry in America at $3 trillion. It is humongous. How humongous? I make this point over and over again. I don't think I can make it enough. It's the fifth largest economy in the world, the American health care system. It's bigger than the French economy. It's just shy of the German economy. We will catch up to them before the end of the decade, because health care in the United States, even though costs are coming down, is still growing faster than Germany. So, there's no more important, it seems to me, aspect of the economy, and keeping it functioning well and not growing at outrageous levels is very important.

Second point: costs are very concentrated. And they're concentrated in two ways. First, they're concentrated on patients who have chronic illness. Eighty-three percent of costs in the American health care system are about chronic illness. They're not about acute problems- you get hit by a car, you break your arm, you slice your finger and need stitches. Those account for about 15 percent or less of health care spending. It's all about chronic illness. So when we look at issues of hospital mergers, et cetera, one of the big lenses has to be the lens of chronic illness. To re-emphasize this point, ten percent of patients in the United States consume two-thirds of the dollars. Costs are not spread like peanut butter across the population. They're very, very, very concentrated. And how those people are affected is important.

Second concentration is to remember that hospitals are the big fish. They're the predominant part of the health care spend. Thirty-three percent of all costs go to hospitals, the 5,000 or so acute care hospitals in the United States. Physicians are number two with 21 percent of the spend. And everything else is, I like to say, in the weeds. Drug companies are 10, 11, 12, 14 percent depending on how you want to count them. Public health, dentists, home health care- all single digits and lower. So it's hospitals and doctors, and nothing else really matters. Obviously that's an exaggeration for effect, but that has got to be the focus.

Second, there is wide variability in the prices charged by various health care actors. The profit status of various health actors. And there's no really strong link correlation to meaningful measures on quality metrics. So this price quality relationship is haywire when it comes to health care, and we know that.

Third, we're still largely paid by fee-for-service. And we know, traditionally, in the fee-for-service world, hospitals profit only by a few things they do. They do many, many things, but the margins are concentrated in a few areas. Transplant surgery. Neurosurgery. Cardiac surgery. Orthopedic surgery. Oncology. That's it. Consistently, those are the profit centers. Everything else is not. The reason they don't like psychiatric wards or regular medical wards- typically not big winners. So again, concentration in where the profits are made. And that, I think, should focus us when we look at various mergers and other actions.

We have been having lots and lots of hospital consolidation, hospital purchasing of physicians, and I think it's very important to emphasize- as was suggested by the chairwoman- that consolidation and integration are two different things. We've had rapid growth in hospital consolidation. Beginning in 2010, we've had a few years where there's a lot over the last decade or 15 years. In 2010 there's been a consistent increase with anticipation and then passage of the Affordable Care Act. Today, 60 percent of hospitals are part of a health system, and most other hospitals are considering joining them. And very few are thinking they can go independent.

Similarly, there's lots of purchases of physicians, so that most physicians now classify themselves as employed in one way or another. Growth in the non-independent physicians is where the action is. Thirty-five percent of physicians see themselves as independent practitioners. Seventeen percent are in solo practice. Those are dramatic changes over the last few years. Fifty-three percent of physicians self-describe as employees either of hospitals or of medical groups. And that is a trend that has radically accelerated.

I think most of this action in the hospital consolidation market is motivated by two factors at the moment. As suggested, leverage. Leverage to negotiate with commercial insurers. Very, very important. And I think that's a leading motivation for hospitals. An increase in Medicare payments by having physicians bill in their hospital affiliation rather than as independent practitioners, on the physician merger side. Both those goals for increasing revenue and increasing prices can be achieved with consolidation but no integration.

Let me make a sixth point. If the system is to improve quality and reduce costs as we go forward over the next decade to get to that important way- and by the way, when I say reduce cost, I mean control cost growth, so that it's GDP or less- then the focus is going to have to be, I think, on five things. One, we have to reduce the emergency room use. Two, we have to reduce hospital utilization. Three, reduce specialist care and how specialists care for patients. I think if you look at places that have really achieved high quality and low cost, those three things are the central elements of what ends up happening and where the cost savings are. We also have to narrow price variation between providers of the exact same service, and that means not just narrowing it up but narrowing it so that the median and average are lower over time. And five, we have to reduce a lot of unnecessary tests and treatments, and we know that there's a ton of that in the system. And the last thing I would say is, again to remind the DOJ and FTC, the cost and the

value of mergers are calculated, and clearly the threat of an antitrust suit raises the uncertainty - just the threat- raises the uncertainty in the parties. Raises therefore the cost of doing a merger. And just the threat alone, I think, can have a very important effect on actions.

That's, I think, the truisms of the current system. So let's go to three, to look at the mega-trends going forward. What really is happening going forward? What is sort of inevitable to happen? And I'm going to highlight three of them.

The first is, again, as the chairwoman said, this change in payment to focus on value, risk, and that, I think, is not inevitable. We could reverse, but I think it's pretty close to inevitable. So I think there's going to be an increased focus on paying for value and putting providers at risk. And I think that's going to be concentrated on hospital and provider groups. The Medicare announcement a few weeks ago about shifting payment off fee-for-service to alternative payment models is good. I've been working on that for a number of years, when we couldn't get it into the Affordable Care Act. But that sort of timeline is very important, I think, to the market. A lot of the market- hospitals, health systems, physicians- are ready, but they find themselves, as they often say, between two boats. Doing both. Being schizophrenic. The amount of risk is not yet enough for the tipping point, and it's very important that we get to that tipping point.

Just to give you a few statistics from various surveys. And these surveys are all over the place. I've just taken some. In three years, 49 percent of medical facilities will have a meaningful, value-based revenue stream. Again, self- reporting. And 40 percent of health plans predict that value-based models will be a majority of their business in three years. I think those are all really important. And that, I think, is an important shift that, again, it's not quite inevitable. We could go back. But I think the Medicare announcement, especially if it's followed up with some very concrete action in that space, is going to be good.

But let me simultaneously say that not all risk, not all value-based payments are the same and ought to be treated the same. I'm very skeptical about the force and the effect and the power of one-sided shared savings that's built on a fee-for-service chassis that isn't predicted and scheduled to go to a two-sided risk model. I don't consider that risk-based payment or value-based payment. I do think putting providers in a capitated mode where you can measure quality is the right way to go, or the ultimate goal. There are various paths to that. When I look around the system and when I travel to do case studies- which I'm doing a lot of for a new book- what I see is the places that have the most innovation are the places that are either Medicare Advantage plans or have some other capitated arrangement, because they are really forced to innovate how they're delivering. And, that has been, I think, a major catalyst.

I do believe that risk and value-based purchasing at the individual physician level- first of all I'm not sure I want it at the individual physician level, but even at the small physician level- is going to evolve more slowly than at the health system and medical group level. That's largely in part because we don't know how to translate those value-based, risk-based payments at the organizational level to the individual physician to get them to do the right thing. We have not actually studied very well provider incentives to get them to do the right thing. That's, again, another project I'm actively working on. Mostly we're doing it now by trial and error. Even places that have done a very good job about getting to high value, high quality, low cost care- it's

haphazard. There's no science behind it. So one mega-trend, I think, an increase in value-based, risk-based payments. What exactly that trajectory is, whether the trajectory as outlined by Medicare is going to be the right one. But I think early in the next decade we are definitely going to be well past the tipping point.

Second is the digitization and the tele-whatever of health care. That, I think, is definitely an inevitable trend that is definitely going forward quite rapidly. There's clearly EMR proliferation because of the Recovery Act. The EMRs are going to improve. They're going to become much more minable, a lot of natural language processing and thinking are going into that, and I think we are going to have very usable EMRs that really do work. Doesn't mean we won't have waste and a lot of false starts, but again, by the end of the decade. A lot more remote monitoring of patients. Going to become just a lot more common and, I think, integrated into regular care. Remote connections with patients. Not just monitoring, but the connections. Using urgent care over the internet. Things like StatMed. Grand Rounds. Referrals over the internet. Taking pictures of your dermatological or whatever else, and getting a doc to read it without ever seeing the doctor. Those are just going to become very, very common.

And then I think we're going to, in the next decade, in the 2020s, get real-time performance assessment. We're not going to be needing these once-off licensing boards and things like that. We're going to be mining EMRs and getting real-time quality assessment of doctors as things evolve. I do think that's coming. I think that's how we are going to have ongoing certification of physicians and their quality, as EMRs become much more minable over time. And I think that's going to really transform how we certify docs.

Third, there are going to be a lot more actors in the health care space. And I think this is going to be very important, both in terms of institutions and in terms of types of providers. So we're going to have a lot more health care providers interacting with patients, whether it's dietitians and pharmacists just interacting with many more patients, medical assistants doing a lot more, health care extension workers working with patients in the community, call centers who are going to intersect with patients on compliance and medication. We have some companies that are call centers, basically, working on end-of-life care with patients. So just a lot more actors involved in patient care. Clearly, pharmacies are expanding their role. They're going to much more aggressively expand their role. I don't think it's a smooth path. There are going to be a lot of hiccups, but you can't interpret the CVS on getting rid of a two and 1/2 billion dollar service line of smoking-related stuff without believing that all of them are jumping in pretty heavily into the health care business. Walmart and other such companies are going to be expanding in the health care industry and become providers, whether it's through primary care visits or other things.

Lots of new web-based providers, whether, again, the Grand Rounds of the world that not just give you a referral to the best doctor in your area, but are beginning to have doctors come over the net and give you a second opinion. Stat Doctor for urgent care. Those kinds of companies are coming in. And I think there's also going to be companies with a lot better information about health care than doctors being able to predict and being able to provide decision supports over time.

Fourth, what are the implications of these mega-trends for where we're going? Well, we're in the midst of a big transition period. And I know it causes some people harm, some people really good things. We should remember it's a transition. And I unfortunately think in this transition we have some people, some organizations, that are really, really innovative and really trying to get to better health care at lower cost. But I think largely we've got a lot who are still acting with what Charles Prince- does anyone remember that name? He was head of Citibank in 2007. You'll remember his quote. He famously said, in 2007, "As long as the music is playing, you've got to get up and dance." We're still dancing. That was 2007. And then in 2008, guess what happened? We stopped dancing. And we had a mortgage bubble-driven collapse. I think a lot of players in the health care marketplace are still dancing. And they are still believing that these mergers- you can consolidate- they're still doing it largely for leverage. Because 80 percent of their payments at the moment are still fee-for-service, and leverage allows them to increase the billings to commercial payers, and buying physician practices allows them to bill Medicare at a different rate.

And therefore I'm worried that we might be repeating a lot of the mortgage crisis mentality. And we could have a relatively abrupt shift, and a lot of these institutions will not have been prepared for the transition, and that could create its own crisis. Because learning how to adapt to a value-based environment and payment system is not something that happens overnight. It takes a lot of time. It takes a change of infrastructure. A change of IT. Care processes, complete evolution. Change in incentives. Changes the whole provider culture. And I think that we still are witnessing lots of systems that haven't adapted and are still firmly rooted in the leverage increased margin of the old system.

The consolidation of payers and providers, I think, is more or less inevitable, to a limit. Now, let me distinguish two stripes of consolidation and integration. One is horizontal. As the chairwoman said, hospitals buying hospitals. And I actually put in here physicians mainly, again, for leverage. But it's horizontal to be responsible for the continuum of care from primary care to secondary care to tertiary care. That is worrisome if they're still highly in the fee-for-service market. I think it's less worrisome if they're taking on a lot of risk. And, a large part of their payments are risk-based payments and value-based payments, and I think we ought to look at them differently depending upon what that fraction is.

The second integration- and here I would differ from the way the chairwoman characterized it- so I view hospital/hospital and hospital/physician integration as a horizontal integration, basically, of providers. The vertical integration I see coming are health systems taking on risk directly. Not taking on risk from a payer, but taking on risk by running a Medicare Advantage plan. By actually offering their own plan in the exchange, like North Shore Long Island Jewish did in New York. By directly contracting with employers to provide comprehensive services for their employees, like Presbyterian did in Albuquerque, New Mexico with Intel. I think this vertical integration is what you're going to see evolving. This year, Mount Sinai and, I believe, Partners in Boston are offering MA plans. You're going to see a lot more of this happening over time.

So, from my standpoint, horizontal integration is much more worrisome, especially if there's no evidence that there are plans to lead to integration. No IT integration, no care process integration.

And that would be especially true if there's not a high proportion of risk-based payments now to those providers. Then buying a community hospital outside is to increase your leverage, increase the flow of high-pay commercial patients to your tertiary center. It's not really about the integration of care.

I do believe that you need some scale to be able to do integration. It costs money to upgrade IT. To do process improvement. To employ allied health workers. To be able to provide more care at home. Past some point, however, bigger is not better. It's just more impersonal. And I don't know that we know exactly what that point is.

Now if we do get to true integration- not just consolidation, but integration across the continuum of care, and even vertical integration- that's, I think, inevitably going to lead to more narrow networks that are responsible for the continuum of care of patients. And being able to manage patients across that continuum, so that they don't go off to any specialist. They don't go off to a hospital where you're not responsible for the quality of care. I think those narrow networks are good. I am an advocate of those kinds of narrow networks. Because you can and you are responsible for the quality of care. I have called that the Kaiser-fication of American health care. And I think that is a good thing. Most health policy people over the last decades have thought Kaiser is a great model. Group Health and Puget Sound, great model.

And the big perplexity is not that it's a narrow network, it's limiting people's choice. The big perplexity is why hasn't it expanded beyond their niche markets? Right? That's been the question. If it's such a great model, why not? Well, I think payment and lots of other things have inhibited them. But the worry hasn't been, wow, they provide narrow networks and that restricts the choice of their members. Yes, it does. But because they provide very high quality care across the spectrum, we don't worry about that narrow network. And it seems to me that narrow network isn't the worry. The worry has to be, what's the quality of that network? And for things that they can't handle, do they have a safety valve? So I am, again, with all the caveats I have raised, I think that it's not the narrow network that should cause problems.

In a transition, narrow networks would be a problem. I enter one system and my cancer care, for example, has been in another place, that is a problem. And I agree we have a lot of problems with the transition, and we need to be sensitive to people in that transition. But the narrow networks, per se, as a steady state phenomenon- which I think they are going to be, again, towards the end of the decade and into the 2020s- I don't think is a problem as long as we can guarantee and assess that quality and make sure it's high quality across the board.

So last, let me just say we're in transitions. We're part way between fee-for-service and alternative value-based payments. We're part way between the digitization- we have not great, maybe C plus, B minus EMR and EMR usage, and we're not fully there. We still don't have full digitization across the spectrum. But it is pretty clear, I think, that these transitions are going forward. And they are going to be complete, by which I mean will be past the tipping point on the payment side by the end of the decade, and past the tipping point on the digitization side and the ability to share data and to mine data, again, by the end of the decade. So we do need to look, as we proceed, not just focus on the transitions and what defects we're having in the transitions,

but what's going to happen at the end of the decade. So that we don't have monopolies that don't really care about quality of care.

So what needs to happen to make this go forward? Well, I can't say it enough, and I say it as much as I can, which is a lot, therefore. We need to push on payment change. We need to assess the amount of risk that hospitals and health systems are engaged in, and likely to be engaged in the near future. That assessment of risk, financial risk- by which I don't mean shared savings on a fee-for-service backbone- I think should be incorporated into the measure of how you look at this consolidation. Because I think the more risk that's present, the less I worry about- I mean, the more incentive there is to really integrate care and the less I worry that it's merely consolidation to increase leverage for fee-for-service negotiations.

And then I think we also, as we look forward, need to assess whether these health systems that are trying to consolidate and trying to merge are really doing the things that are necessary to operate in a value-based, risk-based payment system. And you need to assess that. Have they gone through and are they doing major initiatives on process improvement? Have they incorporated lien or not? What are their physician payment formulas? Are they switching off relying on RVUs to relying on some other system? Very, very important. If they're still paying largely on RVUs, you know this is about a leverage deal.

Are they exploring alternative care sites out of the hospital? Do they have a very vigorous home care system, or a system for hospital at home? Are they partnering in those areas to deliver more care out of the hospital? I think those are critical questions that suggest to you they are working along the integration line. And how are they working on digitization? Do they have data warehouses that they actually use, not just for financials but to manage care?

And, most importantly, I would think, are these kinds of indicators of really taking value-based payment true? Are they not in the pilot stage? Are they actually part of the operations of the health system? What I worry is a lot of people do these things on pilot stage. I would reemphasize, we do want multiple competing, integrated delivery systems. Even if we have Kaisers, even if they're good, we still want competing ones because people get lazy. People get stuck in ways.

And finally, let me just reemphasize and go back to the truisms that I mentioned at the top. A very important lens for looking at these mergers is not just everyday people. A very important lens is people with chronic conditions, because that is what the health care system is about. It's the ten percent of people who have these chronic conditions. It's the 83 percent of payments around chronic conditions. So one of the things we need to look at is how are these mergers going to affect not just general people, not just general prices, but what are we going to be doing about not the colonoscopy rate, not the mammogram rate, but hospitalizations for people with congestive heart failure or COPD. Amputation rate for diabetics. Use of shared decision making for care of these chronically ill patients. Cancer care. And more care at home. Better care for these patients. It seems to me we have a health care system focused on chronic illness, and our evaluation of the various actors ought to be through that lens, since it's the dominant lens.

Let me just end by saying I began in 2010 the bringing together of FTC, DOJ, and CMS on this antitrust thing, because I thought it was going to be pivotal. Clearly, we wanted integration so that people would have the infrastructure, the capital, to actually innovate on the continuum of care and really focus on people with chronic illness and keeping them healthy. And, we knew that there were risks in putting players together. But any time you're going to go through a big transition like we're doing now, because of the ACA and because of other factors like digitization in health care, you are going to have lots of uncertainty.

And let me just say that let's not over-rely on the past models we have had, because I don't think they're going to be as predictive going forward as we would like. That isn't to say having competition isn't important. It's vitally important. I'm a big believer in that part of the marketplace. But our past models for what constitutes competition may not apply in a new and changing environment, and may require some creative work by people who are much smarter and more technically sophisticated than I am.

Thank you. And I will just say I'm going to go in and out today, not because I don't think this is an important meeting, but because I have a few other meetings along with people at the FTC, among other things. And I will be very interested in what transpires. So thank you very much for having me speak to you. Appreciate it.

[APPLAUSE]

PROVIDER NETWORK DESIGN, CONTRACTING PRACTICES, AND REGULATORY ACTIVITY

Moderators:

- **Helen C. Knudsen, PhD, Economist, U.S. Department of Justice, Antitrust Division, Economic Analysis Group**
- **Stephanie A. Wilkinson, Attorney Advisor, FTC, Office of Policy Planning**

Panelists:

- **Paul Ginsburg, PhD, Norman Topping Chair in Medicine and Public Policy, University of Southern California**
- **Kim Holland, Vice President, State Affairs, Blue Cross Blue Shield Association**
- **James Landman, JD, PhD, Director, Healthcare Finance Policy, Perspectives and Analysis, Healthcare Financial Management Association**
- **Lynn Quincy, Director of the Health Value Resource Hub, Consumers Union**
- **Fiona M. Scott Morton, PhD, Theodore Nierenberg Professor of Economics, Yale University School of Management**
- **Anna D. Sinaiko, PhD, MPP, Research Scientist, Department of Health Policy and Management, Harvard T.H. Chan School of Public Health**

STEPHANIE WILKINSON: Hello, my name is Stephanie Wilkinson. I am an attorney advisor in the Federal Trade Commission's Office of Policy Planning. I am joined by Helen Knudsen, an economist with the Antitrust Division of the US Department of Justice, and we will be co-moderating today's panel on provider network design and related contracting practices and regulatory activity.

Narrow provider networks and tiered provider networks have received a lot of attention recently. The use of these types of networks may be an important tool for health plans looking for ways to reduce costs and offer consumers lower premiums. These networks may also be effective for health plans who want to steer patients to high-quality providers.

However, some people have raised concerns about the trade-offs the consumers must make between price and choice when selecting narrow and tiered networks. Do consumers really understand what they are getting with these products? And do these networks offer adequate access to high-quality providers, particularly specialists?

During this panel, we will examine the competitive implications of narrow and tiered provider networks and how they affect consumers. We are also interested in understanding the extent to which contracting practices between providers and payers, as well as legislative and regulatory activity, may impact the use of these networks.

HELEN KNUDSEN: We're very fortunate to have a distinguished panel that can address these issues. We're joined by Paul Ginsburg, the Norman Topping Chair in Medicine and Public Policy at the University of Southern California; Anna Sinaiko, a research scientist in the Department of Health Policy and Management at the Harvard T.H. Chan School of Public Health; Kim Holland, a Vice President of State Affairs for the Blue Cross Blue Shield Association; Lynn Quincy, Director of the Health Value Resource Hub at the Consumers Union; Fiona Scott Morton, the Theodore Nierenberg Professor of Economics at the Yale University School of Management; and James Landman, the Director of Health Care Finance Policy Perspectives and Analysis at Healthcare Financial Management Association. We now invite Paul Ginsberg to give a presentation framing the issues that will be covered by this panel.

PAUL GINSBURG: Well, thank you. It's great to be here. As she mentioned, I'm going to try frame this, give you the concepts behind much of the discussion we'll have today.

And the context for network strategies is the insurer's role as a bulk purchasing agent for enrollees. Basically, this is insurers using their size to represent large numbers of enrollees to get better prices for them. And that's what network strategies are all about. And network strategies are particularly important today, because the provider market, as you heard from Dr. Emanuel, is becoming much more consolidated. He mentioned the horizontal mergers. I'm particularly concerned with hospital acquisition of physician practices as often reducing competition substantially. And this really is a strong headwind for purchasing.

Now, in this network strategy, the insurer leverage with providers is going to be based on their ability to shift volume from high-priced providers to other providers. And what I'm going to argue is that the network strategy, particularly the strategy of narrow or tiered networks, is potentially a more potent approach in doing this, in getting lower prices, than strategies of high deductibles and information on prices for consumers. You know, they're not alternatives. You can do both. But I think that the network strategy has the potential to be particularly potent.

I think one of the reasons it's more potent is that the tasks for enrollees or patients are so much simpler, so much less information for them to process and to gather. And in a sense, they're making choices about whether someone is the network or not, as opposed to looking at thousands of prices.

