

**One-day Conference: “Delivery Systems Matter! Improving Quality and Efficiency in Health Care”: Lessons from and Opportunities for integrated Delivery System
03/17/04**

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Male Voice: Thank you George and if I could invite the next panel to the stage. I wanted to also note that kaisernetwork.org is taping this session and it will be available for those of you who want to see sessions you've missed or would recommend it to others and the discussion that we just started and some of the questions will continue throughout the day so I expect that we'll get back to a number of these. We're going to shift to Lessons from and Opportunities for Integrated Delivery Systems and our moderator is Jamie Robinson, Professor of Health Economics and chair of the division of health policy and management, and an astute observer of the changing scene. Jamie.

Jamie Robinson: Thank you. The questions that followed up the last panel were a perfect setup for where we're going and we in turn, this panel will be setting up the discussion for the afternoon because clearly the right question to pose to all of this is the American question, which is if you're so smart, how come you ain't rich, okay. If this is all such a great

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

idea, how come America hasn't embraced it, well, maybe America is dumb or maybe there is a little more to this. So what we are going to do in the next hour is consider directly these questions about what have been some of the success factors and what have been some of the challenges that have faced group practice organized delivery system