Now, the exchanges created by the Affordable Care Act are the ideal marketplace for narrow network plans. For one thing, the enrollees in those exchanges are very sensitive to premium differences, so that, if you can reduce your premium through a narrow network strategy, that will be noticed and that will have an impact. For one thing, affordability of health care is really a challenge for most of the people in this market. There's something like 85 percent of those obtaining coverage through the exchanges are getting tax credits because their incomes are below 400 percent of poverty. So it's a group where affordability is an issue.

The fact that the tax credits were designed so that they would not vary with the plan purchased- they just depend in an area on your income and family size. So that by their not varying, it means that if a consumer chooses a lower-premium plan, the full difference in premium accrues to them. It does not reduce their tax credit.

Finally the metal tiers- the Bronze, Silver, Gold, Platinum- make plan comparisons much easier. Benefit structures are very complex. But if you understand that a Silver plan means an actuarial value of 70 percent, then you can more confidently choose among Silver plans based on their network, based on particular shape of the benefit design, without worrying that you have inadvertently gotten much less comprehensive coverage.

The other aspect of these exchanges environments is the absence of a "one size fits all" requirement. What I mean is that a plan can have a network that's very attractive to maybe half the people, a third of the people in the network, and that's just fine. Because they can attract a lot of people who it is attracting, and they don't have to worry about the people who are not attracted to that. A very different situation than you find in most employer-based environments, where often there is little if any choice, and the plan chosen has to really be attractive to almost all of the employees.

And research by McKinsey has shown us that almost half of the products in the Affordable Care Act exchanges are narrow. That shows kind of the power of this environment.

Now, the initial focus of limited networks is on unit prices. And basically, it's a tool to shift volume to lower-price providers, to negotiate lower prices with some providers in order to get into the narrow network. I think there's a longer-term potential to spur provider efforts to contain costs. And this is going to depend on how many people in a market are in these products, so this could actually magnify the stakes for providers.

Now there's potential, and some use so far, of broader measures of price, and even including quality into the measurement. So plans can examine per-episode spending on different providers, spending per enrollee over a year. And by using more sophisticated measures of price, more relevant, broader measures than just unit prices, this can actually more effectively steer patients to those that are truly efficient and have higher quality.

This becomes a basis for dropping providers from a network, so that if a provider might have agreed to- their price they agreed to is low enough, but the plan doesn't want them because they're very, very inefficient with these broader measures- this is the source of controversy that I'll get to later, with "any willing provider" clause. But this is a controversial thing.

I think these broader measures of price and measures of quality are a real enhancement, as long as the analytic tools are good enough. And that's debatable as to how good they are now. They clearly will get better. There are strong parallels, analytically, between the tools that you need to do narrow networks and the tools that you need to do reformed payments. And the progress that we make in defining bundles or episodes of care and measuring quality will be applicable to both of these.

I want to say something about narrow versus tiered networks. Narrow networks are likely a more powerful tool for those consumers interested in enrolling in them, because their steering incentives are stronger, and thus the result is a larger discount on the premium. But I believe that tiered networks have the potential for even broader consumer interest, because it involves choices at the point of service, rather than for a year. And just think about the popularity of

preferred provider organizations over restrictive HMOs, historically, and the popularity of tiered formularies over closed formularies, and you can see what I'm talking about.

Indeed, tiered networks are probably more compatible with ACOs, or particularly broad ACOs. In California, you see that this is the model used for California ACOs, where the ACO is a tier within the network. There's a lower cost-sharing offer to use ACO providers.

So the question is, why are there so few tiered networks? I don't have data about tiered networks, but in all the experience I've had recently doing site visits, I rarely encounter them. Massachusetts has them, and Anna Sinaiko will tell you about them.

I think clearly insurance exchanges are a favorable environment for the narrow network products, but employer plans really are a favorable environment for tiered networks. I think a key thing is that contracting practices have been blocking the tiered approach- specifically, provider demands to be placed in a preferred tier as a condition of contract. And this is referred to as anti-steering.

And Massachusetts has taken a number of steps that have supported the development of tiered networks. Some of them come from the purchasing side. But also, there is regulation of contracting and a specific prohibition of anti-steering clauses, and Anna will tell you more about them.

Now I want to talk briefly about network regulation. The context for this is unexpectedly rapid growth in the tiered network products. And I think some of the problems that have been experienced do need solutions. But I think also, as we look for solutions to them, the popularity of the narrow network products- you know, all the consumer interest in them- I think fortunately is leading policymakers to proceed cautiously and, as they develop regulations, have concern with suppressing the product in a way that's not going to be good for consumers over the long term.

There have been transparency shortcomings. And it's really essential that we work towards having real-time accuracy on provider directories. Part of this can be done through better IT. It's possible that contracting between plans and providers may have to be done in a more structured manner in order to deal with some of these transparency issues, so that providers aren't jumping in and out of the network all the time during the year.

Turning to network adequacy, I think consumers need most support when it comes to choosing specialists for conditions that they do not currently have. If you don't have cancer, if you don't have neurosurgery needs, how can you, or even would you, assess the adequacy of the network for you, of these diseases you don't even have? So I think support on specialists is more important than figuring out if there are enough primary care physicians within 10 miles of your house.

I think there's also a need to use network adequacy to prevent risk selection through lack of specialists for some expensive conditions. But I think assessing the adequacy of specialists is very difficult, especially given the trend in a number of specialties towards increased

specialization. If you have a retina problem, you have to go to a retina specialist within ophthalmology. You can't go to other types of ophthalmologists, which makes network adequacy very complex. To me, the alternative of a very strong, fast appeals process, I think it's going to have to substitute for a lot of detailed regulation of network adequacy. If someone needs a very specialized physician, rather than planning that specialized physician to be in the network, just having a good appeals process to get to that person if they're needed.

There's another problem that comes up a lot, which is what about physicians that patients don't choose? You know, ED physicians, assistant surgeons, anesthesiologists. My only point here is that this is a compelling challenge that applies to all networks. This applies to broad networks as well as narrow networks. And I think it's a problem that needs to be addressed by policy. But it's really a much broader problem than a narrow network problem.

I want to say a few things about "any willing provider" laws. Most of them date to the 1980s, when leading physicians were worried about being excluded from the newly-important managed care plans. The magnitude of the new interest is really not clear. There was a recent vote in South Dakota to adopt an "any willing provider" law, but that seemed to be an issue unique to South Dakota about physician-owned specialty hospitals, rather than a general issue.

I think "any willing provider" laws pose a particular threat to cutting-edge approaches to networks. It's a threat to using broad measures of price and quality, and it's also a threat to plans that Dr. Emanuel was talking about, that limit the network to a major delivery system.

So here are some concluding thoughts. Narrow networks are a particularly potent competitive tool to address high and rising medical prices. Substantial evolution in narrow networks is likely. The analytics are going to help measure more meaningful prices and quality. And there will be an evolution of regulation of transparency and network adequacy, hopefully in a way that does not shut down this very powerful market-oriented tool.

And I think the potential for tiered networks is going to be heavily dependent on regulatory steps to support. I think the tiered networks have a very large potential to meet consumers' needs, but they've been very slow in getting off the ground. Thank you very much.

[APPLAUSE]

STEPHANIE WILKINSON: Thank you, Dr. Ginsburg. We now invite Anna Sinaiko to give a presentation that will address the price and quality effects of tiered and narrow networks. Anna?

ANNA SINAIKO: Great, thank you. So I just wanted to start out making the point that this idea of using network design, managed care network design, to steer patients to a preferred set of providers is not new. It's something we've seen before. And in particular, we've seen managed care plans in the late 1990s, where HMOs used closed networks to steer patients. PPOs offered more flexible benefits, so that they still set up in-network versus out-of-network providers, but provide some benefits to cover services received from out-of-network providers.

The difference from what we're talking about today is that then, provider inclusion in the network was largely determined by a provider's willingness to accept the plan's fee schedule and other preauthorization requirements. And so turning toward the idea of tiered networks, I see tiered networks as rising in part from the lessons learned from the managed care backlash, which is that patients, consumers, really value choice of physician. And so tiered networks are broad networked plans, and there is coverage for services provided by doctors and hospitals that are in the worst-performing tiers.

But what's different is that these tiered network designs have tried to take advantage of some of the advances in technology over the last decade or so that have allowed for evaluating provider performance at the individual provider level, at the hospital level, medical group level, or even individual physician level. And so what plans are doing is evaluating provider performance, as Paul mentioned, and looking at performance on quality metrics- most often claims-based process measures, but additionally, other quality measures- as well as resource use.

And so the most common thing we see are looking at case-mix-adjusted use of resources at episode levels to evaluate provider performance, and then divide providers into strata according to their performance. And so plans place the highest-performing physicians into a preferred tier. Average providers go into a middle tier. And the worst-performing physicians go into a worst-performing tier. And patients or consumers are informed of this quality and cost-efficiency information when they learn about the tiered networks.

However, not only is this quality information designed to give patients an incentive to choose preferred providers, but also, there's a financial incentive. And so patients will pay less at the point of care when you see a preferred provider. In the case of doctors, this is usually a lower copayment. Sometimes it's also the lack of coinsurance. And in the case of hospitals, it's usually a lower deductible.

The theory suggests that patients who aren't willing to pay the added cost to see non-preferred providers will switch. And from the provider's perspective, it's this loss of market share, or the threat of lost market share, that provides an incentive for them to change their behavior and improve performance that's consistent with the measures on which they're being evaluated.

The difference from the limited network plans is that the incentives and limited network plans are just stronger. I won't say much here. Paul covered this very well. But some limited network plans are, in fact, using the same quality and cost-efficiency criteria to exclude physicians from the network. But for providers in particular, the incentives to be included in the network are much stronger, because the costs to patients to see an out-of-network provider are much higher.

We've seen a lot of limited network plans emerging in the ACA exchanges. But when we think about tiered network plans, they're offered, but they haven't grown as fast. Although recent survey from the Kaiser Family Foundation and Health Research and Educational Trust on employers does report that about one-fifth of employers are offering a tiered network plan, and most major commercial insurance firms offer tiered network plan to employers, there's been a lot lower take-up of these products. The exception is that certain markets in the US have seen a lot more of them.

Employers or purchasers are part of the reason for that in certain markets. For example, in Massachusetts, the state's agency responsible for providing insurance, known as the Group Insurance Commission, launched a very large initiative to develop tiered network plans in the mid-2000s. But along with that, the regulatory environment really created an impetus towards these network products because of two factors. In the 2010 legislation that was part of Massachusetts' overall push towards cost control, they included a prohibition of anti-steering clauses in the contracts, which sort of allowed for these products to come on the market, and required that all medium and large health plans offer a tiered network product in at least one plan.

And it's a combination of all of these things that have, I think, allowed tiered networks to really take a big role in the Massachusetts commercial market. The latest data from 2013 report that 13 percent of the whole commercial market in Massachusetts is in a tiered network plan.

So in terms of the impact of these products on consumer behavior, we really don't have a lot of evidence yet. There's strong evidence, when you look at patient response to tiering of pharmaceuticals, that patients switch away from more expensive drugs when they get placed in the top tiers, or most expensive tiers, of a formulary. But physicians, hospitals, are very different than pharmaceuticals for a lot of reasons. Most importantly, or one of the most important ones, is that people really trust and value the relationship they have with their physician. And so I would think the response we would see here from patients would be lower than that we've seen from drugs.

I'm going to talk very briefly about three recent studies that have looked at the impact of these tiered network designs and limited network designs where the establishment of the network was based on evaluation of provider cost and quality, to give us early evidence on their impact.

The first is a study from Las Vegas conducted by Meredith Rosenthal and some colleagues that looked at the impact of excluding a small percent of providers from a PPO network who were determined to be the lowest quality and least efficient. For patients who continued to see these doctors, their out-of-pocket costs were quite high. Just to have an office visit, the out-of-pocket cost was estimated to be $50. If there were any additional services as part of the visit, the costs were higher relative to a $15 co-pay to see an in-network physician. And this study found a dramatic switching of patients away from the excluded physicians, much higher rates of moving away from those doctors than those doctors had experienced in previous years.

Turning to Massachusetts, this is a series of work that I have led over the last few years. As I mentioned, the Group Insurance Commission launched a large initiative to implement tiered networks in its plans. I think this was, in large, a desire to try to reduce cost growth in the plans. They had tried some other initiatives, like disease management, and hadn't seen the results that they'd liked. Also, I felt like simply moving to high-deductible plans was too blunt of an instrument.

And so what the GIC did is they got all six of their health plans to pool their entire books of business to create individual performance profiles on physicians in Massachusetts to take advantage of sample size. The tiering initiative was focused on specialist physicians. I conducted

a survey about a year after these tiered networks were implemented and found still low awareness of the products among the membership. The majority, just slightly more than 50 percent of members, knew about the tiering, and only one fifth of patients reported knowing which tier their physician was in. But among those that knew, almost half reported that it was very important to their decision of which doctor to see.

Another point I just make briefly, because I think it's one to think about, is that 40 percent, only 40 percent of people, reported that they trusted their health plan to give them information about higher-value physicians. So we might want to think a little bit about sources of this type of information and whether that has an impact on consumer response.

In terms of the actual impact on choices, we found strong evidence that people are quite loyal to the physicians that they'd seen previously. And I should describe the tiering here a little bit more. All the non-Medicare health plans had a tiered network, where there were three tiers. And the copayment differences across tiers was $10. So really kind of minor, small differences in cost.

People did not switch away from doctors they'd seen previously, according to their tier ranking. But there was evidence that when choosing a new doctor, the doctors in the worst tiers, the worst-performing tiers, earned lower market share of new patients than their average or top-tiered colleagues.

Really quickly, the Massachusetts GIC also launched a limited network plan initiative in the last couple years. It gave patients a very large financial incentive, which was a three-month premium holiday, to enroll in a limited network plan. Twelve percent of GIC members moved into that plan, and the effect on overall spending, relative to a control group, was a decrease of four percent. For those that actually moved into the limited network plan, their spending went down 36 percent.

So all of this early evidence, I think, comes together to suggest that network design- in particular, tiered networks and some of these limited networks- can be a tool that is in the set of tools for policymakers and purchasers to use to try to encourage higher-value purchasing and higher-value choices by consumers. But you know, choices of doctors and hospitals is complicated. And so I think we want to make sure we're doing a good job of educating people about the tiered networks so they understand their choices, and about limited network plans, so they understand their plan enrollment choices. And also, I think further work will be important to understand the variation in these impacts across types of consumers, and also to look more closely at how providers are responding. Thanks.

[APPLAUSE]

HELEN KNUDSEN: Thank you, Dr. Sinaiko. We now have Kim Holland to present the payer perspectives on the use of narrow and tiered networks.

KIM HOLLAND: Good morning. And good morning, everybody. The Blue Cross Blue Shield Association represents the federation of the 37 independent Blue Cross Blue Shield plans that operate in all ZIP codes in America, actually. We currently insure about one in three Americans.

And I tell you that mostly to give you some scope to our sense of opportunity, as well as our obligation, to be part of improving health care for all Americans.

One of the things that I can tell you, that is similar to every single Blue Cross plan out there, is that at the end of the day, they want to develop products that people want to buy. So in many respects, the market today is not much different than what it has been. People are looking for value. But value means different things for different people.

Certainly cost is an important part of that. We could agree, I think that that is perhaps the most singular barrier to people accessing health care services today. But they also want high quality, and they view that in a variety of different ways, but broad coverage, and what they view as quality physicians and providers. And they want choice. Americans are not necessarily a "one size fits all" culture, so they like to know that they have an opportunity to select the types of plans and benefits that meet their particular circumstances.

So our efforts are really around serving the market and responding to those market needs. Our relationship with physicians are critical with respect to that. And networks are an important part of our ability to bring those kinds of products and services to the market and work collaboratively to insure affordable health care and access to Americans.

So today, what I'd like to share with you is some of our early learnings. Although I mentioned that the market seems to be similar in many respects, what's probably changed most dramatically, from the health plans' perspective, was where they were working with employers, in large measure, to model plans and services and support, now we're working with individuals. The exchange has broadened the opportunity for individuals to view health care products and services and to make their own independent choices. So as you've heard, we're just beginning to learn about how individual consumers are making choices in the market.

So I thought you'd find it interesting to see some of our learnings from the open enrollment period that sort of kind of just closed- because we're having a few special enrollment periods. But we have a little bit of information on that. Some recent consumer research that we've done, that I think will augment Anna's comments, and I'm sure Lynn will have something to say about them. And then some of the resources and tools that we are developing to bring information not only to consumers, but to providers, as well.

So let me move on. This is a busy slide, but I'll just highlight a couple of things. If you look at the box on your left, one thing I'll point out to you is as of today- this is to 2/11, but this has been updated, actually, for 2/17. We have 87 percent of the plan's selections, the individuals would be eligible for subsidies.

Now I make a point of saying selections, because it's a two-part process. People select a plan. That doesn't necessarily constitute an enrollment. But it does give us an indication that the majority of people that are going to exchanges, obviously, are people that are able to avail themselves of the subsidies that are being offered.

We've seen HHS exceed their enrollment goals as of the date of this report, which was on the 11th. It was 10.4 billion. The estimate by HHS, or the goal, was 9.1. So we've seen a rise. And as of 2/17, we've actually seen an increase in this to 11.5 million people enrolled in the exchanges.

I think the other thing that I would point out to you is that about 70 percent of the enrollees have selected a Silver plan. And you'll recall that the subsidies are based on the second-lowest-cost Silver plan in a market. So once again, I think that's an indication of the fact that people are looking to leverage those subsidies to maximize value in their choices on the exchange.

I just thought you'd find this interesting. It gives you an idea of the growth in enrollment across the board. The red bars are the state-based exchanges. Blue bars represent the federal exchanges. Again, this has just been updated. The average enrollment is up 60 percent over 2014. So we've seen some big subsidies.

I'm not going to spend a lot of time commenting on why the state-based exchanges are lower. There's a variety of reasons for that. Some of that- this does not reflect Medicaid enrollment.

However, obviously, the size of a Medicaid population can indicate where people are enrolling. A larger Medicaid-eligible population, where they've have products available to them to expand, won't be enrolling in exchanges. So that could be one contributor to the difference there. But I think the important message here is that we're seeing enrollment in the exchanges up across the board.

An important part of our analysis has been looking where people are making purchases. And I think to the point we're talking about today, if you look at the graph on the left side, I draw your attention to the second dual bars there, the Silver plans. And what we're looking at here is an evaluation of the price differential between the average Silver plans in given markets when you have a value network versus a broad network.

And by this, we're looking at hospital only, but looking within a rating region where a broad network would have over 70 percent of the hospitals in that region. A value network would have something less than 70 percent. So it's aggregated there. But you can see the price differential there- 13 percent at the Silver level, and rising up as you get into the higher-benefit metal levels.

The other thing that I think is significant, based on Dr. Emanuel's comments this morning, is the concentration of the market. And the price differential that you can see within a hospital, the more competition that you have in hospitals. So note, when you have ten or more hospitals in a particular market, the price differential is substantial- ten percent to 38 percent in terms of the differences in Silver plan pricing.

So in terms of insurance companies, again in responding to market needs, there's a number of different factors that go into network and product design. Competitive positioning- obviously all carriers are looking at their position in the market and trying to determine how they can make their products most attractive, recognizing that indeed, as you've heard today, consumers do care very much about maintaining their physician relationships, as well as feeling like the network

that's provided to them gives them the scope of services that they need today and may need in the future.

Lots of regulatory compliance issues. Dr. Ginsburg mentioned that, and we'll talk more about that, I'm sure. So I'll leave it here. But most insurance plans/health plans, too, are required to be accredited by NCQA or URAC, or another accrediting body. And those organizations are looking at developing more robust measurements of network adequacy. So an important part of our positioning, obviously, is making consumers feel comfortable that we have had third-party scrutiny over our networks. And then most importantly, again, is consumer needs and preferences- the value, the cost-benefit analysis that I mentioned that an individual will go through, and importantly, access, geographic and demographic considerations, and that provider selection.

So I mentioned to you that we've recently concluded some consumer research we performed. This is a national study. It is a statistically viable study of 1,300 consumers. There was an oversampling for exchange consumers in this. But we learned a couple of things.

First of all, I'll tell you a little bit about the model. We chose what we refer to as a choice-based model. This was intended to replicate, as much as possible, the kinds of choices that people face when they would make a health plan selection. So it gives them an opportunity to choose between different variables- price, network, other service features- as they're making those decisions.

So the approach does have the advantages of kind of replicating that. But I do want to add a word of caution in this. We actually don't know how they react at the time they buy. I mean, this is a rather sterile environment. They're imagining what they would do if in this situation at the time they would actually make a purchase. Obviously, they could respond quite differently. But it gives us some indication of what people are looking at when they go to an exchange, for instance, and are making a choice of various plans and features, what's important to them.

So our main takeaways that came out of this is that cost, not surprisingly, is critical. Not just premium cost, but really out-of-pocket costs, as well. We found that three out of four individuals would trade some kind of network choice for lower premiums. And that those value networks that I mentioned- when you look, again, at something less than 70 percent of the hospitals in a service area being included in the network- they become more attractive when they are discounted by at least ten percent and that there is about $1,000 savings in out-of-pocket. So obviously, again, consumers are making careful value judgments about their out-of-pocket costs, not only in terms of premium, but benefit co-pays and deductibles and so forth. But value networks do become attractive when there is a differential that is significant enough to get their attention.

They also view access as being able to see the doctor that they prefer. And I think that supports what Anna was saying, is that in this case, mostly primary care physicians, the ones that they're likely to have a relationship, the hospitals are a secondary choice for most consumers.

Moving on to some of the transparency tools that we're developing- at the end of the day, as you would agree, information is power. And we certainly want to put power the hands of consumers to be able to make informed decisions about the health care providers that they're selecting and the health services that they're selecting. This is certainly an evolving element within plans. Numerous health plans of all type, not just Blues, are featuring more and more types of tools, everything from an app on your mobile device to other more detailed tools that allow individuals to really comparison shop, not only for providers, but to look more closely at what their out-of-pocket expenses are going to be, or likely to be, for given services.

The more these types of tools become widely available, frequently- and I can tell you that within our system in large measure- these types of tools are readily available in the group market. But increasingly, we are certainly recognizing the need for individual consumers to have this type of information available. That work is rapidly under way.

Also, a lot of work, even from a geographic and a mapping standpoint, helping consumers understand or be able to select a physician quickly. If I am in a particular area and I have an emergency care, can I find a physician that can see me? Can I find an urgent care facility? And those types of features are being readily made available on apps for members of various health plans.

So again, we'll see more tools being developed. We're just at the beginning, I think, of this. But it's an exciting endeavor that I think will really advantage consumers.

And more broadly, we recently released a report, the first of several that will come. We titled it "The Health of America Report." This is a collaboration between the Blue Cross Blue Shield Association and Blue Health Intelligence, which is an aggregated database of information about health plan and our member data across the country.

STEPHANIE WILKINSON: Kim, I'm sorry. I hate to interrupt, but I think we need, if it's possible, to move on to the summation and maybe come back to this in the Q&A period.

KIM HOLLAND: You bet.

STEPHANIE WILKINSON: Thank you. Sorry.

KIM HOLLAND: Happy to do that. Let me point out- I just want to make one point on this one, is the study compares hip and knee replacements in a variety of MSAs, and we found that costs can vary up to 313 percent within one area. So this information is used- then can be made available to physicians. Obviously physicians hold the pen on how individuals move through the health care system. And to the extent that this can inform them about referral patterns and high-cost providers, it can also influence their decisions, and ultimately save money for consumers as well.

So that's just the beginning of the work that's underway. And I'll pass this on to Lynn and look forward to questions.

STEPHANIE WILKINSON: Okay, thank you so much. We'll now have Lynn Quincy from Consumers Union provide the consumer perspective on the use of narrow and tiered networks.

LYNN QUINCY: Thank you very much. And we always appreciate when the consumer perspective is invited in, because we don't want to get competition right just because that will make the economists happy. What we're really trying to do- all right, economists. What we're really trying to do is get health care right for consumers. And in case there's anyone who doesn't know, Consumers' Union is the policy and action arm of Consumer Reports Magazine, so please update your subscriptions.

[LAUGHTER]

So consumers care deeply about health care costs. This is a "top of mind" issue for them. That will not be a surprise. We also know- it's already been teed up- providers are out there directing most of our nation's health care spending. The physician's pen is the most expensive piece of medical equipment.

And as you know from our prior speakers, these narrow and tiered network designs have the potential to signal efficient, high-value providers and keep premiums down for consumers. So they're an important cost control tool. But we have to understand what's going on behind the scenes, in terms of how consumers are using and understanding these tools.

Okay. The truth is, we know very little about how they respond to these new designs. Just because they're enrolling in plans that happen to have a narrow network doesn't signal anything about their understanding of the product they've just purchased. The only study that I'm aware of that directly observes the patient's response to such a product is the one that Anna- I'm always citing Anna's work, usually on the same panel as her- where you saw her survey data. So I won't repeat it.

But frankly, understanding of how the tier design works, she found, is very low. I'm not going to belabor that. So my global point would be that we need to be very circumspect about exactly what we do know about consumers' understanding and ability to use these designs.

So there's some similar theoretical or experimental work, similar to what you found, where consumers, if they're given a valid structure for weighing pros and cons, will say, you know what? In order to preserve my benefits and keep premiums down, I'm willing to go and use a narrow network. So this is not a real world scenario. This is carefully crafted focus groups.

And there are two key points here. One is, a valid structure for weighing pros and cons, which doesn't exist in the real world. And the consumers who participated in these groups reported that they assume that the narrow network has uniformly high provider quality. That is a fundamental assumption that was the basis for them being willing to make that trade-off.

Back in the real world, consumers are very likely to struggle to navigate these designs, in part because they lack a basic understanding of the role provider networks. So they're ill-prepared to make informed decisions about the role these networks are playing. Consumers- the truth is, not

people in this room, but out in the real world- consumers have very low health insurance literacy. They understand premiums, they understand co-pays, and pretty much everything else about how health plans work is very befuddling to them.

So just think about trying to navigate a mortgage disclosure. You may know everything about health care, but there's other areas of real life that are actually very hard to navigate. And that's what it's like for consumers trying to navigate health care designs.

Only one third understand that HMO means a Health Maintenance Organization, and only 20 percent know the PPO stands for Preferred Provider Organizations. Well, those are just labels. They're jargon. Maybe they really understand, behind the scenes, what those things mean. But unfortunately, they don't.

There's a brand new health insurance literacy measurement tool that really digs down and says, all right, here's health plan features. Which ones are generally true of health maintenance organizations? Only 50 percent got it right. Which ones are generally true of PPOs? Only 22 percent got it right. Between those two designs, which one gives you the fewest choice of providers? Only 50 percent got it right.

So we're talking about network designs that have been in place for a long time, not these brand new ones. So we need to be very cautious before we say that consumers understand and are embracing these designs.

And that's why the weakness of consumer protections in this area is particularly important. Well, what's weak about the protections? As I think it was Paul, and maybe Zeke as well, teed up, current standards for network adequacy are very weak, and they rely on self-reported data by the health plans.

Whether it's you've been licensed by your state regulator, or you've been accredited by NCQA, it's pretty much self-attestation. Yes, I have a rubric for network adequacy, and we attest that we've followed our own rubric. It's not a common rubric, and it's not uniform throughout the geographic area.

So perhaps even more important, there are no summary measures that would signal to the shopper whether the network is narrow or broad. Let's think about that for a moment. Network design has become the most opaque feature of all the things a health plan shopper has to consider. Sorry, it was either Paul or Zeke talked about how we've got metal tiers and standardized benefit structures. So those things are less difficult to navigate than they used to be. But network design- only ASPI, apparently, based on all the information I've seen, has a clue as to how many are narrow and how many are broad.

So consumers are very disadvantaged, coupling this low health insurance literacy with the complete absence of a signal telling them whether it's a narrow or a broad network. They also don't know if it's a high quality or just low cost, or perhaps even neither. One study that hasn't been mentioned yet is the study by Urban which found that narrow networks aren't always the

lowest-cost plan. They found some of the narrow network plans were higher cost than a broad network plan. So again, consumers are very disadvantaged in trying to navigate this landscape.

Another aspect here that's actually very important- if you're not in an HMO or an EPO, one of the things you're buying, when you're out their purchasing health care, is some financial protection from consuming care out-of-network. They also have no summary signal that says how much protection is that? Is 140 percent of Medicare being paid out-of-network providers better or worse than 40 percent of usual and customary? Maybe there's a few people in this room who know this, but the regular consumer doesn't. So that's another aspect of network design where we have to help them.

Unfortunately, provider directories are the basis for selecting a health plan, and they're also the basis for assessing network adequacy. And it turns out- there's been a lot of sort of "secret shopper" type of studies going on- that there are very high inaccuracy rates in these provider directories, 50 percent or greater. And while this is becoming understood- I think there's work being done to try to do more to regulate these things and to measure them- obviously that, again, leaves the consumer very disadvantaged in terms of navigating this landscape.

Forget the inaccuracy that might be present in the provider directory. Sometimes they're just hard for consumers to find. It's hard for them to marry up the directory that goes with the narrow version of a given health plan because they're similarly named products. I'm just going to make up a name. But it could be Blue Choice Value and Blue Choice Gold, or something. And just getting the directory to match the name can be very hard for consumers.

Well, enough about that. I'm very conscious of our timekeeper over here.

So what are some new rules that would make the market work better and make these products play the role that we would like to see them play? Well, not surprisingly, we would like much more robust requirements to ensure the accuracy of provider directories and ensure that consumers can rely on them as they do their health plan shopping, and as they, in turn, go to use their health plans, so they're not faced with unexpected charges. Unexpected charges from an out-of-network provider was the top consumer complaint in New York state, according to a fairly recent study. We want remedies for consumers that rely on erroneous provider directory. That alone will provide a lot of emphasis to get these to enhance the accuracy of these directories.

We need those robust minimum standards of network adequacy. And these have to be, as has already been discussed- it can't just be that we've counted all the providers in a given geographic area. We need to know that the distribution of providers that are accepting new patients is aligned with the needs of the population that's going to enroll, and aligned with the benefits that they've been promised. If they have an oncology benefit, they need oncology providers out there. If children can enroll in the health plan, then they need pediatric oncologists.

You know, it's a tricky space. We still want to obviously find the high-value ones and preserve the lower premiums. But consumers can't be- you know, the first imperative is to ensure that the plan they purchased delivers the benefits that they were promised.

And so this is fairly new, but it's important. We need summary measures of the relative network strengths, so consumers can rank order their plan choices. Well, what does that mean? Again, right now, we don't know- there are no signals at the point of health plan shopping. Is this broad? Is this narrow? Is it high quality?

We need to develop those signals, consumer test them so we're sure that they're understandable to consumers, so the consumers can start playing their role in the marketplace, and saying, “Aha! Low premium, narrow network.” And they're actually making the explicit trade-off that they can't make right now.

Here's my final point. When health plans assemble their provider networks, the rubric they use- you know, how do you get into the narrow band- should be transparent, should be publicly available. And that's all for me. Thank you.

[APPLAUSE]

HELEN KNUDSEN: We now have Fiona Scott Morton to cover provider-payer contracting practices that affect the use of tiered and narrow networks.

FIONA SCOTT MORTON: Great, thank you very much for the invitation to be here. I'm going to waste one of my minutes in defending the economists, who've already been slammed twice, though we've only going for two hours. I'll say that economists very much care about consumers, but there's a methodological limitation. You can't go out and talk to each consumer that is affected by a merger, or your enforcement decision would come way too late for it to do any good. So we have to use data and other kinds of summary statistics.

In terms of economists' ability with statistics, I think it's ironic to be criticized by a physician over that, since physicians are well-known to be the bottom of the barrel for statistical ability. Indeed, the last 30 years- the last 30 years of the low-fat diet that has made America obese turns out to have been caused by physicians who didn't know how to interpret statistical data. So that's too bad.

[LAUGHTER]

All right. I will now turn to my actual topic, which is health care contracting. So I'm going to start with some assumptions. I'm going to really just talk through kind of the possible anti-competitive benefits and harms from the kinds of contracting practices that we've been discussing. And I need to set the stage with something that maybe is not so typical in a more competitive marketplace, and that is that costs and margins vary a great deal.

And they vary across providers. The academic medical center versus the community hospital, for example. Lynn, or maybe Kim, was alluding to a study that Blue Cross Blue Shield has done, and I have a colleague at Yale, Zack Cooper, who's done work using HCCI data that shows that private prices within a city for a quite homogeneous service vary by an astonishing amount. So, you know, one provider's charging $100, and the other is charging, literally, $400. So there's an enormous range of prices and margins.

And you also have different margins across different services- brain surgery versus broken leg. You know, surgical service versus an imaging service. Why have these arisen? It's not entirely clear, I think. The literature doesn't really talk about this. Is it a political constraint? It's embarrassing to charge as much as the brain surgery actually costs? Is it historical accident? Is it just market size and fixed entry cost? There aren't that many providers of burn units?

Anyway, we have this huge range of prices and margins, and that situation is going to give the insurer an incentive to purchase cheaper items from one provider or a subset of providers. So that's the form of narrow network that we're worried about- or celebrating.

Suppose a provider has some market power. What are they going to do with that market power? They could use it to bargain for a higher price from the insurer. Or they could trade off some of that higher price in return for certain contract terms.

These might be anti-tiering, anti-steering, bundling- you know, all-or-nothing contracting. No carve-outs- I want you to buy everything from me, and you can't take infusion services out and do that separately. Gag clauses- you can't tell anyone in your plan about the prices that are being charged. And of course, exclusive dealing, which the Department of Justice has a nice case on that topic, United Regional Hospital of Wichita Falls.

So these are the kinds of contracting practices that we have seen in some settings. I think they're going to arise when there's some market power on the part of the provider, because tiering- you know, if you're the insurer, leaving out that provider, it might be quite costly to the commercial success of your plan. So it might be actually attractive to have the provider with market power in the plan, but just at a higher price, as opposed to entirely out.

I think we get concerned when market power could be used this way. Why? Now before I go on to why, I just want to point out that last point. Hard to do if you have a high-deductible health plan. Some of these things, like gag clauses- it's a little unclear to me how those would work if you have a consumer with a high deductible health plan, because the consumer does eventually have to pay.

So what are possible theories of harm from anti-tiering, anti-steering, bundling provisions? I think the story has to be one similar to a foreclosure story. By forcing the insurer to include me in the top tier, since I'm the hospital with market power, or whoever it is with market power, I attract lots of consumers because of my reputation and my market power. And I prevent a smaller entrant, a smaller hospital, a smaller provider from growing, entering, achieving economies of scale- something that we think is good.

So that might aid monopolization. I'm going to prevent the entry of a competing provider into some areas of service. So that was the story in the United Regional case, for example. The dominant hospital didn't want the smaller hospital to expand into other areas. You also can get an impact on prices in these scenarios, where if the competing provider knows it can't grow- it's the small imaging center and the dominant hospital has a “no carve-out clause”- the smaller imaging center can't compete for that business, and therefore can just charge a higher price because they're not going to get more business by charging a lower price.

Okay, so we have these two theories of harm that you could imagine arise. Now, what are offsetting efficiencies that could be discussed or offered by providers as justification for these contracting practices?

A big one that I hear a lot is that cross-subsidization is necessary. We couldn't have a psychiatric ward unless we had high prices in orthopedics. And we don't want orthopedics carved out, because that will put the rest of our business at risk. I think most economists would say that that's really not a great idea, that society really benefits from clear price signals. If psychiatry is expensive, or brain surgery is expensive, we sort of need to know that it's expensive, and then we can design public policy to subsidize it, or to raise money for it, or to tax people to provide it. And if broken legs are cheap, we should pay a low price for broken legs. So the cross-subsidization doesn't work for me, personally.

The provider doesn't know the true profitability of each service. And it needs to sell the whole bundle, because it really doesn't know whether it's making money off of MRIs or broken legs or brain surgery. That one is a little hard for me, also. I feel like cost accounting is a well-developed field. Firms hire these people. They could go out and do some work there.

More plausible story is the provider needs the referrals from one service to the other. If you take away broken legs, then somehow that impacts referrals into more fancy orthopedic services. The provider needs scale in order to keep average costs down. And if you take away some part of the business, then the rest of the business has to cover that same set of fixed costs.

Unrestricted networks provide consumers with more choice. Well, that's certainly true. But remember that we're here discussing the choice/price trade-off. Consumers will be confused by plans with restrictions. That may well be the case, but it's not clear that these contracting restrictions would be the answer to that. It might be that the things that Lynn was talking are really the answer to that- clear metrics for what the plan does and what its quality is.

Okay, so that's really the story. You know, these contracting practices, what they could achieve, what the harms might be, what the efficiencies might be. I just want to point out that we've gone through this in pharma. Part D, for example, has protected classes, where you're not allowed to have a narrow network, essentially. And prices are much higher in those categories, in the sense of- Mark Duggan and I have a paper where we show that everywhere else, prices go down. But you can't create competition in those classes, because it's just not allowed. So that's sort of an "any willing provider" kind of setting.

Now it's true that we don't have relationships in these pharmaceutical markets, and so are our situation with physician providers might be different. I will say that as often as one hears that, one also hears that physicians today are only given eight minutes to see a patient, and so no one has a relationship with their doctor anymore. So if that's really true- I mean, I don't, certainly. If that's true, then maybe relationships are not that big a deal.

Certainly the thing for me, I think, that's an issue here is switching costs. If I'm in a narrow network and I switch to another narrow network, will my EMR be portable? I have no relationship with my physician. But it really matters to me that the person behind the desk has

the last 15 years of everything that went wrong and can see it. And so if I meet somebody new in a different narrow network, if they have access to all that information, that's kind of like a relationship. So I think that we haven't paid enough attention to the technology and the way the technology could lower switching costs for consumers.

Okay, I think that I'm going to skip the last slide, because we haven't really touched on those things today. So thank you.

[APPLAUSE]

STEPHANIE WILKINSON: Thank you. Jim Landman will provide our final presentation, which will cover the provider perspectives on the use of narrow and tiered networks. Jim?

JAMES LANDMAN: Thank you. Thank you, everybody, for being here this morning. So just a little word about the Healthcare Financial Management Association, we are an association of over 40,000 individual members. Because of the professional fluidity of our membership, we have members in a variety of settings- hospital and health system, physician practice, payer consultant, and vendor. And given that really kind of cross-industry member representation, we do put a very strong emphasis on building and supporting coalitions with other associations and industry groups to build consensus around some of the challenges that the system is facing.

So the first slide is a survey. These are our hospital and health system-based senior financial executive members, a survey we did of them about four months ago, looking at various factors that might be influencing their pricing strategy and their exposure to those factors. So you can see this was a random survey that we sent out to 1,000 of those senior finance members. Wide geographic spread. The respondents are about 50 percent in standalone hospitals, 50 percent in systems or system-affiliated facilities.

And you can see that tiered or narrow networks are the second factor to which they were seeing some moderate to high levels of exposure. Just over 54 percent of the respondents were seeing moderate to high levels of exposure. I'm sorry this got cut off, I see, on this slide, but the first was use of high-deductible plans.

This is from the McKinsey study. This was just looking at the first year of the exchange. They looked at 20 urban markets, approximately 80-some carriers, 120 plans, all in the Silver network. And they were looking at the changes that occurred from 2013, the plans that these carriers were offering in the individual market, to the plans that were being offered in the exchanges in 2014.

As you can see, there was, in terms of competition and choice, particularly for the consumer, there was a strong effect here. You had much more choice of narrow or ultra-narrow networks. And just to give you a sense of how McKinsey was defining these, they defined it by the number of the 20 leading hospitals in the market not participating in the plan. So if it's a broad network, there's fewer than 30 percent not participating in the plan. If it's a narrow network, it's 30 percent to 69 percent of those top 20 hospitals not participating in the plan. And if it's an ultra-narrow network, it's more than 70 percent of the top 20 hospitals not participating in the plan.

And again from the McKinsey report, the narrowing of networks definitely produced premium savings. The difference between broad and narrower Silver network offerings produced a medium premium increase for the broad networks of 26 percent. So, in other words, the broad network were priced at a median level, 26 percent on premium above the narrower Silver plans.

But the lower-priced narrower networks were more likely to exclude academic medical centers. And this was really interesting. So the exclusion of academic medical centers has produced some- and children's hospitals, I'm going to be grouping within that academic medical center category, as well. It has certainly produced some litigation in certain states, as well as appeals to the state insurance commission on network adequacy grounds. Especially the appeals to the state insurance commissions seem to have been successful, in terms of getting the AMC included.

I think that this flurry of activity that we saw in the first year of the exchange- and it was really in just a few states. I think that will really die down as we get more into this. I look at it as more of an initial reaction to the impact of these plans.

What I find interesting here, and what I'd love to know, is on the lowest-price plan- so it's the presence of AMCs by price- what's happening in that 44 percent of the lowest-priced plans that do include an AMC? So what are those looking like? That, I think, in terms of network adequacy, and what we're thinking about- you know, one of the reasons you buy insurance, of course, is if something really bad happens, you have access to the services you need. So to the extent we can figure out how an AMC, which would be offering that broadest range of specialty and subspecialty services, is working out in one of these lowest-priced narrow networks, that's really one of the big questions, I think, coming out of this study.

Another big question. Do consumers understand what they're buying? I'm not going to spend a lot of time on this because Lynn covered this. But this is another study that George Loewenstein did. He looked at the extent to which individuals could correctly identify four basic components of traditional insurance design- deductible, copay, coinsurance, and out-of-pocket maximum. Only 14 percent in that study could correctly identify all four of those components. And then they were also given a benefit design and a hypothetical inpatient hospitalization stay. And only 11 percent could correctly answer a fill-in-the-blank question about the out-of-pocket cost to them of the hospitalization.

So there is a big point on consumers understanding and having really accurate information on who is and who is not in the network. I have to say that narrow network plans do offer, on the upfront, the ability to make- you know, it's an easier choice, perhaps, than the tiering networks. And you can look- and let's assume that you have really good updated provider directories. You can tell if your primary care physician is in that network. You can tell if the hospital that you might prefer is in that network, or the health system you might prefer is in that network.

But there still are problems in, again, the ability of the consumer to navigate the current health care system. So let's say I have an emergency, and I take care to go to an in-network hospital emergency department. But unbeknownst to me, the emergency physician in that emergency room is with a group that has not contracted, that is out-of-network. And I am now receiving out-of-network care without really being aware of it.

Or even more so, say I have a procedure scheduled, and I go to an in-network hospital, and my surgeon- I know my surgeon is in network. But my anesthesiologist, or somebody who actually maybe comes in the room after I'm under anesthesiology, performs a service that is out-of-network. So how do we- and I think this is an issue that both payers and providers have to work out. As these narrow network plans become more prevalent, how do we work together to ensure that the consumer is being able to better navigate this very complex in-network/out-of-network structure?

Just a point on the employer adoption and the difference- some of the issues with employer adoption of tiered and narrow network plans thus far. You can see this is from the Kaiser Family Foundation HRET, a survey of employers from last year, from 2014. And you know, some pick-up on the tiered networks, 18 percent. The narrow networks, very low, eight percent. And I've just been asking some of our members just to kind of confirm what were some of our suspicions about this.

One of the problems, if you think of designing a narrow network plan- well, let's just talk about a fairly sizable metropolitan area. So you have a large employer in a fairly sizable metropolitan area. They have employees, probably, coming from across that metropolitan region. If you have a competitive provider market, you're likely going to have some providers that are more dominant in certain divisions of that metropolitan area than in others. So it can be very hard for an employer to offer a narrow network plan to their employees, because it's going to be much more attractive based on where their employees are actually living.

Now what we're seeing in some markets, some very interesting developments are independent systems coming together to form networks, and often working with plans and employer coalitions so they can create an attractive cross-geography- without consolidating- cross-geography network that can offer a nice alternative. And the best of these, the most flexible of these, also allow the network members to kind of break off into smaller subsets to do contracting, as well. So we're seeing some real innovation there.

Now, obviously you're going to have fewer competitors in these sorts of things, because you're looking at a pretty broad- you're looking at networks that are going to be able to compete across the geography of the metropolitan area. So you will have, just by nature, fewer, probably, competing networks in that type of arrangement. But it's something that makes it a little more attractive, I think, for the employers.

And then I just wanted to go through a couple of questions for providers on some of the contracting questions. So this first few kind of come together from a provider. So how many providers are going to be in the network? What services will they be contracted to provide?

And can I trust my projections, as a provider going into this narrow network, regarding the rates that I'm negotiating for? So let's say I'm willing to drop my rates, but I'm anticipating a certain increase in volume. I probably want to be sure that there won't be other members of the network who, unbeknownst to me, are getting incentives to drive patients who have signed up for that network to get care there that's going to throw off my rate and volume projections.

So this is an area, perhaps, where a surgical use of anti-steering or prevention of carve-outs could actually be pro-competitive, in the sense of enticing a provider to come into a narrow network, accept a certain cut in rates, and have some validity to their volume projections. So it really is, you know- when we start getting into these contracting clauses, think about the various contexts in which they might play out. I certainly think, and most providers would agree, that if you're looking at tiered networks, or fairly nonexclusive narrow networks- so networks that aren't being designed with one provider and a plan together- do you know what the criteria are for tier designation or for inclusion in the network? Do you know what the pricing and the quality benchmarks are? And that should be actually good for the market, as well. Because providers can then try to get their price, and get their quality up, their price down and their quality up, for inclusion in those tiers or inclusion in those networks.

And then this last group is very interesting. I heard a presentation last week on a narrow network- it's an exclusive provider network. It's been developed actually with the state Blue. And they are working- the target for the provider is total cost of care. So it's a risk-based narrow network.

And the contracting considerations start changing there, as well. The need to keep those patients in network becomes very important, because the provider's now responsible for total cost of care. And there's some other questions like, so who's going to take the lead, between the payer and the provider, on care management with the patient? So really kind of working those out.

And then even more critically, then- I mean, data is important in all situations. But what data is the provider going to have access to? What data will the plan be providing? Some really interesting- and not for any lack of will on both sides, but you run into some HIPAA considerations, where both sides are fairly conservative about exchanging that data. And that can make it very difficult, too, with these plans. We were kind of looking at some of those barriers within the industry, as well. So I'm out of time, and I will stop.

[APPLAUSE]

STEPHANIE WILKINSON: Okay, thanks to all of our panelists for those presentations. And we will now move into the question and answer portion of our panel. I'll just go ahead and say to the panelists, as we pose questions to you, and if anybody wants to respond, just please go ahead and place your name card on the end, like this, and we will call on you.

And to members of the audience, if you'd like to fill out question and answer cards that some of our staff will be walking around passing out, please feel free to do so. We're going to be trying to cover a lot of ground here in the final portion of our session, so I hope to be able to get to some of those questions. But even if we don't get to them, it is still helpful for us to see your questions. It's part of what we will analyze, as we go back and look through the workshop record. I would also say to the webcast audience, if you want to submit Twitter questions, you can do that on the #FTChealthcare Twitter feed.

Okay, so the first question I want to ask is just pretty basic. I mean, we've had, in some of the presentations, information about the competitive effects of narrow networks and tiered networks.

But I'm just curious, beyond what has already been presented, is there additional empirical evidence or even anecdotal evidence that any of the panelists would like to share about what are the actual effects of these networks that we've seen, in terms of either cost reductions or even improvements to quality?

And I'm particularly interested in understanding, what is the critical mechanism by which cost reductions may occur? Is it the consumer response to lower premiums? Or is it a provider response to being excluded from a network or a preferred tier? Sort of which one of those is the most critical factor? So I'll open that up. Okay, Paul?

PAUL GINSBURG: Well, as far as quantitative information, one thing that didn't come up, although a number of people referred to the McKinsey work on exchanges, is they did come up with a premium differential in the 15 percent area. So that's kind of a starting point. Now of course, these premium differences were set based on projections by the plans, rather than the experience.

STEPHANIE WILKINSON: Anna?

ANNA SINAIKO: Thanks. Yeah, I just wanted to say a bit more about the study of the limited network plans offered by the GIC in Massachusetts. This was work- I wanted to say in my talk and forgot to say it was work conducted by John Gruber and Robin McKnight. And I mentioned briefly that the overall effect was a decrease in spending of four percent, but they looked a little bit more at why that is and what happened.

And they found that the limited network plan, the number of providers that were excluded wasn't that small. Most people who went into the limited network plan were able to keep their PCP. And they found that people who were in the limited network plan largely had more efficient providers, so there was less spending. But they were still referred- there was no difference in the hospitals, or the quality of the hospitals, that they were referred to. And there was a higher use of primary care by those patients, relative to their control group. So it gives a little more information about what was going on.

STEPHANIE WILKINSON: Okay. I think Jim Landman was the next person with their card up, and then I can call on-

JAMES LANDMAN: Yeah, I just would say I think it's probably a little early to determine the competitive effect yet of the narrow networks. We're still very much in a state of flux. And we saw, both on the provider side and on the payer side, decisions by some significant organizations to kind of sit out the narrow networks, or even participation in the exchange, in the first year.

So I think as we get a few more years in, and these become more of a factor and you see actual significant uptake of these narrow network plans, that's going to be starting to change provider- so some of the providers want to see, are these going to actually get significant consumer uptake? Because we've tried this before in managed care, with HMOs and things, and there have been issues with it. So I think there's real interest in seeing, this time around, have we moved to a

system where there really is willingness to trade off choice and price? And as that willingness becomes more manifest, we'll get a much better sense, I think, of the competitive effects of these.

STEPHANIE WILKINSON: Okay. Thank you. Fiona, did you want to say something?

FIONA SCOTT MORTON: Yeah. Just to highlight the- I mean, we know that the provider response is happening, I think, in both cases, the limited and the tiered. But if you have a narrow network plan, the first issue, as Jim said, is do people buy it? That's the consumer response.

But I think we touched on the trick of- the consumer response in the tiered network really is how well-informed the consumer is, and do they understand their out-of-pocket payment? So unless you have some kind of tool that explains to the enrolled consumer, you'll pay $500 to go here and $200 to go there, that type of tool is what's going to get you elasticity of demand. If the consumer doesn't know those prices, then obviously her behavior is going to not change very much.

STEPHANIE WILKINSON: Okay. Thank you. Next, I'm interested in discussing the relationship between market structure and provider network design. So, one factor of that is what degree of provider competition is necessary in order to implement narrowed and tiered networks? Jim?

[LAUGHTER]

JAMES LANDMAN: Well, you know, so I was talking about those examples we're seeing where you're getting these fairly big networks assembling to try to compete for a regional employer. And at that level, if you have a dominant provider and then a group of smaller providers who are really trying to compete against each other, you probably don't need that many networks to compete effectively.

I think another interesting issue that came up on the calls, as you move into more rural areas, competitive choice of narrow networks becomes very hard to do. Because just because of the logistics of it, especially at the hospital level, you just can't design a population to support a hospital competition. So that becomes difficult. And I think the solutions for the rural markets are something for us to really kind of be thinking about, as well. How do we bring this level of choice and price competition to rural consumers?

STEPHANIE WILKINSON: Fiona?

FIONA SCOTT MORTON: Yeah. Because I'm the economist, I should probably say something here. I mean, there's an obvious answer, which is if you have a monopoly provider, you can't have competition in networks. So we know the end limiting state.

I think that this is really an enormous question for US policy going forward. We have chosen in this country to handle health care costs through competition, the way we've designed the Affordable Care Act. And so that's only going to work if we have competition. And the extent to which we have competition among providers, I think, is just absolutely critical in determining

whether all these strategies work. And I think it's a great area for research. I think we really don't know the answer.

STEPHANIE WILKINSON: Paul?

PAUL GINSBURG: I just want to throw in thoughts about the possibility that to the degree that narrow network approaches are fairly common and significant in a market, whether in fact that could make a concentrated market more competitive than without them than if, say, high-deductible plans were the only two. You know, when you consider, hypothetically, a market, two hospitals, one has 70 percent market share. Presumably you could still run on a narrow network plan. But perhaps if everything is broad network, that's going to be a very concentrated market.

HELEN KNUDSEN: Thank you. Another question that we have is, how does competition in health insurance markets affect the implementation of tiered and narrow networks? Kim?

KIM HOLLAND: Okay. So we've seen- one of the things that's happened in the last two enrollment periods with the exchange is the increase in the number of plans that are actually participating on exchanges throughout the country. And we've seen a marked increase and a slowing of the premium costs as a result of that. I mean, I can tell you that there are many markets in this country that are highly competitive, that we've seen the second-lowest-cost Silver plan actually was reduced. The average cost of the second-lowest-cost Silver, which is the benchmark for subsidies, as you're aware, was reduced as a result of new players, niche players, whether that be Medicaid single payers that have traditionally not offered full health insurance products to a non-Medicaid marketplace, the co-ops playing in states.

So I think the extent to which there is additional competition will certainly have an effect on price. I think the important thing, again with respect to insurer engagement an entering into new markets, is effective regulation that ensures that they are adequately solvent and able to take on the capacity that will follow them if their rates are low.

HELEN KNUDSEN: Great. Thank you. Lynn?

LYNN QUINCY: Just a quick point. We have a lot of economists on this panel, and I think they would probably all agree that the two questions are actually interrelated. For the health plans to be effective competitors, there actually has be an underlying competitive provider market.

HELEN KNUDSEN: Great. Jim?

JAMES LANDMAN: Yeah, I was just going to say something very similar. You really need to have- when we think about it, pricing in health care really is a two-step thing. What is the ability of the insurer to negotiate rates competitively with providers? And then what is the ability for the consumer to have a choice of health plans, and competition among health plans to drive down the premium? So it's the price that the insurer is negotiating, and how that's turned into premium, and what the competition is, at that level, to bring the premium down for the ultimate purchaser.

HELEN KNUDSEN: Great. Thank you. Fiona?

FIONA SCOTT MORTON: Just one thing I think that is worth considering here. We've seen these narrow network plans arise in health insurance exchanges where people are spending their own money and are not buying for a group. I think one of the reasons that elasticity of demand has been so low in this area historically is that you have an employer aggregating a group's preferences, communicating them to a benefits consultant, who goes out and finds an insurer, all of which is done with pretax dollars, and is not salient to the employee. So why would an employer end up in a narrow network, with that set of factors? When you think about an individual family trading off a narrow network versus dollars they have plans for, to spend on other things, I think it becomes more clear why the narrow network is in the interest of the insurer to put together.

HELEN KNUDSEN: Great. Thank you. Paul?

PAUL GINSBURG: I just want to follow up on what Fiona was talking about, that nobody's brought up the issue of private exchanges yet. And there's a lot of hype with them, and it's really hard to know if they're going to become an important part. But in the same way that the public exchanges are an ideal environment for narrow networks, so are the private exchanges. Because this frees the employer from the "one size fits all" requirements. If, through private exchanges, a wide choice of plans is offered, then having narrow network options in that choice is much more viable.

HELEN KNUDSEN: Great, thank you. So a number of you have touched on kind of having concentration on both the provider and payer side. So to what extent might limited networks or tiered networks enhance competition, even when we have concentration on both sides of the market?

LYNN QUINCY: I think it's already been said, but if you have too few providers in a market, you're unlikely to be able to use this design.

HELEN KNUDSEN: Paul had mentioned that perhaps when we have, you know, two hospitals, one with 70 percent share, one with 30 percent share, we still might be able to get a limited network. I don't know if you want to address that further, Paul.

PAUL GINSBURG: Well, I was just throwing out an idea. And it's really an empirical question, and someone should study it, as to whether, in fact- say the implications for prices of different degrees of market consolidation is affected by the structure of the network strategy of the plans in that market. I mean, I think it's way too early to study it, because we've only had significant- you know, forgetting about those studies of employers, as far as having significant narrow network plans, is one year old.

HELEN KNUDSEN: Another question that we have is, are there are circumstances in which limited networks might be considered anti-competitive? Jim mentioned lawsuits involving the exclusion of AMCs [Academic Medical Centers] from networks. Should we be concerned about AMCs not being included in networks?

JAMES LANDMAN: I think- a lawsuit alleging that exclusion from a narrow networks is anti-competitive is a very tough road to hoe. Just within the basic framework even. I'm not an antitrust lawyer, but from what I know, the framework of antitrust law, that's a tough road to hoe.

I mean, I think really the big point with the AMCs is also from a consumer standpoint, understanding what you're getting in the network, and understanding what you want your insurance to be covering. And understanding that if something does happen, these are what my choices will be.

So really, again, how do you communicate? This may be partly a message that the AMCs need to focus on. Like, you know, when you're making a network choice, remember, if this happens, this is where you're going to want to come.

So this is something still to be really kind of figured out. You know, the McKinsey data suggested that it certainly is possible for AMCs to participate in competitive narrow networks. So there's a challenge on their part. There's certainly a challenge on the consumer part, of getting them to understand what they're buying into with a narrow network product and the range of services they get.

And there's challenges, you know, on what the appeals processes are. If there's a service a patient needs that's not provided for in the narrow network, how they go about accessing that, how easy they're able to get access to those services, and what the structure is there, as well.

HELEN KNUDSEN: Great. Thank you. Fiona?

FIONA SCOTT MORTON: I just wanted to make the link between those comments and my presentation. I mean, the road you go down is the consumer understands that the AMC is really valuable and wants that option. And to keep costs down, the plan would like to tier the AMC, because that reduces utilization of that high-cost resource, but gives people options when they have dreadful diseases.

And then the question you get to next is, does the AMC want to participate in a tiered fashion? Or would they like to say, look, it's all or nothing? Because your plan will be much more valuable if you have me in it, and so I am going to say no tiering, and you've got to put me in all or nothing, and that's going to raise costs. So that's the path that you'd be worried about, I think.

HELEN KNUDSEN: Thank you. Paul?

PAUL GINSBURG: Yeah, I just want to raise the point, as we're talking about academic medical centers and their challenges in more competitive environments, that economists for decades have been talking about the issue of, if we want academic medical centers to perform certain functions, like graduate medical education, burn center units, that inevitably lose money, the more competitive the markets are that they participate in, the more there's a need for a policy solution to maintain these services, if indeed they truly are valued by the public.

HELEN KNUDSEN: Thank you. Kim?

KIM HOLLAND: I just wanted to comment that I think frequently, strategies with respect to insurers, in the development of narrower networks of any kind, is to take advantage of AMCs and other institutions, through Centers of Excellence and other tangential networks where there is, for instance, facilities that provide a high number of particular procedures and have strong records of excellence and costs and so forth, where to ensure that a patient, a member that needs specialty care has access to the very best institutions out there. So I think it would be- I would hate to have an audience leave here thinking that a narrow network automatically excluded an important facility that provided unique and specialized services effectively within any given market. Somebody raised the point of the importance of good appeal processes. Paul, it may have been you. Most insurers do indeed provide for appeal processes to accommodate the needs of patients with special health care needs.

HELEN KNUDSEN: Thanks. Jim?

JAMES LANDMAN: Yeah. Just one of the strategies we're seeing with academic medical centers is they're aligning themselves with regional health care systems, and then are figuring out what procedures- lower acuity kind of standard hip and knees, that sort of things- can actually be going out to some of the high-volume, high-quality community hospitals within that network. And then as a whole- so one of the things we want to be looking at, now, that means that probably, you're going to be having higher-acuity and higher-cost care happening at the academic medical center. But you want to be thinking about, now, within this network that the academic medical center is participating in, can we get a strategy where you produce a lower total cost of care across that system, by the moving of some of these lower-cost procedures out to a lower cost setting?

HELEN KNUDSEN: Anna?

ANNA SINAIKO: Yeah, I just wanted to add this is sort of one of the differences I see between tiered and narrow networks on this point, a little bit, is to the question of whether consumers value academic medical centers or some of the more expensive facilities. I think that with tiering, we're asking people to make that decision at the point at which they need care. And that might be a very different decision than when they're enrolling in a limited network, and they have to project out going forward. And so one thing I'm really interested in is the question of whether we can better elicit patient preferences and willingness to pay for those higher-priced places through tiering, as opposed to through the limited networks.

HELEN KNUDSEN: Lynn?

LYNN QUINCY: This is very much tied up in the fact that we don't have good quality signals for consumers, so they have to take cognitive shortcuts. They have to say, well, I think this academic medical center over here is probably best in every aspect of hospital care, rather than being able to distinguish where other hospitals might be equally good or better. So part of the problem here, in terms of what is consumers' response to the exclusion of an academic medical center, is that they really don't have a trusted, actionable, usable quality signal that they can use to say, oh, this narrow network contains a hospital that's of perfectly acceptable quality. They have no basis for saying that right now.

STEPHANIE WILKINSON: Okay, thank you, Lynn. And that actually fits very nicely with some of the questions that we've been receiving from the audience. Many people have been asking about how the narrow networks and tiered networks are designed, and how are providers selected for those networks? Do consumers understand that these networks and tiers are not necessarily based on outcomes? And are there efforts being made to communicate how tiers are calculated and exactly what they mean for consumers? I don't know if anybody wants to add anything additional to that concept.

LYNN QUINCY: Well, I can maybe just reiterate that I think we have to dial it back even further. They may not even know they're in a tiered network product or a narrow network product. So if they don't realize that, they can't even ask the follow-up question, which is how are these tiers designed? So I think we have a lot of work to do. So Anna needs to get busy.

[LAUGHTER]

KIM HOLLAND: I might just add- and first with the caveat that there is no single way, all right? With every plan, every insurer has a different strategy. Based on the environment itself that I mentioned to you before- their competitive positioning, their geography and demography. I mean, we spent some time talking about the reality of it. In a highly dense population with multiple facilities and lots of providers, you're going to have a different type of environment than you will if you're in rural area.

I used an example not long ago about coming from Oklahoma, and the panhandle of Oklahoma has a total population of 2,500 people. It's not even enough people to support a single primary care physician practice. So the dynamics that exist in that kind of environment, in terms of how a provider or payer is going to negotiate or include people in a network is totally different than it will be in a very densely populated urban setting.

That being said, once again, I think this is an evolving issue. There are no single standards for quality out there, I think. And that's one of the challenges.

But that, too, is evolving. So the more we learn about providers, the more information that we're able to analyze and compare, that put tools in the hands of primary care physicians so that they are better informed about their referral patterns and what options they have, in that regard, the more outcomes data that's available, not only through our data but also through what is being made available increasingly through CMS, will inform payers, as well as providers, in terms of what benchmarks and standards are becoming the norm out there, for their own purposes.

So I would say that in some markets, cost is the primary driver. I mean, a network is going to be established based on cost, with the assumption that most- I guess with the assumption being that most providers and most hospitals have a reasonable level of quality, and providers have a reasonable level of performance. As time goes by, more and more data's going to be used to inform those decisions, and at least be the basis for which networks are established going forward.

LYNN QUINCY: Could you also speak to how transparent the plan's rubric is, you know, out in the marketplace, when you form the networks?

KIM HOLLAND: So in terms of the selection process?

LYNN QUINCY: Yeah. Could a consumer who did care to know how you formed your network, the rubric you used, or other plans, as well?

KIM HOLLAND: Sure. I think again, it's going to vary. And I would say that it's probably in most cases, it is not just a black-and-white "check the box" type of criteria established for doing that. Once again, it's going to be, in large measure, dependent upon a provider agreeing, right?

LYNN QUINCY: But is it knowable or proprietary?

KIM HOLLAND: I think it's going to vary. I don't know, Lynn. I can't tell you on a-

FIONA SCOTT MORTON: I think it has to be proprietary, because it's going to be a source of competitive advantage.

KIM HOLLAND: Right. Certainly the contract itself, in terms of the financial negotiation, is proprietary. The extent to which they're using geography and demographics and whatever other criteria goes into determining the adequacy of the network, and appropriate access given their membership, and what have you, I would say probably in general terms, I don't know that it's proprietary. Whether it's broadly disseminated? Probably not. It is a competitive tool. Certainly.

STEPHANIE WILKINSON: Jim, I think you're next.

JAMES LANDMAN: Yeah, just to keep following up on these comments, I mean, this intersects with one of the topics that was so important in last year's workshop. There's the whole question of price and quality transparency. Because I do really think that we need to have strong both price and quality signals available to the consumer to understand the trade-offs that they're making.

And there are all sorts of things in the industry that have prevented that in the past. We worked with a very broad coalition last year on a price transparency report, trying to kind of work through those issues, on both the payer and the provider side, about how we can provide much better price and quality transparency as an industry to the consumer. And there's a lot of stuff that has to be worked through, but it's really essential. And as we're moving into these narrow network products as quickly as we are, it's so important.

And you know, some of the transparency tools that you were showing, Kim, that health plans are developing and third-party vendors are developing a very helpful, to the extent that we can get sort of coalition around meaningful quality standards. But I do think when a consumer's also purchasing a narrow network plan, it certainly is important for them to have some understanding of what the conditions were for the inclusion of that provider, that particular provider, in the network.

STEPHANIE WILKINSON: Paul?

PAUL GINSBURG: Yes. Two things to say. One is I want to go back to something that Dr. Emanuel said, where he was envisioning the ultimate narrow network being a network consisting of an integrated delivery system. And I think that would be a very desirable direction to go in, because at that point, it's the integrated delivery system's brands that all of a sudden is much more meaningful to consumers, than just a list of who's in the network.

The other thing I wanted to point out, insofar as the insurer criteria for inclusion, I agree with Professor Morton, that this is really an area of innovation that needs to be somewhat protected as proprietary. I think there is an obligation to be very transparent about who is in the network. But I think that we're probably going to see a need to be somewhat transparent about the analytical tools that have been used. Because, at least in interviewing I've done, one of the biggest problems in all approaches which steer, and even alternative payment mechanisms, is giving providers the confidence in the analytic methods used. So they're sorted as to low or high preference status. They'd like to have some confidence that there's something behind that.

STEPHANIE WILKINSON: Lynn, briefly?

LYNN QUINCY: Yeah, just two quick points. I quibble a little bit with the need for this to be proprietary. I know we are in a period of innovation. But it seems very unfair to consumers to really not know how a value network was constructed. You know, was it based purely on cost, or was there a quality standard? So I think we need to just maybe be cautious before we pronounce that it must all be proprietary information.

And the other thing, it was mentioned twice, the need to get these better tools in front of consumers. I think we need to hold ourselves to a slightly higher standard. Health plans actually have fantastic tools for consumers right now, Catalyst for Payment Reform did a survey. Ninety-eight percent of plans have tools for their members that show how much it would cost to go and see a given provider. Only two percent of enrollees use those tools. So you can't just build it. We have to ensure that these tools are usable by consumers, that they contain information that they trust, and that they actually bring about the result we're looking for.

STEPHANIE WILKINSON: Another question that we've received from the audience. When you look at the competitive impact of narrow networks, how can you study the impact of patients who forgo care due to lack of access? Are there any panelists that might want to respond to that question?

LYNN QUINCY: I'll kick it off, but I hope others will weigh in. This is a big concern. And one of the reasons that it's a concern is when consumers have a problem with their health plan, they actually are very uncertain about how to complain. They will often call the health plan and go down that route, but many of them don't realize that there are other areas where they can go if they didn't get coverage that they thought they should have gotten. For example, they may not even realize they have a Department of Insurance- this is true- who could also help them with remedies.

We know there's very robust evidence with respect to when there's a cost-sharing barrier to accessing care, that people will cut back on both needed and unneeded care. So it's a concern. It's something we should be measuring as we try to figure out where is that sweet spot in terms of network design? And I know others have stuff to say, so I'm going to let them say it.

STEPHANIE WILKINSON: Anna?

ANNA SINAIKO: So in the empirical design of some of these evaluations, what's important to do is make sure you're looking at the experience of consumers, patients in limited network plans, against that of a comparison group, a valid comparison group. And look at both before and after the introduction of the plan, to understand the impact.

So what that comparison group does is, in effect, sort of provides counterfactual. And what's particularly nice about John Gruber and Robin McKnight's study is that they have a very valid comparison group. In Massachusetts, the GIC introduced limited network plans to state employees but not local municipal employees. So similar groups who had similar trends and experiences prior to the introduction of limited network plans. And then what they do is they look at, after the introduction, what's the difference in spending by people enrolled in the limited network plans relative to the comparison group.

And directly to the question about long-term health impacts, you just continue to look through time, what's the overall spending over time? What are the health outcomes over time of those two groups in comparisons to each other? The evidence we have from this particular study is still early, but I know that's something that the authors plan to look at over the next year or two.

STEPHANIE WILKINSON: Jim?

JAMES LANDMAN: Yeah, I actually think a well-designed narrow network might be more effective in addressing the problems of patients avoiding care than a high-deductible health plan. Because if it's well-designed and you're not being hit with that huge deductible or out-of-pocket pocket maximum that you see in a lot of the high-deductible health plans, a well-designed narrow network that's really thinking about benefits and copayments and things might actually a more effective means of avoiding that problem.

STEPHANIE WILKINSON: Kim?

KIM HOLLAND: Yeah, I would just echo Jim's comments. I think narrow networks, in and of themselves, have been around for a long time, in the form of an HMO. And in many respects, some of the narrow network plans or tiered network plans today are less restrictive, in that they do provide some out-of-network benefit.

The important thing, to Lynn's point, is making sure people are informed when they make those choices. They understand what the limitations are, and it's clearly made available to them that there are good appeal processes, so if somebody does have that extraordinary circumstance, they have an avenue to go. Regulators do monitor this. Increasingly, they are focusing on network

adequacy. And so there'll be more and more robust tests to ensure, hopefully, the adequacy of a network.

Health plans care about that as well, because again, regulation is, in part, intended to create a level playing field. So we are interested in ensuring that all players in the market have to hold themselves to the same standard. So again, I think over time, as we gain more information and these plans become more prevalent, or not, we'll know more about exactly what's happening in the marketplace, and for the benefit of consumers, hopefully.

STEPHANIE WILKINSON: Okay, we are officially at our ending point. But if the panelists would indulge us, we do have a fairly long lunch break. And if we can just go over just by a few minutes, there's just a couple more questions. And we're having such a good discussion, I'd just like to see if we could address these final points.

HELEN KNUDSEN: Okay, another question from the audience. Can limited networks be a tool for risk or adverse selection? Fiona?

FIONA SCOTT MORTON: Yeah, this was the slide I skipped in my presentation. There's a student from Harvard on the academic job market at the moment who has a paper that essentially discusses the problem of an adverse selection death spiral. If you have the expensive provider excluded from the limited network, the limited network attracts the low-cost people who are healthy and don't plan to consume medical care. And the full network attracts the expensive people, and that causes premiums to go up in the expensive plan the next year, and have the death spiral until there is no consumer left. There's no plan that wants to buy from the expensive provider, because there's nobody left in that group.

So one of the interesting questions for policy is whether you want to, for instance, allow tiering. Because in tiering, a plan can include the expensive provider in their network, just at a higher out-of-pocket cost to the consumer, and that limits its use and perhaps prevents this death spiral. So there are interesting kind of subtle problems that occur because of adverse selection, and I think there's a rule for regulators and network adequacy people thinking about the impacts of their decisions.

HELEN KNUDSEN: Anna?

ANNA SINAIKO: Yeah, I agree. I agree. I think this is a really important question. And I think that variations in how patients respond to these network designs is really important. And in particular, how people who are sicker respond.

There's evidence that suggests that sicker individuals are “stickier” to their current providers. The study I mentioned in Las Vegas found that those who did continue to see excluded providers had worse health status than others. But I think the flip side is that when you're choosing a provider for the first time, it may be those individuals who are sicker, who expect to use more care, who have stronger incentives to both choose the higher-quality provider and also just to minimize out-of-pocket costs in choosing the lower-cost tiered provider.

And so tiered networks may be a solution around some of the stronger adverse selection concerns we see around limited networks. I think this will be really important, going forward, to understand as we think about how to regulate these designs.

HELEN KNUDSEN: Thank you. Lynn?

LYNN QUINCY: We've been making a lot of parallels or references to tiered formulary designs. And we have seen this phenomenon in the tiered formulary designs, sometimes inadvertently on the part of the health plans. But it is something, just to reiterate what's already been said, that we really have to carefully monitor. Because there's a little signal there that we might see that.

HELEN KNUDSEN: Great. Going on to the contracting practices that Fiona discussed, to what extent might certain contracting practices affect incentives for innovation and network design? And to what extent are these contracting practices affected by price and quality transparency initiatives?

FIONA SCOTT MORTON: I'll just take the first half of that, since that's quite a lot already. Can you just repeat it? I want to make sure I get it right.

HELEN KNUDSEN: Sure. To what extent might certain contracting practices affect the incentives for innovation in network design?

FIONA SCOTT MORTON: Yeah. So let's imagine that we had a setting with a provider with market power, and the provider with market power said, you may not carve out any services. I'm going to sell you my whole bundle. If there was an insurer trying to do something like Centers of Excellence, that Kim mentioned earlier- I'm going to send all of my people need a transplant to the same place, or all of my people who need some fairly tricky service to a provider I've identified as having good outcomes and low prices- that kind of strategy would be precluded if you had this contract that said, I'm selling you the whole bundle.

So certainly, innovative contracting practices, bringing in, perhaps, a new imaging competitor to your market, things like that could be blocked by contracting practices. So that could be a concern. I agree.

HELEN KNUDSEN: Kim?

KIM HOLLAND: I just wanted to comment on just the contracting today, because first and foremost, contracting is an agreement between parties. It's not one imposed on another. So there's lots of give and take in contracting today.

But increasingly, health plans approach contracting on a partnership basis. I mean, they're sharing resources and sharing information with providers so they can make better diagnostic decisions on behalf of patients. I mean, we are finding, within our plan system, increasingly where the health plan is actually providing different kinds of financial support to physician offices, ensuring that they have adequate information about their patient base and other resources that improve the quality of the delivery of care that they're able to render.

So I think it's important, again, to know that this isn't an "arm's length" agreement, in many respects. It's not a "hands off" agreement. But increasingly, it is that partnership between- whether it's the hospital or the physician or any of the ancillary providers, to ensure that patients get the care that they need.

HELEN KNUDSEN: Thank you. Jim?

JAMES LANDMAN: Two points. First, I think it would be important for us, as an industry, to get a better understanding- we were talking about this in some of our preparatory phone calls- of the prevalence of these contracting practices. I mean, how big of a problem are they, actually out there? Nobody seems to have a very good handle on how wide these various contractual clauses are being used.

But as I suggested at the end of my presentation, there are good uses of contracting provisions and bad uses of contracting provisions. And to Kim's point, we're seeing that that's total cost of care narrow network that I was describing was dependent upon this very close partnership between payer and provider. And those are becoming more and more common. And both sides need a certain amount of flexibility to come up with some of these new products that are going to be actually appealing, and probably have a very strong, potentially pro-competitive effect.

So two points. We need to get an understanding of how prevalent these are and how they're being used, but also get an understanding of how some of these contractual provisions, or things similar to them, can actually be used in the creation of pro-competitive market products.

HELEN KNUDSEN: Great. Kim again.

KIM HOLLAND: Yeah, and just to follow up on a couple of points. One, in terms of the contracting itself, one of the levers, of course, an insurance company has with a provider, if they breach an agreement or whatever, is to take them out of the network. Rarely is that a solution that pleases people, right? It doesn't please the plan. It doesn't please the provider. It certainly doesn't please the patient. So looking for ways in which health plans can support the patient and, again, provide them with what they want, what they need, in order to achieve a mutual objective is important.

What we worry more about, actually, then contracting issues are legislative activities that would impede our ability to contract. I think Fiona mentioned "any willing provider" legislation. There are several states right now that are considering "any willing provider" legislation that is being brought about by their local medical associations. So legislation, even well-thought-out- or excuse me, not well-thought-out, but well-intentioned, probably is the better way to phrase that- can be a real impediment to being able to accomplish the objective of lowering costs and improving quality.

STEPHANIE WILKINSON: Thank you, Kim. And just to wrap up our panel, just following up on the points about the legislative and regulatory activity that it may be affecting the use of narrow networks or tiered networks, are there any additional examples that any of the panelists might like to raise? We're aware that for example, in New York, there was a recent surprise

balance billing legislation that was passed. We're also aware that the NAIC is considering some revisions to the Network Adequacy Model Act of 1996. And I don't know if anybody would like to discuss, perhaps, some of those key revisions that are being considered. So I'll open that up.

KIM HOLLAND: I don't mind to start, and I know Lynn will chip in here, because we've been collaborators, colleagues, for the most part on these issues. But a couple of things that I would raise. First of all, the NAIC is reviewing their Network Adequacy Model Act that they've had. They had a model that they developed in the 1990s that has not been broadly adopted in the United States, and so they're updating that to harmonize with ACA regulations, and certainly consider the environment of today.

So there's lots of discussion on that at the NAIC. For those of any of you that have ever sat in or participated in any of their meetings, it's a very democratic process. Everybody gets a say. But at the end of the day, the regulators make a decision. So it's like making sausage. It's not very pretty sometimes, and it's really long and drawn-out. But I think it's a very important and effective process. Because all stakeholders are represented, and you really do have an opportunity to hear from others about the issues that are important to them.

So their model is still in the stage of development. There's lots of varying interests, in terms of the scope of regulation, actually, that will be developed. And then states have to individually determine whether they're going to adopt the regulation in its form, or add to it, or whatever. That will be a state-by-state option.

But I do think it does set at least a standard. We may have a difference of opinion at times, Lynn, in terms of just how high a bar we want, as far as the floor for that standard. But I'm sure we certainly agree that there does need to be one that's uniformly applied, so consumers are protected.

STEPHANIE WILKINSON: Okay, Paul, I think you had your-

PAUL GINSBURG: Yeah. I just wanted to say I was certainly impressed that New York State moved so quickly to address this- what they called surprise balance billing. I like to refer to it as “providers that consumers don't choose.” But when I look at the solution of an arbitration process, with really no guidance to an arbitration process as to, well, what should the fee level be? I'm not very comfortable that they've solved it.

Seems to me that you can either go regulation- which some states have done, saying that, well, you know, if you're this type of physician, and the patient hasn't chosen you, it's a percent of Medicare that you're limited to. That's a viable approach. Another approach would be saying, you know, that if a hospital is in-network, then it has to, as part of that agreement, make sure that physicians that patients don't choose in the hospital are part of that network. And that just becomes a market thing that presumably is going to affect how much the hospitals have to compensate those providers to do that.

STEPHANIE WILKINSON: Lynn?

LYNN QUINCY: Well, I'll make a couple points. To speak to what Paul just said, I think that in New York, they are using arbitration in the extent that a consumer ends up with legitimately an unexpected out-of-network bill. I think we have to give it a chance, because there's a lot of trade-offs between all the sort of options, about what do you do? Who gets paid what, in this circumstance? Arbitration takes the consumer out of the middle, so obviously, we like it. And we have to be careful about not ceding too much power to either the plans or the providers right up front by saying, this is what the outcome is going to be.

So you know, it's worth seeing how it plays out in New York. This is just being implemented, so we don't know.

Another sort of regulatory move that is of interest, at least to us, is Texas. I don't often get to say Texas. But they have a new requirement where in-network hospitals have to report on how often the ER docs are also in-network. And, as a result of this report, something we know about Texas that we don't know whether or not it's true in any other state, only 50 percent of in-network hospitals can offer up, at the same time, an in-network ER doctor. So obviously that leaves the consumer extremely vulnerable to a surprise out-of-network bill, which we don't want to see. So that's worth looking at.

The other thing we might say about the NAIC's process- Kim covered it beautifully. And as she sort of implied, it won't necessarily be adopted by all the states. There's a lot of states that are actually well out in front already of what is, by its nature, sort of a consensus document.

But it is also something that the Health and Human Services is waiting on. They've sort of signaled that they're waiting for the NAIC to complete their process, and then they're going to dive into this space. Which is just of interest as we think about where are these future regulations going to come from? You know, who's going to come down and say, okay, we're going to get bigger and bolder about standards for network adequacy and summary measures for consumers?

STEPHANIE WILKINSON: Jim?

JAMES LANDMAN: Yeah, I believe the medical surprise billing law also has provisions that allow patients to challenge the adequacy of specialist care within their network. It sets up an appeals process for that. It's going to be interesting to watch how that plays out. Because if that becomes a widely used and a very cumbersome process, you're going to want to see some pretty clear standards about how they're making that determination on adequacy of access to specialties. Because that could really have a chilling effect on the ability of payers and providers together to be very creative in the development of these narrow network products. So how that appeals process is going to work, as well, is going to be very interesting to watch.

FIONA SCOTT MORTON: I mean, balance billing just really reduces the benefit to the consumer of a narrow network. I think I've chosen a narrow network and I have low out-of-pocket costs. I go to the hospital, I've picked a physician, and then surprise, I have a high bill anyway. Perhaps I should have just bought the broad network plan to begin with, and my costs would have been the same.

So I feel there's really a competition angle to this surprise balance billing. I think that to encourage narrow networks to take off, you really- there has to be a policy solution to this. Because it inhibits competition on the basis of a narrow network.

STEPHANIE WILKINSON: Okay. Thank you. I hope that everybody will join me in thanking our panelists for a truly excellent discussion of these issues.

[APPLAUSE]

So we will now break for lunch. For your convenience, there is a cafeteria that's located in the building. It's just around the corner. And I'd also like to thank the audience for indulging us on that extra time. I hope that everybody felt that was worthwhile.

Please return to the auditorium and be seated by 2:30 for our afternoon panel on Health Insurance Exchanges. Thank you.

EARLY OBSERVATIONS REGARDING HEALTH INSURANCE EXCHANGES

Moderators:

- **Peter J. Mucchetti, Chief, DOJ, Antitrust Division, Litigation I Section**
- **Natalie A. Rosenfelt, Attorney, DOJ, Antitrust Division, Litigation I Section**

Panelists:

- **Cynthia Cox, MPH, Senior Policy Analyst, Program for the Study of Health Reform and Private Insurance, Kaiser Family Foundation**
- **Daniel T. Durham, Executive Vice President for Strategic Initiatives, America's Health Insurance Plans**
- **Keith M. Marzilli Ericson, PhD, Assistant Professor of Markets, Public Policy, and Law, Boston University School of Management**
- **Pinar Karaca-Mandic, PhD, Associate Professor, Health Policy and Management, University of Minnesota School of Public Health**
- **Kevin Lewis, MPP, CEO, Maine Community Health Options**
- **Richard M. Scheffler, PhD, Distinguished Professor of Health Economics and Public Policy, School of Public Health, University of California, Berkeley**

PETER MUCCHETTI: Well, welcome back to the FTC DOJ workshop on health care in competition. My name is Peter Mucchetti, and Natalie Rosenfelt to my left. We are your co-moderators for this afternoon's panel. Natalie and I both work in the Litigation I Section of the Antitrust Division. That's the section in the Justice Department that handles all of our civil antitrust health care investigations.

This afternoon's panel focuses on early observations regarding health insurance exchanges. One goal of the Affordable Care Act of course was to create health insurance exchanges that would generate competition among insurers, which in turn would lead to lower premiums and greater choice for consumers. When the exchanges began operating roughly a year and a half ago, many states did see new insurers enter the health insurance arena, and millions of individuals have now purchased health insurance on public exchanges. Our panel today will discuss these developments, how the exchanges are affecting competition, and how the exchanges are impacting consumers and their choices. Let me turn it over to Natalie now to introduce our distinguished panel.

NATALIE ROSENFELT: Thank you, Peter. Make sure I put the microphone. Thank you, Peter. Good afternoon, everyone. We're very pleased to have this group of six distinguished and accomplished panelists here with us today. I'm not going to give detailed bios of the panelists because there is a bio packet, but I will briefly introduce the panelists in the order in which they will speak.

Our first speaker, Cynthia Cox, is a senior policy analyst at the Kaiser Family Foundation Study of Health Reform and Private Insurance. Cynthia will give background on the

exchanges and discuss some of the early results. Our second panelist, Kevin Lewis, the chief executive officer of the Maine Community Health Options Co-op Plan will give an overview of the co-op program and talk about the experience of his co-op. Our third panelist is Dan Durham, the executive vice president for strategic initiatives for America's Health Insurance Plans. Dan will talk about competition and consumer choice on the exchanges.

Next we have Professor Keith Ericson, assistant professor of markets, public policy, and law at the Boston University School of Management. And Keith will talk about his work involving consumer decision making on the exchanges. Then we have Professor Richard Scheffler, distinguished professor of health economics and public policy at the School of Public Health at the University of California, Berkeley. And Richard will discuss his work involving the California health insurance exchange and how provider and insurer concentration affected premiums. And our final speaker will be Professor Pinar Karaca-Mandic, an associate professor at the University of Minnesota School of Public Health in the division of Health Policy and Management. And Pinar will speak about her work on marketplace models and premiums.

After the panelists make their presentations, we will have some time for questions and answers. And to the extent there are questions from the audience, we'll do our best to try to get to them. With that, I'll turn it over to Cynthia to give some background on the exchanges.

CYNTHIA COX: Great. Thank you so much for having me. So I'm looking forward to sharing some of Kaiser Family Foundation's recent research on exchange market enrollment, insurer participation, and market concentration. But before I jump in, I do want to give some basic background about where things were before the Affordable Care Act.

So I'm going to focus on the individual market for now. This is the market where, as you may know people who don't get coverage through their employer, or through Medicare, or Medicaid, go to purchase their own coverage. And this is the focus of many of the ACA's market reforms. So do I need to go to the next slide?

So in the individual market in most states there was concern that it was not very competitive. For example, there were only a handful of sizable insurers participating in most states, and the largest insurer generally controlled more than half of the market. So as you can see here in this slide, market concentration as measured by the Herfindahl Index has consistently stayed highly concentrated in most states' individual markets.

So the concern was that- first of all, in the absence of competition, there was concern that insurers may not have been passing along savings to consumers. Additionally, there was concern that, instead of competing by offering better value, insurers may have been competing by avoiding the sicker or higher cost enrollees. So this practice meant that not only were some of the sickest or most in need of care without access to it, but it also meant that even people with coverage were often unable to shop around for a better value.

So what the Affordable Care Act does is it attempts to address these issues by ensuring guaranteed access to coverage. So this frees people up to shop around regardless of whether

they have a preexisting condition. The ACA also creates new markets called exchanges. And these markets are designed to encourage insurers to participate.

First of all, there are subsidies available in the exchange that encourage people who may have otherwise gone without coverage to enroll, and this makes the market more attractive. Additionally, insurers compete to be either the benchmark plan against which subsidies are calculated or one of the lowest cost bronze or silver plans, and that's because enrollees have to pay the difference between their plan and the benchmark plan, so they're cost sensitive even when they're receiving financial assistance. And consumers also may have to switch plans from year to year in order to take full advantage of their tax credit.

So how successful have these markets been so far? So in the first two years- well, in 2014, we saw that about eight million people had enrolled by the end of open enrollment. And most of the people who enrolled last year picked either the lowest or second lowest cost silver or bronze plan, which was as expected. By 2015- I think we're still waiting for a couple of states' final numbers- but enrollment will be somewhere between 11 and 12 million across the country, and this is close to the target of what the CBO have projected, but it's somewhat slower to ramp up in enrollment than we initially would have expected.

But we do know that the individual market over all- so including people who are purchasing through healthcare.gov or their state's exchange and also people who are going directly through an insurance company or a broker, that overall this market has grown substantially in the past two years. We are still waiting on final numbers, but I would not be surprised if this market has doubled in size just since 2013.

So with this rapid growth it's just- first of all, that the market is healthy and stable. And second of all, that there are likely to be shifts in market concentration. It's unlikely that with such rapid growth we would see the exact same distribution of market share in a state as we saw before the ACA.

So this slide just shows that enrollment really depends on the state and even in areas within states. So we're likely to see that the ACA will affect states differently and also even regions within states.

So back to the main question. So we want to know whether exchanges have encouraged insurers to participate, and second of all, whether they have improved competition. So we've seen from 2014 to 2015 the average number of insurers has increased. On average, there were five insurers per state in 2014, and that increased to an average of six per state. There were only three states that saw a net decrease in the number of insurers, and most states saw an increase.

So again, this is a sign that the market is stable. It's a positive sign for market stability, but what we also want to know is not just the number of insurers, because there could be- let's say there's six insurers in a state, but five of them are very small, and the sixth one controls most of the market. Then in that case, the market would still not be very competitive even though there are a fair number of insurers participating.

So what we would like to see is market share becoming more evenly distributed within the state, and unfortunately we don't have a lot of good information on this. We're relying on a handful of states that have made this information public. HHS has not made this available for states that use healthcare.gov, so these are only state-based exchanges. So there are seven of them that have released market share information and each of them for 2014.

So I'll walk you through a few examples just to show the breadth of experiences in these states. So you can see the orange bars are the 2014 exchange market concentration, and the blue bars are their pre-ACA, or 2012, markets in the individual markets. So this is before the ACA's market reforms were implemented.

So California, this is an example of a state where it's exchange market early on in 2014 was already looking more competitive than its pre-ACA individual market had looked. You can see that market share is more evenly distributed across insurers, and Health Net in particular stands out because it was a relatively small insurer before the ACA that had picked up a significant piece of the market, particularly in southern California where it was one of the lowest cost plans.

In New York, you'll see something similar. New York's market also became- the exchange is more competitive as of early 2014 compared to its pre-ACA individual market. And again, the lowest cost insurer, which in this case was largely Health Republic in most of the state, was able to pick up a significant piece of the market in New York's exchange. It was a new entrant and also a co-op plan, which is notable because, as we'll hear later, co-op plans have had varying degrees of success.

So we're starting to notice a pattern that in at least in the states where we have this information, that if a smaller or new entrant has come into the market pricing low, they generally have had enrollment success, at least in these states. Minnesota is yet another example of this. Minnesota's pre-ACA individual market was highly concentrated, so it was not very competitive. Blue Cross Blue Shield held more than half of the market and PreferredOne was a very small plan which entered into the exchange offering not only what was the lowest cost plan in the area, but also the lowest cost plan in the entire country. And it was so low, in fact, that a 40-year-old would not have qualified for tax credits in most cases where that same person would have qualified for tax credits living almost anywhere else in the country.

So by having such low premiums, PreferredOne was able to pick up more than half of the market, and in the end of open enrollment, Minnesota's exchange market actually looks pretty similar to its pre-ACA individual market, except that the dynamics have turned on their head. And PreferredOne also left the Minnesota market, as some of you may know, and- so I can go into this in more detail later- but this is an example of when premiums may be too low.

Finally, I'll wrap up by talking about Connecticut. Connecticut's market is also interesting because its exchanges actually- at least early on in 2014- was looking less competitive than its pre-ACA individual market, and this is largely because Aetna and United Health, which were

two of the three largest insurers, both decided to not enter the exchange in 2014. So this left WellPoint in a position to be able to seize more of the market than it had before in the pre-ACA individual market. And it's an example of a state where competition is not necessarily going to improve, at least early on.

So what we would like to see is some effect on premiums, but as I'll go into in a bit, it's really difficult to use these first couple of years of premiums. First of all, insurers were operating with very limited information, and they, in 2014, had no experience operating in these completely reformed markets. And even in 2015, they generally had maybe one or at most two quarters worth of data before they were able to submit their rates for 2015.

So in general, we saw a lot of insurers using the same methodology or similar methodology to set their rates as they had in 2014. But as you can see in 2014, there was a significant amount of premium variation across the country, and part of this could be due to essentially luck, where insurers may have priced wrong or priced very well. But also it can be because potentially because of insurer market concentration or provider market concentration and also the underlying health characteristics of the population.

So what we've done is looked at- one of my colleagues at Kaiser Health News- have looked at new entrants into the market to see if there's any relationship between a new entrant coming in and premium growth. So this just shows across a variety of cities that premium growth and premium decreases really vary tremendously across the country too in 2015. But on average, premium growth was moderate. It was a two percent increase in the benchmark plan from 2014 to 2015.

So my colleagues at Kaiser Health News analyzed the data for federally facilitated exchanges and found that on average in places where there were new entrants coming into the market, they saw more modest premium growth. So there was an average of one percent growth in those areas compared to an average of seven percent growth in areas that did not have a new entrant. So again, this suggests that there could be some relationship between new entrants and insurer competition and premiums, but again, I would just caution that this is still very early on and it'll take some time before pricing reaches an equilibrium in this market.

So what can we make of all of this? Well, first of all, we know that market concentration has stayed fairly consistent from 2010 through 2013, and these are the years for which we really have good data. So there haven't been much changes on average across states, but in 2014 the ACA introduced new market reforms that encourage insurers to start competing based on price and value, and we've seen insurers entering into the exchange markets and pricing competitively.

We've also seen that in some markets- particularly in California and New York- the exchange markets have been able to become very early on more competitive than their individual markets were before the ACA, but we also saw from the case of Connecticut that there's no guarantee of early success. So I'm going to close there, and we can talk about some of the other trends during the Q&A, but thank you for your time. I look forward to hearing the other panelists.

[APPLAUSE]

PETER MUCCHETTI: Thank you, Cynthia, for starting us off. We very much appreciate that, and now we're going to turn to Kevin Lewis who has been right in the thick of things with the Maine co-op. And they're getting off to a great start in 2014.

KEVIN LEWIS: Thank you very much, Peter, Natalie. It's a pleasure to be here. As Natalie mentioned, what I'm going to endeavor to do is talk about the co-op program in general, but just as they say about community health centers, which is the world that I came from previously, if you've seen one co-op, you've seen one co-op. So we're all very different.

One common theme amongst us is that we have brought in competition and choice to all of our markets, which was the intention of the ACA in the creation of co-ops in Section 1322 of the law. The genesis of the co-op program is really as an alternative to the public payer option that was discussed early on and fell by the wayside.

So one of the principal components of a co-op is that it's member led, and we have all had to engage in the weighty task of having member elections. And I tell you, it was hard to get ten percent of our membership this last fall, adults amongst our members, to vote. So we had to really reach out, and encourage them, and say, really, we mean it. We want you involved.

It's one additional facet of the way we want people to be engaged in their health care, which is also the governance of the plan itself. Two-thirds of all of our contracts must be on individual small group market, so that really brings us in alignment with the exchanges in the sense of where we have most of our business. I also mentioned that we have 22 co-ops operating in 23 states, so not quite half of the country. The plan initially was to be able to provide the opportunity for a co-op in every state. That fell short when the funding for co-ops was essentially taken off the table back during the fiscal cliff debate. So that was the end of 2012, December 31 of 2012, and we have moved quickly since then into operations and hopeful that with time we'll be able to demonstrate the efficacy of co-ops.

So I'll move into some of that efficacy and what we've seen thus far, and I'll attribute some of this work to Cynthia and Kaiser as well NCSL. But we have seen that insurance premiums- and this isn't scientifically founded, if you will, but rather there's a causal link it seems that premiums are about eight percent lower in states where co-ops exist. So as some people like to say, it's the turtle on the fence post. Not quite sure how it got there, but something happened to get it there.

And we've seen that in co-op states, co-ops offer 37 percent of the lowest priced plans, and that certainly was the case in Maine as in other states. Co-op plans are the most likely of all insurers to be within ten percent of the lowest priced plan, and this was a study out of the National Council of State Legislatures. And from 2014 to 2015- and this is attributed to Cynthia's work- premiums for the second lowest cost silver plan dropped by 1.9 percent in states with co-ops, but had risen by 1.5 percent in non-co-op states. So that's a delta of about 3.4 percent. Pretty impressive when you look at the impact across the country.

And our enrollment at the end of 2014 topped half a million. So half a million compared to the eight, I think, is a pretty good start, and we're expected to see some pretty good gains, I think, by the time the dust settles on 2015.

So let's move into what I know best, which is our own company, Maine Community Health Options. And just to give you a feeling for how it is that we're organized, our mission is to partner. And so we'll get into some of this later as we talk about how we relate to providers and how we have structured ourselves, but it really is a partnership foundation not only with our members, but with providers themselves to provide affordable high quality benefits that promote health and well-being.

And so every aspect of this is what we look at and use as our compass on a day to day basis as we make management decisions and prepare now for 2016. And the reason we came about wasn't just because the funding opportunity announcement hit the streets in the summer of 2011. In fact, we have been organizing in various ways in the Medicaid arena, Medicare arena, and commercially to provide a fundamental difference in the way that care could be paid for, and that providers could be incented, and members could be engaged.

So when the co-op opportunity did come around, we were very well poised, had already been establishing a network. It just so happened that the network was more oriented towards the Medicaid arena, and we were able to shift the focus over into the co-op. But that's important because the driver of our existence really is in our vision, which is we need to be competitive as a state. One of the ways that we can contribute to that competitive advantage is to drop the cost of health care overall, but we don't want to drop the cost of health care without improving the health of the population as a whole. So it really speaks to the triple aim for those of you familiar with the IHI's triple aim.

So I talked about some of the underlying purpose here. I'll just hone in on a couple of points, which is our value-based insurance design. It's one of the ways that we are able to immediately provide some innovation where, as a new company with zero members, approaching providers and saying do you want to take on risk and engage in payment reform is really a nonstarter. So we are able to start with a value-based insurance design focused on the benefits and reduce the cost share- eliminate the cost share for office visits, generic drugs, DME and durable medical equipment, and labs for people with certain chronic conditions so that they can maintain a high quality of health and avoid hospitalization, re-hospitalization, but would drive down the costs while they have better health outcomes. So it really does align well with ACO development, which I'll talk about briefly towards the end.

Secondly, as part of our VBID model is behavioral health integration where we look to really support the integration of care at the local level. So we offer the first three visits to a behaviorist, whether it's for a substance abuse treatment or mental health services, at no cost to the member to get over that financial barrier and hopefully mitigate the stigma or offset the stigma associated. Third, we partner actively with providers so that we not only support PCMH, but our care management team, which we have in house, works closely with providers so that we are in sync in terms of what the patient and our member- what they're hearing and how we want them to work with the provider towards adherence and compliance.

We have a broad PPO network. Again, in terms of a partnership model, we want access to coverage to yield access to care. It doesn't make much sense to us to carve out large portions of the state. If you know Maine, you know that all the rest of New England can fit within the state of Maine, so it really is imperative that we have easy access to care. And that's not saying that all care is created equal, and we'll get into some of that as well. Last I would just mention that we have, I think, an average display of products on the individual family side as well as the small group side.

So some of the challenges that we faced mentioned earlier- starting with zero members. We don't have much street credibility in regard to our membership, and we certainly didn't have any brand name recognition when we came out as a new company. And I would mention that we couldn't use any of the federal startup loans for our marketing efforts, so we had to secure other financing. Those are interesting conversations to have. Fortunately we have a great banking partner. We had some foundations within our GRP that were very sympathetic and supportive.

Lastly, I think this is an ongoing challenge that Cynthia touched on in terms of appropriate pricing and balancing enrollment growth with solvency. So obviously enrollment growth is important, but that has to be balanced with sufficiency and reserves to maintain those risk-based capital ratios that are regulatorily defined- and co-ops have an even higher threshold to meet than most state regulators require. So we have a 500 percent risk based capital ratio whereas most states require a 300 percent RBC level.

So those are some of the challenges, but the results, I think, are compelling. In terms of what we've been able to achieve, we thought we'd hit 15,000 members at the end of the first year. In fact, we hit over 40,000 members. And at the end of the open enrollment here 2.0, we're up at about 73,000 members and in the 81 percent market share for the overall FFM in the state of Maine.

We were able to drop our premiums by almost a percentage point on the individual side and by ten percent on the small group side. And we've expanded to all of New Hampshire for 2015, so all ten counties. And there in New Hampshire as well as in Maine we have been able to contract with all of the hospitals across the states.

So just to give you a feeling of before and after a bit like what Cynthia was showing you at the national perspective, if you look at the smallest slice of this pie chart, that was the individual group and individual market. The small group market is the second smallest slice of the pie, and the remainder is split between large group fully insured and self-insured large group.

So what happened after the ACA? Well, we saw actually a doubling of the non-group market from about 32,000 members to about 64,000. So even while that doubled, our largest competitor still saw its numbers increase from 2013 to 2014 in the non-group arena where even with our sizable gains in membership. So it tells me- it confirms the fact that many of the people coming into coverage never had coverage before. So we not only- it's not as if we're

raiding the small group market. There is, I think, some migration from small group into non-group, but by and large, most of our members didn't have coverage before coming to us.

So as we look to the future, I mentioned our compatibility with accountable care organizations. We continue to work with ACOs. In fact, part of the team back at home is in discussions with an ACO right at this moment. And we're very hopeful about the efforts that we can together not only inform, but achieve in terms of the triple aim in reducing the cost of care while improving the health outcomes for the population.

Part of the real, I think, secret sauce that's not all that secret is greater transparency and engaging consumers through better portals so that they have better information, and also engaging providers, so us providing information to providers that it's actionable and timely, not just the two month old data that gets round and filed immediately because it's worthless at the point of receipt.

So I think we are at the point now that IT- particularly in health care, we're starting around the corner, and I'm very hopeful about the use of that as currency to really engage not only in a service model, but in an action oriented model that providers and members can attain the kind of care that they want and need through shared decision making. There's a lot of emphasis on choosing wisely. But these are, I think, empowered by that greater transparency. So I will stop there and look forward to the question and answer period.

[APPLAUSE]

NATALIE ROSENFELT: Thank you very much, Kevin. Now we'll hear from Dan Durham from AHIP, who will give us another insurer perspective from AHIP.

DAN DURHAM: Well thank you. It's a pleasure to be with you this afternoon, and I look forward to our discussion after the presentations. My presentation today will focus first on the priorities of consumers and then secondly how health plans are delivering value to consumers in this competitive market. And then I'll focus on the challenges we face in terms of offering affordable premiums, looking primarily at provider consolidation as well as high priced prescription medicines. And then finally I'll end on next steps in terms of looking forward, what are health plan priorities, and what are we doing in this marketplace.

To start with, consumers are clearly engaged in this marketplace, and it's very much a consumer driven marketplace. They're focused on value, and for them, that meets affordability, high quality care, as well as choice. And there are a lot of choices in this marketplace whether you look at the middle tiers from bronze to platinum, or if you look at the different network designs that are available to consumers, they have the choice in a competitive marketplace, which is very important.

In terms of how health plans are delivering value in the exchange, I just wanted to highlight for you some results that we have on this slide. A recent Commonwealth Fund report found that 73 percent of adult individuals in exchanges were either satisfied or very satisfied with their plan. And health plans are also working to ensure that there's choice with regard to the

breadth of the network. And McKinsey did a study in June of last year where they looked at all 501 rating areas across the United States, and they found that there is that choice, that 90 percent of individuals can choose a broad network. Ninety-two percent can choose a narrow network.

And so that is an important area for consumers to consider when they purchase. And for those that are willing to make the trade off to have a more narrow network, less choice in providers, but are focused on a lower premium, then that choice is there for them in the marketplace versus others that may have a lot of providers and they want to find a network that includes their providers. They have the choice for a broader network as well. So that choice and competition is important in terms of what we're delivering in this exchange marketplace.

We have some challenges ahead, challenges to assure that we can have affordable premiums going forward. The chief driver in this is the high price of specialty drugs. For example, we've seen over the last year some new prices for Hepatitis C drugs, and these are just terrific new products in terms of their ability to cure Hepatitis C. But they come with an astounding price tag. First we saw Sovaldi come on the market for $1,000 a pill, $84,000 for a course of treatment. And that was followed by Harvoni, which is a combination treatment that was priced at $1,125 a pill, about $95,000 for a 12-week course of treatment.

So these are very expensive specialty meds that have incredible price tags that go along with them, and the issue here is that there are many more of these specialty meds in the pipeline. And that is certainly going to put a strain on our ability to provide affordable insurance coverage going forward.

The other thing I want to focus on here is with regard to provider consolidation. This is another serious challenge that health plans are facing. We've seen that for health plans that are buying services in competitive markets where we have competitive hospital systems, competitive group practices, and the like, lower premiums. And this is very important in terms of consumer benefit. And we know that in markets where we don't see this type of competition that consumers pay the price, and it comes in the form of higher premiums.

We recently sponsored a study that Scott Thompson authored, and it was published in the Antitrust Health Care Chronicle just last month. And Scott took a look at premiums in the California marketplace, and his studies showed that there is a significant correlation between the level of hospital concentration in the market and premiums. And so where you have more highly concentrated markets in the San Francisco area, the premiums are higher, and in some cases substantially higher than what you have in markets that are more competitive, say, the southern LA County area. I know Richard has a study too that he'll talk about when he gives his presentation.

But clearly this is an area where we've got some concerns. The FTC and the DOJ are focused on the consumer harm here, and we feel very strongly that that focus needs to continue into the future.

And then with regard to prescription drug prices, I touched on this earlier, but I think it's an important one to emphasize why consolidation. Health plans are striving to deliver value in the marketplace, and that means collaborating with providers on quality and negotiating on price. It's difficult to negotiate in a consolidated market on price. We have little leverage.

And it's the same situation, we find, when it comes to drug manufacturers that have a new single source drug with no competitors on the market. Plans are essentially price takers in that scenario, and it in turn drives up premiums.

I spoke earlier about Harvoni and the price tag on this new Hep-C drug. We have a statutory protection in the ACA. It's called the out of pocket maximum that limits the co-insurance individuals pay, and it's for all the co-insurance on the essential health benefits included in plans. And once they reach that out of pocket maximum, they don't pay any more co-insurance, whether it be in the form of a deductible, or a copay, or co-insurance.

So if you look at a $95,000 treatment as we have in the case of Harvoni, individuals in these new plans are paying at most six percent of the cost of that drug. Health plans are paying 94 percent. And for lower income individuals- say, an individual at 150 percent of the poverty level- we have cost sharing reductions, and so they're paying one percent of the cost of that very expensive medicine, and the health plans are paying for 99 percent.

So we have consumer protections on out of pocket spending, on cost sharing for prescription drugs and other services provided under the essential health benefits. What we don't have is statutory consumer protection on price. And as we continue to see these new breakthrough drugs released with astounding launch prices, that is going to drive up premiums. And so that's another area where we need to focus on solutions in terms of how we can achieve sustainable pricing, because innovation is critical. While at the same time, some of these prices that the manufacturers are charging are just out of this world, and so that's why we're very engaged in putting pressure on the drug manufacturers to step forward to be more reasonable in terms of their pricing decisions.

Just to wrap up, I do want to focus on next steps. Clearly, collaboration that health plans are doing with providers is very important. We're focusing on value and not volume through innovative benefit designs, whether it be patient centered medical homes, global budgets, bundled payments, and other innovations that drive value. And we will continue to do that in this exchange marketplace. Performance measurement alignment is also critical, and we're focused on consistent quality and outcome measures in exchange plans as well as across the service delivery sector. Whether it be a Medicare, Medicaid, and employer plans, it's very important to have some synergy and some alignment along the lines of these performance measures.

And transparency is critical. For consumers to make decisions based on quality and cost, they need meaningful, actionable data to enable them to pick the provider that provides the best quality care at the lowest price. And we also have to focus on removing barriers to quality care. For instance, in states that have specific restrictions on nurse practitioners and physician assistants, those ought to be lifted so that we have more availability in terms of primary care

needs of individuals in this new marketplace. And that's an important part of the value equation.

And then finally we need to improve the evidence base so that providers can make informed value-based decisions on which drug or device works most appropriately and is cost efficient, as well as which type of procedure is the least invasive and delivers the best outcome for consumers. So with that, I'll stop, and I look forward to our discussion afterward.

[APPLAUSE]

PETER MUCCHETTI: Thank you very much, Dan. Our next speaker is Keith Ericson, who comes to us from the Boston University School of Management. Keith, is there any truth to the rumor that you accepted our invitation just to get away from the snow up in Boston?

KEITH ERICSON: It's 20 degrees warmer here.

PETER MUCCHETTI: Excellent. Please take it away.

KEITH ERICSON: All right, so want to take you on a quick tour through what we know about consumer decision making on the health insurance exchanges. I'm going to highlight four key aspects. First, what we know about price sensitivity, and I'll show you that that varies by age, and that's really important for understanding the market. Second, the role of standardization, and consumers choosing plans, and then plan generosity they actually choose.

Third, dovetailing off of this morning's panel, I'll talk about networks, and how consumers value networks, and whether they can observe them. And finally, we'll think about the year to year transitions, renewal decisions, and the defaults that consumers face.

So we have two exchanges that we can actually learn from before the ACA. One is the Massachusetts Health Connector, which was established by state reform. It's very similar to the ACA. Prices are posted. There's no health rating guaranteed issue. And a few differences, but we can skip over those for today.

Medicare Part D is a health insurance exchange, a prescription drug insurance exchange, and that has, again, many similar features to the ACA exchanges. So we can look at both of these contexts to learn about consumer decision making. We could look at enrollment data from the ACA exchanges, except that it's not available, and that's a big barrier to research at the moment.

Alright, so start at price sensitivity. This is crucial because we need to know how consumers substitute amongst plans when insurers raise premiums. That's going to determine insurers' ability to charge markups over cost. That's going to determine price competition.

And so looking at the Massachusetts exchange, early work I did showed that there's a big gain on the exchange to being the cheapest plan as opposed to being just the second cheapest plan. And that's equivalent to a $300 to $500 premium decrease otherwise. And moving from third

cheapest to second cheapest by lowering your premium $500, well, that extra $2 it might take to make it the cheapest plan, that's a big deal in terms of getting market share.

This is consistent with some very price sensitive people in the market. It's also consistent with heuristics-like choose the cheapest plan. Other work has shown that the order in which things are listed- not just in health insurance- matters, and the cheapest plan is always listed first, so there's kind of an implicit endorsement of this being a good plan.

It also suggests that the competition at the bottom of the market- very price sensitive down there- is going to look very different than competition at the top end of the market where you might have a lot less price sensitivity and higher markups. I should note all these papers are available on my website, practicingeconomist.com.

The next feature of price sensitivity is looking at how it varies between individuals, and one very important fact is that it varies based on age. People over 45 for a split, they're about half as price sensitive as people under 45. Now we don't know exactly why that is. It could be that they're sicker. It's sure that they're richer, and that's going to have implications for their price sensitivity, and there's these preexisting relationships with their doctors. But it's going to have a result that insurers want to charge higher markups over cost for older people versus younger people.

But then we turn to the exchanges where we have these limits on age-based pricing. It links the prices of young people and old people. And the first order effect there is that's going to lead to big transfers away from young people towards older folks, who are sicker, but richer. We may or may not think that's a good policy goal.

But this paper I have with Amanda Starc shows that it's also going to have a big effect on pricing, and insurer profits, and market efficiency. So we estimate that this age-based pricing link leads to lower insurance profits by about $300 per person per year on the Massachusetts exchange. And the intuition of what's going on is insurers are setting price to the marginal consumer, the person who's affected by the price change, but because young people are very price sensitive- they're the people who are substituting. They're the people insurers are pricing towards. They're young and inexpensive, and that's going to push down prices.

We have these lower prices, so that's going to transfer money in part from insurers to consumers, but it's also going to change the relative prices of things and make the market more efficient. And we get an estimate that this raises consumer surplus by about $600 per person per year. You net out those two numbers, and you get a gain to market efficiency of about $300 per person per year. So this is very important, and thinking about age based pricing regulations turns out to have a big effect on the market.

Next thing I'm going to touch on is standardization. So consumers face a lot of choice. Arranging plans in tiers helps consumers compare these plans. We talked a little bit about that this morning. Note that some of these features- the tiering is not a neutral thing. Gold is an implicit recommendation that that's a better plan, and there is a recommendation contained

there. I think Eric Johnson and co-authors have some work showing that if you change the names of tiers, that has an impact on what consumers choose.

It's hard to compare though within a tier. So is a silver plan that has a $250 higher deductible, but five percent lower co-insurance, is that a better deal? I don't know. I'd have to run some numbers. Consumers probably don't know either, and that's going to make price shopping difficult within a tier.

So based on that, back in 2010 Massachusetts- very nice natural experiment- standardized cost sharing within tiers. So they created sub-tiers- bronze, low, medium, high, et cetera- and within each sub-tier, the cost sharing parameters- deductibles, co-insurance, et cetera- were standardized across all the different insurers. I'll show you what I mean in the next two slides.

So this is the pre-standardization decision set up. It looks kind of like Orbitz, or Kayak, or any kind of thing. There's a bunch of options listed. The prices vary, but if you look at the big mass of words on the right hand side, there's a lot of complicated copayment structure going on and hard to compare against plans within even a tier.

Post-standardization becomes much simpler. You have here these six different tiers. Within each tier, you have constant cost sharing parameters. And you can break it out, and you'll see that there are a bunch of different brands offering plans in each tier.

They vary based on price. They vary based on network and on brand, but they don't vary based on their cost sharing parameters. That enables consumers to shop on price and understand a little bit more what they're getting.

So we take a look and see what happened as a result of standardization, and so what we find is that there's a shift towards more generous plans as a result of the standardization in Massachusetts. Bronze plans went down by about five percentage points. High deductible plans dropped from about half the market to about 30 percent of the market. And in surveys about what was important to consumers, it finds that tier became more important in their decisions.

One surprise we found is that, despite people thinking one of the motivations behind this policy change was to increase price sensitivity, we find little evidence that it increased price sensitivity. You'll get an estimate of about zero with some confidence interval around that suggesting that it's not going to change markups very much in this market.

But we do see big winners and losers between different brands, major shift in brand choices. Neighborhood Health Plan, already the market leader post-standardization, jumped about 10 percentage points, and Fallon Health Plan was the biggest loser as a result of what the plans were induced to offer when they standardized these plans. And we estimate that this made consumers better off by the expanded choice that was offered to them as well as by the extended choice, was the primary aspect there.

A third point we're going to touch on is networks, how consumers value provider coverage networks. Very crucial. We had a whole panel about this this morning. It's hard to observe networks. It's hard for a researcher to observe networks. There's hospitals, many hospitals, and even more doctors. And until very recently, there's been no direct choice evidence about how consumers value health plan networks.

We have a lot of evidence on how the joint product of employers and consumers choose networks, but a direct consumer choice of networks is very limited. So some work by Anna Sinaiko, and Jon Gruber, and Robin McKnight as mentioned earlier today.

So I'm going to talk a little bit about the Massachusetts experience and talk about their networks. They had a very useful search tool, so in comparison to a lot of what was going on the ACA exchanges, it was actually relatively easy to determine whether a hospital was in the health plan's network during this time period, so that's good. And we're going to go ahead and use that tool to assess network breadth on the exchange.

We're going to measure network breadth in a few different ways, and the one I'll talk about today is just by the percent of all hospital admissions state-wide that would be covered by a given insurance network. So if you would have covered all the admissions because you have a very broad network, that's great. You get 100 percent. If you cover half of those admissions, 50 percent. We're going to then look at consumers' willingness to pay based on their plan choices and relate the two.

So this is the graphic that we come up with. We find that, indeed, consumers are willing to pay for broader networks. The x-axis on this graph is the percent of hospital admission events covered as we measure it. The y-axis is consumer willingness to pay as determined by their choices on the exchange relative to the most generous plan, Blue Cross. If you look at that, Blue Cross, Harvard, and Neighborhood Health Plan are the three most generous networks, and they are, indeed, the highest value in terms of consumers' perspective.

Down on the bottom, we have Tufts' narrow network plan, the narrowest network and the least valued by consumers. So it's a pretty close relationship between network breadth. It's going to vary by age. I'll come back to that point. And our estimates are if you would take the Blue Cross versus Tufts limited network plan that 30-year-olds would be willing to pay about $750 per year more for the broad network and 60-year-olds about $1,500 per year more for that broader network.

If you look at this graph closely, you'll note that it's hard to distinguish different networks within brand. So Fallon offers two different plans, direct and select. They have different generosities as we measure them, but our willingness to pay measures can't distinguish between the two. Consumers don't seem to be willing to pay more for the more generous Fallon plan, and if anything, the point estimate goes the opposite way that they actually might be willing to pay a little less for the more generous plan.

Of course, the confidence intervals overlap. So it looks like it's hard for consumers to distinguish networks within brand. We don't know much about that, and I think that's another step for research going forward.

We also don't know much about context where the network info is much more opaque. So I've been talking about hospital networks, which are at least countable. I can look at the 90 or 110 hospitals in Massachusetts. We don't know about doctor networks, and we don't know about other states where their network information was either wrong or very difficult to access.

Last point I'm going to touch on is the year to year renewal decision. A big feature of health plan markets is that there's inertia in plan choice. We know that from the employer market. We know that from Medicare Part D, and I'll talk a little bit here.

We also know that because of this inertia defaults. For people who aren't thinking active decisions, those matter a lot. So Medicare Part D has a very interesting program for low-income subsidy recipients. The policymakers were concerned that these folks wouldn't make an active choice when they were enrolled, that they got the subsidy. They wanted to get them into the program, and so there was initial assignment default. If you as an LIS, low-income subsidy recipient, didn't make an active choice, they assigned you to a random plan below the benchmark, and that's the zero point on that graph up there.

You see that default matters a lot, that plans right below the benchmark have much higher enrollment than plans right above the benchmark. It matters in year one, but if you look at and trace out the enrollment from year to year, that effect persists. So plans that were priced the same in year two, but one was below the benchmark in year one and one wasn't, that has a big effect on their year two enrollment. So these initial conditions matter. These defaults matter.

There's another aspect of defaults that's important, and that's the re-enrollment default. What happens when I show up in year two and I don't make a decision? I don't tell you what I want. Do I get dropped from coverage altogether? Do I get automatically re-enrolled in my same plan? Do I get switched to a different plan, the cheapest plan, the plan that would be free for me?

In Medicare Part D, low income subsidy recipients had this automatic switching default. If they didn't do anything and a firm raised its price, they'd be automatically switched to another plan that was below that benchmark. In contrast, high income enrollees, standard enrollees had to actively switch between brands. If they didn't do anything, they'd stay where they're at. That's going to have a big impact for price elasticity in later years. Low income subsidy recipients can be much more elastic around that benchmark point compared to high income enrollees.

Now, consumer decision making has consequences. For firms, I've been talking about markups. Here in the Medicare Part D market, what we can see is that insurers respond to inertia by using what I call invest then harvest pricing. Other work in the literature calls it bargains then rip offs, but that's a little pejorative, so I call it invest then harvest pricing.

So if they do offer low prices in early years, you get a base of enrollees, and Humana was a big practitioner of this strategy. In Medicare Part D, they explicitly said that's what they're doing. Once you've captured enrollees, you can raise prices on them in later years because it's costly for those enrollees to switch, and they might not be paying attention. And so that's what we see.

If you look at the distribution of prices in 2010, if you compare the distribution of prices for relatively new plans- that's that right there- to the distribution of prices for older plans, the older plan distribution, more expensive, shifted out. And if you do a regression or result comparing otherwise similar old versus new plans, older plans are about 20 percent more expensive than equivalent newly introduced plans. So we see that in part D, and that has some costs because there's this churn between plans. Some people are sticky, but some people make active decisions and move between plans. It bears some cost to do so, and that lowers the ongoing relationship in enrollees' health. So it's going to have big consequences for the ACA as we move forward, I think.

So to wrap up, we have health insurance exchanges offer consumers a lot more choice, but they offer them difficult choices. Health insurance design can help consumers. If you think about defaults, and recommendation, and standardization, consumers can compare plans. This is in some sense taking the role of what employers did outside of the exchange in terms of guiding their employees decisions. Looking forward, I think there's lot more work to be done on consumers and provider networks, including the disclosure of network information and how we can help consumers make better decisions there. Thank you.

[APPLAUSE]

NATALIE ROSENFELT: Thank you very much, Keith. Now we'll hear from Richard Scheffler about his work involving California's health insurance exchange. And thank you, Richard, for leaving the warm, sunny weather of California to be with us today.

RICHARD SCHEFFLER: Well, I was really pleased to get the invitation until I had to find a taxi this morning at six degrees Fahrenheit, and my overcoat still had moth balls on it from being in my basement. But it's really a delight to be here. It's a very impressive group and great meeting.

I'll also make one other observation. After me, you'll hear from Pinar, who's teaching at the University of Minnesota, but is a proud Berkeley graduate. I notice that all the Berkeley people are to the left of the podium here, and I wonder if that was just a random accident or you had some thoughts about that. If someone would load up my slides, I would like to get started on- maybe I do that. OK.

So that's who I am, and you've already seen that in the write up. Am I pressing this right?

KEITH ERICSON: Sometimes you do it a couple times.

RICHARD SCHEFFLER: I did, but I've already passed seven slides of mine by doing that. So this is the overview of what I'm going to talk about. California is unique, and I'm going to dig down into it briefly because it's what's called an active purchaser model. So six or seven states had exchanges, and rather than just let the insurers with some scrutiny list their prices and other information and have the consumers pick among them- which a lot of states did- California is an active purchaser model, which means that they helped select the insurance that was put on the exchanges and negotiated directly with them.

So this is a new model that there aren't a lot of markets where you have an advocate, so-called a big brother, who negotiates for you and does some decision making for the consumer before they get a chance to do their enrollment. So I'll tell you a little bit about the governance- very little- but to give you some idea, a little bit about how successful, and they were very successful in enrollment, a little bit about market share, what the model does, some premiums, and then some comments about narrow networks. The second part of my talk is some analytics that I was able to do with the premium data, and here it's initial, of course. We only have one year's worth of data, but I did find what I think you'll find quite interesting- relationships between the concentration of the provider and the insurer market and the variation in the premiums within California.

So Covered California has an independent entity, a sort of quasi-governmental state, a five member board- two appointed by the assembly, two by the state, one by the governor. The Secretary of Health was elected to chair it. It's financed by putting a tax or a fee, depending on what you want to call it, on the insurers. So it doesn't cost the taxpayers of California any money.

And essentially they decided- and the major thing they decided, and the important thing they decided was that California's health care plans listed on the exchanges would look like the Kaiser Small Group HMO. And so talking about making a big decision, that was a big decisions. So if they didn't have the benefit coverage and it looks like Kaiser, they were not going to let them on the exchange.

Dr. Emanuel said we're going to Kaiser-ize. the entire country. Well, in Covered California, Kaiser-ize the exchanges in California by that major decision. But they set up a website that actually worked. Not surprising. We're in the high tech part of the world. We've got a lot of Berkeley, Stanford graduates, and we can actually set up a website. And it worked pretty well. It's used for Medi-Cal, which I won't cover, but it's the same website- and also for the small business program as well.

So as I said, the active purchaser model- they put the criteria down for the insurers. They had 30 insurers that wanted in to the market. So that's the counterfactual. They picked 11. So the question is- and we'll never know the answer- would they have done better in premiums and other outcomes if they had let all 30 enter, assuming that they had some criteria for solvency and that kind of thing?

But they decided no. They were going to have 11. And they negotiated with them for premiums. Though, how they negotiated and the way they negotiate is still unknown, except

they did negotiate. And we know little about it, even in California, how that happened. They also were very afraid, even though they got 30 insurers initially, that they wouldn't get enough market entry. And so they guaranteed a lock in for three years of their plans that they selected.

They were also a bit worried, I think, about the issue of adverse selection plans- might cherry pick them, might skip the first year, because what you expect to happen in the first year is that sicker people on average are going to enroll and then come in the second year, and thinking at the risk adjusted mechanism isn't good enough to really pick up what they had done. Well in any event, they did do that and they limited the number of plans. This is now changing a little bit because in the recent updates I've got they're now allowing some insurers to come in in Medi-Cal and some insurers to come in in particular markets that have few plans. So this in fact is the changing.

So California was hugely successful, and quite frankly, without California, in my view there would be no Obamacare. About one out of seven enrollees in the program happen in California with only about ten percent of the country. So one of the things about the active purchaser model, when they own it, they promote it. They advertise it, and they may make sure it works, rather than just a website where things are posted.

So I won't go through all the data because I've done that already. Eleven plans and there's the tiers, which are not surprising. Most people went to a silver because that's where the subsidy was, and then bronze.

Believe it or not, they actually got President Obama- at least, someone in his office- to write an editorial in the San Francisco Chronicle and other papers- written by the president to help enroll people, to give them confidence in this. And of course, we were big supporters of Obama. We're a very blue state, so Affordable Care Act made a difference in San Francisco. It's a little story about how someone who was very old did better with insurance.

So the enrollments are doing well this year. Also, they've got about 425,000 more enrollees, and they expect the total to be about 1.7 million. That's a lot of people. And not on the slide, the subsidy, the federal money that went into subsidize the purchase of these plans, is estimated to be over $2 billion. So there's a lot of federal money in this subsidy in California and quite a huge- not unexpected, but when you add up the numbers, $2 billion is a lot of money even to Washington folks, I hope.

So a little bit about the market share. These are statewide numbers, and this is a bit dangerous. We heard some comments that California's market became more competitive. You might want to think about that a little bit more because these are market shares at the state level. This is pretty much the same data, but California sold in 19 different markets, and the market shares varied hugely across the state. So I'm not sure I'm convinced that it's either more competitive or less competitive.

I do know one thing, that the top four- the Anthem, Blue Shield, Health Net, and Kaiser- are 92 percent of the market statewide, but again, it varies hugely. So Chinese Community Health Plan is less than one percent, but it's 24 percent, 25 percent in Chinatown. So there's a lot of

variation in these numbers, and I think using statewide numbers to join a conclusion for in California when it was set up with markets- I think I'd have some caution there.

So what happened- and this is the point of my paper, which you're about to hear- is the premium increases- the weighted average was 4.2 percent, which is pretty good. The individual market projections trending up would have been twice that, more than twice that. So I do think that the exchange had an effect on the premium growth, but it was not uniform.

And I won't go through the entire pie chart, but you can see in some markets the increase was five percent to eight percent, and in some markets- in 13 percent of the markets, it was greater than eight percent. And in 16 percent of the markets, the decrease was zero. So there's a huge variation in the state according to market characteristics, which is the point of my paper. I'm going to be digging into that and give you some sense about why you've got these different premium increases in the markets in California.

So there was such an amazing panel this morning. I really learned a lot about networks, and I thought I knew a lot, but that was extraordinary. I won't go through all this in California, but if they had a big problem in California, it was the narrow network. And a lot of narrow networks were sold. And it turned out that if you went on a network, you'd find 25 percent to 40 percent of the doctors weren't actually in the network, or you couldn't find them.

And it's one thing to list them being in the network, it's another thing to know whether they're taking new patients or not. That wasn't necessarily listed, and so it was a big fiasco, so much so in California that the Department of Managed Care, the regulators got more than 100 complaints. There was no directory, and it was just a huge embarrassment for everybody in the state and in Covered California.

So I think we need to be more consumer friendly, and we've heard about that with the networks. Department of Managed Care now regulates them. Twenty-five percent of the doctors were listed in the plans, but they were not taking Covered California enrollees. So there was a lot of misinformation. It was really a fiasco.

It led to Governor Brown, who doesn't like to get into regulation, doesn't like to get into health care at all, signing a bill about the narrow networks submitting annual reports that would be reviewed and made public about their network to try to get some information out there and have them behave better. There's also a bunch of class action suits, private suits in court, about the narrow networks and how they misrepresented themselves to consumers. This is all going on in California. Now it's not like we didn't have narrow networks before and we didn't have some of these problems before, but basically in Covered California, since they were an active purchaser model, the consumer, I think, may have trusted them more to look into these networks than they would into other plans.

Anyhow, back to my particular study. With the approval of the journal editor, I'm able to show you some of the results from this paper that will be forthcoming in a few months. So what I did was some simple analytics. Again, it's only one year's worth of data. Lots of other things I'd like to include in the model, but there's only so much you can do with 19 data points. But I'm

going to look at the impact of medical group and hospital concentration, and then insurance concentration on the premiums.

I picked the premium rates for a silver and bronze plan. They represent 88 percent of the total enrollment. And I happened to pick a 40-year-old individual. It doesn't really matter which one you pick, but what's really the other point in California is all the copayments, deductibles for the plans are exactly the same.

So you have a really nice comparison. You got the age of the person. You've got their gender. You've got an exact plan, and they all have to look like Kaiser and Small Group. So it's a very nice homogeneous product to study across. We couldn't do that in the insurance industry before.

So the imagined market concentration, I used the standard HHIs, and I won't go through the definition. It's a slide for people who want to look at it later, or are not familiar with this. Everybody knows the FTC uses 2,500 as a guideline. One of the measures for a highly concentrated market- moderately concentrated is 1,500 to 2,500.

Let's just take a look at the premiums a little bit in California. These, I just selected ten of them. You can see the huge variation. Remember, it's a silver plan for the 40-year-old with the same copayment deductibles that looks like a Kaiser small group.

The variation is considerable. You see in northern California, it's 327. In San Francisco, 387. If you look at the northern California comment, before the HHIs for the hospital are 5,000. It's usually concentrated though- the medical group concentration is somewhat less.

If you looked at San Francisco, which is literally the highest, you can see that both markets, medical group and hospital group, were moderately concentrated. So you have to look at the interaction between these two, and then to the right, of course, is the health plan HHI. The premiums I'm looking at, by the way, are 2015, and the market share of the insurer is what they got in 2014, so it's not the same year. I won't go through the rest of it.

So here's a simple plot to give you a sense- and of course, there's a regression behind that. There's a regression behind everything economists do. And anyhow, along the vertical is the HHI. There's one outlier data point. Don't pay attention to that all the way to the right, but you can see the positive relationship.

The first time I ran this with these 19 data points, it was startling. The coefficient is highly significant t values, and the adjusted r squared is 0.6. That's enormous with one variable across these 19 markets, so much so I ran it three or four different times three or four different ways, and had two different research assistants run it so I made sure we got the same number. But anyhow, it is the case. So that's the impact of the medical group.

Hospital- so this is the same story line, and in this case, I'm looking at the hospital. And here, just one variable. The hospital explains even more of the variation. Almost 75 percent of the variation in the premium across the 19 markets can be explained by this one variable, and that

is really startling. So there's a lot of action in the underlining market power. Now, Covered California didn't create this. This is the market power that was there before and the provider community, but you can see what impact it made on the premiums.

So then lastly, in a regression model- and I won't go through all of this. There's an unadjusted and a wage adjusted model. I sent this around to my colleagues at Berkeley, and they said, well, what about the underlying cost differences in the 19 markets. Maybe that's explaining some of the variation. So the best I could do was put the underlying wage rates in those markets to adjust for costs and prices in those markets.

So let's look at the wage adjusted model, the r squared there. Now I added all three. I've got the health plan. I've got the medical group and the hospital. The health plan, of course, is the insurer. And what you see- I'm looking at the wage adjusted model. The t values for the hospital HHI is 3.55, very significant. Medical group, very significant. And not significant for the health plan.

So basically the variation in the market cost of the insurance comes primarily from the underlining concentration of the hospital- at least at the moment- and the medical group concentration in California. California has a huge amount of large medical groups, and they pretty much dominate what's going on.

So that's a big deal, and why is it a big deal? Because we're now spending public money- at least from federal money- in subsidizing this market, and we're paying premiums which are higher than they should be due to market concentration of providers and hospitals. It's very, very important.

So one of my six key takeaways, and I'll be done. This is to remind you again, the active purchaser model enrolled 1.3 million people. Just astounding what they did. And in many ways, I think it saved us money, because if we had had to have 30 insurers advertising with TV advertisements and all of that, that would have to be put into their premiums of course. And I think the cost would have even been higher, but they did a great job on media campaigns, outreach, and highly successful.

It's 1.7 million now in 2015, doing well. And I do believe they've had to increase the weighted average on the premium levels. 4.2 percent is about cost trend in California, which was more or less around five percent. In other words, the premiums went up, weighted average, about what overall cost went up in the state, so that's pretty good. And it was much less than they anticipated- 9.8 percent in the individual market.

So the California regulators now are really looking at these narrow networks very, very closely. Want to make sure they're accurate. I think they have to be updated. It's just not a once a year when the consumer makes a choice, but also when the consumer wants to use the network. And they need to be actively monitoring then the status, looking into that significance quite a bit. And I think we'll be getting reports at the end of the year about these narrow networks.

I think the statistically significant positive relationship between the market concentration in medical groups and hospitals in Covered California is important. Again, it's just one year. It'll be interesting to look at the delta and to see what happens with the rate of change in the premiums.

I think they did well, but it is possible that plans offered a lower premium to capture market share and get in- and then later on they planned to use their monopoly power to increase their rates as well. So Covered California is aware of that, and I think they're now allowing more market entry in the Medi-Cal market and also in the particular markets- five or six of them- that only had two or less plans. They are now allowing market entry into those plans to increase competition. So with that, I'll stop. And thank you very much.

[APPLAUSE]

PETER MUCCHETTI: Richard, thank you very much. I'm going to let you discuss later with Kevin whether it was California or Maine that has made the health insurance exchanges such a success. But for now, let's go to Pinar for our last presentation.

PINAR KARACA-MANDIC: Yeah, so thanks. It was great hearing about California's experience, and I guess my presentation is just a broader presentation on exchange models and how they worked, also just looking at the very first year. That's what we have. I would like to acknowledge my collaborators on this particular work. Kelly Krinn was a graduate student at the Humphrey School of Public Affairs when we started this work. And Lynn Blewett, who is the director of SHADAC and a professor in my division, Health Policy and Management, at the University of Minnesota. Let’s see-maybe I'll have Richard do this button thing.

We were talking about the marketplaces. This was the whole mark of the ACA, and over eight million individuals have enrolled during the open enrollment period. And I'm glad to hear what Cynthia said, that its numbers are higher this year as well.

So what we noticed also during the first year and now too is that there was significant variation in the way that the states have designed their exchanges and how they have implemented them. And in this presentation, I will highlight three of the points. One is with respect to exchange governance- there were differences- plan management strategy, as well as plan management authority.

With respect to the exchange governance, we know that the state-based exchanges- they basically had to build an exchange governance body to manage the marketplace. They had to provide an online portal for the consumers for enrollment, and as well as they had to raise revenue on their own to fund the marketplace. And they had to be very proactive in encouraging enrollment and making sure consumers learned and found out their questions and answers, and that they had the consumer assistance.

And then we had some states partner with the federal government- what we know as the state federal partnership model. And yet 27 states defaulted to the federally facilitated marketplace model.

So within the state-based marketplaces, there were differences in what I'm going to phrase as plan management strategy, and Richard already talked about the active purchaser model, but the more dominant model perhaps was the clearinghouse model in which all health plans that meet the required threshold, they were basically accepted to the marketplace. And then the active purchaser model, as Richard was saying- 11 states was the key.

And in the California case, states actually directly selected their insurers. They negotiated the premiums in the provider networks. Some states negotiated the number and benefits of the particular plan. So partnership marketplaces and the federally facilitated marketplaces, they all had the clearinghouse model by default.

One other thing that's kind of interesting is the plan management authorities. So in the state-based marketplaces and partnership models, state by default assumes the plan management authority. So in the case of state-based marketplaces, for example, they approve the qualified player plans, and they're proactive in contracting with plans.

In the federally facilitated marketplaces as well, we had this variant where we had some states which actually conducted the plan management- they certified the qualified health plans, for example- on behalf of the federal government. I call them FFMS, S for the state plan management abbreviation. And then in some of them, the federal government just conducted the plan management as well.

So that's sort of how the U.S. map looked like. We had about 10 states that were state-based marketplaces with active purchasing model, seven states that were state-based marketplaces with the clearinghouse model, seven state that were the partnership models, again, the clearinghouse model. And FFMS designed the federally facilitated marketplaces where the state assumed the plan management authority, eight of them. And then finally, what we call FFMS are the federally facilitated marketplaces where the federal government assumed a state plan management authority role.

Quite a bit of a variation, which raises important questions as to did the plan premiums, for example, vary across partnership, federal facilities, and governance models at the very top level. But also we can ask a question for the state-based marketplaces and say, did the state-based marketplaces with the active purchaser have different premiums than those that actually chose the clearinghouse model?

And then finally, we could actually also look at the federally facilitated marketplaces and ask the question- some of these had the state have the plan management authority. Did they differ from those that didn't?

So a lot of questions we can ask here in terms of these variations of the marketplace models. So we see our study as a first look at this implementation the very first year, and we assess premium differences, essentially, across these different marketplace models. And we look at plan type. We do stratified analyses by plan type- the bronze and the lower silver, the second lowest silver, and the gold. And we control for each set of characteristics at the rating area level

and the state level, so we are going to be thinking about these at the rating area level, the 501 or 502 rating areas.

So naturally our dependent variable was the premiums, and we collected this information through the state marketplace website and the HHS website. So we had premium and plan information for the lowest cost bronze, lowest cost silver, second lowest cost silver, and the lowest cost gold plans. We collected these premiums for a 29-year-old non-smoker individual.

In a secondary analysis, we utilized the health insurance exchange compare data set that was made available throughout our study by the Robert Wood Johnson Foundation. And that basically had information on all silver plans- their premiums and plan information. And they were available for a 27-year-old and a 50-year-old non-smoker individual.

So we had to control for a lot of things that could be related to the premiums at the rating area level at the baseline. If you can think of it as a proxy for the insurance market competition, we controlled for the number of participating insurance companies in the rating area. We also constructed measures of the hospital Herfindahl index if you want to see it as a control for a provider market structure also at the rating area.

We had demographic composition of the rating area- age, race, and ethnicity composition. We controlled for the uninsurance rate, unemployment rate, median household income- all those demand shifters for having health insurance that would be related to the premiums. We also controlled for population health. You would think that the health is related to how big their premiums will be, so we controlled for health status and some prevalence of diabetes, obesity, and per capita medical costs. These are all aggregated to the rating area level.

Of course, a bunch of factors at the state level will be also related to premiums- rate review authority, prior approval or not, Medicaid fee index as a proxy for physician fees, baseline average premium. So one thing you can say is, if premiums are high in one area, they'll likely be high in the next period. And so we controlled for pre-ACA individual market premiums, whether the state recommended an essential health benefit benchmark beyond the ACA default, thinking that premiums will be higher if there is a higher benefit, and whether the state expanded Medicaid under the ACA Medicaid option. So these are some of the key factors that we controlled for.

So in one analysis, we basically examined a premium of these low cost plans with the unit of analysis being a plan type in each rating area. In the second analysis, we examined the premiums of all silver plans using the HIX compare database.

Basically our key independent variables will be compared across was these marketplace models- SBM-A for active purchasers state-based marketplaces, SBM-C for clearinghouse state-based marketplaces, the partnership marketplaces, FFMS, the federally facilitated with states conducting the plan management authority, and then the FFMs. We also controlled for benefit design to our best ability as that's related to premiums as well- the copay, deductible, out of pocket max.

This is just basics, basic descriptions of our findings. So we see that number of insurers is about four to five insurers in state-based marketplaces. Lower numbers in federally facilitated exchanges. Most of our rating areas under the state-based marketplaces are in a state with the Medicaid expansion. And in particular with the active purchaser states, they are in a state for their recommended EHP above and beyond what's prescribed by the ACA.

Most of the demographics actually were fairly similar across the rating areas. Some that I want to highlight- slightly lower prevalence of obesity in state-based marketplaces, and slightly lower prevalence of diabetes and slightly higher prevalence of the uninsured in the federally facilitated marketplaces.

So again, this is basically our model predictions from our regression models that are adjusted for all those covariates I mentioned. If you look at the second row, this is the state-based marketplaces with the clearinghouse model- they do have lower premiums across the board. So that's our reference category, and they have significantly lower premiums compared to all different types of models that we've examined. If you want to compare just among the state-based marketplaces, as you can see here, we find that state-based marketplaces with the clearinghouse model- across the board again of all metal types- they have lower premiums compared to the state-based marketplaces with the active purchaser model.

Another interesting comparison you can do is compare the state-based marketplace with clearinghouse to the partnership models and the federally facilitated exchange models where the state is conducting the plan management. In all three cases, you have a clearinghouse model. In all three cases, the state is conducting the plan management. So in some sense, this is giving us a comparison always at the state-based governance, partnership governance, versus the federally facilitated governance. And here we see, again, the state-based marketplace governance achieved lower premiums. We didn't see differences between the market partnership or the federally facilitated models.

And here you can also then say among the federally facilitated models, did it matter whether the state conducted the plan management or not? And our answer to that is no. Those premiums are very similar to each other and not significantly different from each other.

Fairly similar results for the 27-year-olds and the 50-year-olds looking at all silver plans, except for the 50-year-olds. We couldn't distinguish between the active purchaser versus the clearinghouse models. And again, the federally facilitated marketplaces, state authority on plan management versus not didn't matter.

So to conclude, this is a first look at the ACA marketplace model, so there's a lot to look for and sort of follow up. Our key result is that these SBMs with clearinghouse had the lowest premiums, so now you can ask whether does this mean that the clearinghouse encourages more competition relative to an active purchaser model. That's an important question, but it could go probably both ways.

So one idea is that the higher the state engagement in the active purchaser model, you would think that the state will have a better check on the premiums. They're monitoring premiums, market shares. They're improving negotiations. They are more active in getting new insurers in the market. They are improving enrollment, and they can take measures to avoid adverse selection.

But on the other hand, you may think that being an active purchaser, being much more active means that you have additional certification requirements, and additional certification criteria, additional requirements on the product and the plan choice, additional requirements on tailoring those policies to the state needs. And all of these could come with additional administrative expenses. So I think that's something to probably keep an eye on, or we could just be that it's just too early for active purchaser model to be active. We know that there were a lot of staffing and there were a lot of time commitments and limitations in the first year of the exchanges, so maybe the priority could not be spent as much on the active purchasing.

And there was a lot of uncertainty on who was going to enroll, what they'll look like, how much we're going to spend on them, so that could have affected the insurer entry and exit in pricing, so there are a lot of caveats, but going forward this does provide an important benchmark. Thank you.

[APPLAUSE]

NATALIE ROSENFELT: Thank you, Pinar. I'd like to first thank all of the panelists for their very thoughtful and insightful presentations, and now we're going to have some time for questions and answers. If the panelists could please turn your name card vertically or signal us if you'd like to speak, that would be very helpful. Of course, we're going to be accepting questions from the audience, so if you have questions, please pass them to the conference staff that I see walking around the room right now. And while the questions are making their way up to us, I would like to ask the first question.

We've heard from some panelists today about the new entry we've seen on the exchanges, and we've also heard about some plans exiting the market. I wanted to first ask, what types of entrants have been most successful on the exchanges and are we likely to see going forward? And also, what can we learn from episodes of insurers exiting the market? Maybe Cynthia, if you could start and then others could chime in.

CYNTHIA COX: Sure. So since we don't have plan level enrollment information, it's difficult to say which new entrants are the most successful. But as I mentioned in my presentation, most people are enrolling in one of the two lowest cost silver or bronze plans. So it's likely that, if a new entrant is able to come into the market and offer one of those plans that they will be successful.

So an example of that is United Health. As many of you may know, they did not participate in many states in which they were the largest insurer in 2014, and then they entered into the exchange in 2015 in a number of states. And in many cases, they were able to price in a way

where they ended up being one of the lowest cost silver or bronze plans. So if last year is any indication, they're likely to be successful with that strategy.

And then as far as exits, as I mentioned, PreferredOne is probably one of the most notable exits from the market. This is, as you may remember, the relatively small plan from Minnesota that within the first couple of months of the exchange became the largest exchange plan in 2014, and then they exited the market for 2015. So part of this was probably that they priced too low and did not have enough capital to continue to sustain into the 2015 year on the exchange.

And in leaving the exchange market, they most likely took a lot of consumers with them off of the exchange because people were re-enrolled into the same plan in many cases, even though they were being put into an off-exchange plan and may have lost their subsidies. So this has the potential to cause a lot of disruption in the market in Minnesota. And I think the lesson from this for states is that either through selective contacting or rate review programs, there may be times when the state has to push back on an insurer to charge a higher premium, even though that might seem counterintuitive. But it's important for the stability of the market.

But at the same time, I would just again say that this was the first year, and so not only insurers, but also regulators had a hard time knowing what an appropriate premium was for 2014, so it's really just a lesson for going forward that hopefully there will be- we won't see as many swings in insurer participation and in pricing going forward.

PETER MUCCHETTI: Thank you. Kevin, let me throw out a question for you, and if the other panelists also have thoughts on this issue, we'd be very interested in hearing them. I think you talked about one of the challenges for a new insurer is the need to contract with providers at rates that are competitive with what other insurers in the market have. As a company that had no enrollees in 2013, how did you deal with that challenge?

KEVIN LEWIS: Thanks, Peter. I think as Pinar and Richard have pointed out, it's very market specific and issuer specific, so we dealt with it certainly through the relationships that we already had. We certainly used all of those relationships, had built up a solid basis of trust, and talked with providers, elicited from them what they wanted to see out of the relationship. So we didn't rush to a negotiation saying, give us your best rate, but rather, how do you see this playing out? We're a new entrant to the market. Here's what we want to accomplish. And produced a very constructive result in terms of us having rates that did allow us to compete on price from the very beginning.

NATALIE ROSENFELT: I wanted to ask a question about consumer decision making on the exchanges. Keith talked about how the standardization of plans on the exchanges can help consumers choose more generous plans, but it also seems that standardization of plans can limit an insurer's ability to offer new innovative products. So how should we look at these competing considerations? Maybe both Keith and Dan would have comments on this.

KEITH ERICSON: Sure. So in standardization, there's definitely a tradeoff. You're going to reduce product variety in order to enable comparison. So that's kind of the tradeoff you're

making, and estimating the right point of that tradeoff is important, and in our context it seems like- actually, one interesting thing about our context is standardization actually expanded the range of choice for consumers in Massachusetts. So beforehand you had a lot of different plans offering idiosyncratic plan designs, and now with standardization all the plans have to offer each of these seven different plan designs.

So there's actually more choice in one way in the sense of plan design versus- and insurer combinations post-standardization than pre-standardization. But in thinking about the dynamic aspect of that- those are those plan designs that were at that one point in time- we want to experiment and come up with new plan designs. And thinking forward in later- I forget what year they introduced it- but they started having an experimental plan design option. So you'd have the standardized plans, but then firms could offer additional plans off of the standardized menu that were kind of different and experimental in various ways. So that's kind of one way to manage that kind of experimentation development.

DAN DURHAM: And I'd just add that the statute provides a significant amount of standardization, particularly when you look at the pre-reform market. So in the new marketplace, we have the four metal tiers, we have the essential health benefit. Again, those are things that are much more standardized than we had previously.

And so I think there's a tradeoff here. Adding more standardization, you reduce consumer choice, and I'll go back to the importance of consumer choice in a competitive marketplace. We feel that's very important. And the kind of innovative benefit designs, particularly now that plans and providers are really focused on value, moving beyond a fee for volume to a fee for performance type of health care- it's important to allow those kind of innovative plan designs into the marketplace so we can really drive that value proposition.

PETER MUCCHETTI: Richard, a question for you about one of your slides from the audience. The question is, was it your findings that it was hospital and health plan concentration that resulted in higher premiums or hospital and medical group concentration that had that effect?

RICHARD SCHEFFLER: I should've done a better job in my slides. But essentially the result was it's the medical group concentration and the hospital concentration, not the insurance concentration, that was correlated- and I emphasize correlated- with higher premiums. So hopefully I'm clearer now.

And since I have the floor about this, it's going to be interesting to see if that continues because there are a couple of different hypotheses about the insurance side of the market. One obvious one is to let more insurers in, and essentially that is going to happen.

There's also some literature and argument for not letting more insurers in and having the insurance side of it being bigger and more concentrated when you have a market that's heavily concentrated with hospitals and medical groups. So the big concentration can knock heads and presumably get a lower premium. So some of it is there are some examples of this

kind of thing happening. There's a big knocking heads in the San Francisco Bay Area where I live.

And it was actually my insurance plan, where Blue Shield and Sutter, which is the big mega hospital chain- highly concentrated- decided that they couldn't sign a contract. I know for anybody who had Blue Shield- and I have them as part of my university benefits as the MSO- would not be able to use a Sutter hospital. Well, if you can't use a Sutter hospital, it's very hard to find a hospital for a lot of people. And they sent out notices saying essentially that was the case.

And it went to court, and the Sutter people said we have an agreement that if we can agree it goes to binding arbitration. But more or less the judge who decided this said antitrust behavior in markets is not covered by binding arbitration, so you guys figure this out. And two months later they came up with some deal for a year or two, but we still don't know what that deal is.

And we're not sure who blinked. Was it the insurer that actually couldn't sell insurance without having Sutter? Or was it Sutter who wanted the patients who had the insurance in their market? So there is some issue about bigness in the insurance market, but I think the general sense is that a lot of these markets- in Covered California, they're letting new insurers in markets that have two or less plans to instill more competition.

But the other markets they're leaving pretty concentrated, and I believe they'll get more concentrated. In year two, the big four- statewide, again- has 92 percent of the market. So we'll see how this plays out.

NATALIE ROSENFELT: I wanted to ask a question about future data and research in this area. What kind of data do academics and policy experts need access to for future research on the exchanges, and do panelists have thoughts about any future work, empirical or otherwise, that might be useful in understanding competition on the exchanges? Maybe Pinar, if you want to start and then Cynthia. And if any others have comments, that would be great.

PINAR KARACA-MANDIC: Yeah, I mean I think we could do a laundry list here, all the data we could get. But I mean I think access to exchange in marketplace data not just for federal exchanges, but also state-based exchanges is very useful to track insurer entry and exits, and at the plan level, enrollment data to monitor market shares- from a researcher point of view, is very, very useful.

Another thing is I use the NAIC data a lot in my research. That is basically insurer filings on premiums, and claims, and member years, and at the state year level, separately for the individual market. In the small group market, it would be really good to have data like that separated out in exchange and out of exchange, even dividing the individual market to be able to figure out how the exchange is doing with respect to the rest of the individual market.

A lot of us use survey data like the ACS and the CPS to have some very good questions there on where the individuals purchase their policy in and out of the exchange. Longitudinal data on employers and employer offerings of health insurance, because I think that's going to be a

really difficult question going forward. We know that employer sponsored insurance rates are going down, especially for the small and midsize firms. But how do we distinguish these trends going forward as to those that are related to the ACA versus not is going to be really important. And I think longitudinal data is very important.

RICHARD SCHEFFLER: I agree with everything Pinar said. The two things that I would emphasize is I think we need health outcome data more than anything else, because the whole point of providing health care is to get improved outcomes. And I think we need to know that to justify the plan in the long run.

The particular kind of data that I'm especially interested in in the networks is the kind of data that would allow me to look inside the provider networks and see what the quality is. I'm already guessing that the insurer pretty much picked the lower cost providers. No doubt about that.

But are they lower cost and also lower quality? Are they lower cost and higher quality? In health care, we're not particularly sure. There isn't a generally good relationship between price and quality. But I think I'd like to have that data to look at it because I think I could take a crack at it and really then tell the consumer if you're picking that network, you're getting a better price, but the quality is C, rather A or B. So I really think that would be enormously important information to have.

NATALIE ROSENFELT: Cynthia, did you want to respond?

CYNTHIA COX: My Berkeley colleagues are obviously very intelligent and covered basically everything I was going to say, but I would just emphasize the state-based exchange data. That seems like something that could be included in the public use files, and I spent more of my summer than I would like to admit compiling that data set myself, so I'm sure a lot of other people have been through that. And the NAIC data especially seems like an easy place to add that, and I was a little surprised that it hasn't been added already.

DAN DURHAM: If I could just add to Richard's point on quality, the McKinsey study that I had talked about earlier in my presentation did look at hospital quality performance metrics across all 501 rating areas. And they looked at it for the broad networks, narrow, and ultra-narrow networks, and they didn't find any discernible difference in terms of quality between the narrow and the broad networks, but quality is important. I think more information on that would be important going forward, as well as more data on the impact of provider consolidation on premium price.

Richard's study looks very good. I look forward to reading that when it's published. Similar to the Scott Thompson- sorry about that, my phone’s talking to me- study from Bates White that had similar conclusions in California. But doing studies like that in other states or more nationally just to see the impact would be important research as well.

PETER MUCCHETTI: And let me squeeze in one more question from our audience before we break to go to the networking reception. An audience member asks, is there a risk that insurers

in the early years of the exchanges are pricing low so that they can gain a large share of the market, and then when there are fewer competitors, then they raise prices?

KEITH ERICSON: I think we should expect exactly that. There's a very sound economic logic to why you should do that as an insurer if you're thinking smart and strategically about how consumers make decisions. And we saw it exactly happen in the Medicare Part D market. So we saw a 20 percent increase over five years for a pretty much identical plan, so we should expect to see that going forward in the exchanges. And that's one thing I guess- if you look at the current premiums, they might actually be below what you would think of as the long run steady state premiums as firms are competing heavily in these early years to attract people when they are most active making their decisions.

PETER MUCCHETTI: Richard?

RICHARD SCHEFFLER: Well I think that's one of the reasons that Covered California locked in- or at least locked in with a few exceptions, and they're now using those exceptions. The insurers, the 11 of them that they picked- one dropped out for administrative reasons. They now have ten. To avoid that they said, if you want in, get in now because you may not be able to get in until year four.

Now they're changing that a little bit and letting some of them in to markets that only have one or two players. So they can change that. So I think Pinar's point about the active purchaser now getting active and getting smart is, in fact, starting to happen. The focus in California was get people enrolled. That's where their energy and their efforts went, and now they're thinking about how this market is going to operate, and I think they're making some moves in the positive direction.

A final thought I'd leave with you is a puzzle in this whole competitive insurance market and that has to do with consumer choice that Keith talked about a lot. And there's this literature I know he's aware of in behavioral economics which says that too much choices leads to bad choice- that if you give the consumer more than a limited number of choices- 20 to 30 plans- they don't go through it. They pick the first name they know, and they make bad choices. And so you need fewer choices.

Now, is fewer choices three choices, four choices, five choices? We don't really know. So the question is the tradeoff between what consumer economics tells us- behavioral economics about consumer choice and number of plans, and also balancing that against the competitive effect, which I strongly believe in of having more plans. I think figuring out that balance and getting those two literatures to match out is something that I know my doctoral students at Berkeley are going to be working on.

PETER MUCCHETTI: Great. Pinar?

PINAR KARACA-MANDIC: I sympathize with the question, actually, in a different way. The PreferredOne example you gave- if you enter- if you price very low and if you enter with the uncertainty there is in the market- there is a lot of uncertainty. We knew nothing about

really the expenditure variation of the newly enrolled. If you enter and then you have to exit because you cannot take it. I don't know.

I'm not an insurance company person, but what does that do to you in the market- in the other market segments you are in? Does it leave a bad mark? And I also wanted to ask Keith, what do you think about the consumer inertia? Do you think it will be fairly similar to what we observed in Medicare Part D? This is a very new market. Very new market. Very dynamic people. Very cost sensitive people.

KEITH ERICSON: So there are clearly a lot of differences between elderly seniors buying prescription drugs and young people buying health insurance products on the exchange, but I actually think some of the factors go to having more inertia. If you think about networks are

pretty broad in terms of what drugs are covered, and it's much easier to switch a drug than to, say, switch your hospital or doctor. And so the switching costs are probably larger for health insurance than prescription drug insurance, which might mean people are even more sticky.

Leaving Kaiser might be very difficult because you have to find a whole new suite of providers, whereas switching from Humana to United's prescription drug plan might be relatively easy. Maybe update one generic drug versus another generic drug. So I actually think the potential for this invest then harvest pricing pattern is pretty large there.

PINAR KARACA-MANDIC: I think it will be really useful to know what people spent on in the first year of the markets. If you only think that a lot of the young and the healthy enrolled, then they are less connected to a network. They are less connected to a provider network. You can argue they can switch more easily.

KEITH ERICSON: If you're young and healthy, that's one way you can use the networks as a selection tool, in fact.

PETER MUCCHETTI: I'd like to thank the audience for your very thoughtful questions and thank our panelists for their wonderful answers.

[APPLAUSE]

Two announcements. We are having a networking reception right now. We hope that you will join us, and also please remember to return your lanyards on your way out. Thank you very much.

[END OF WORKSHOP, DAY 1]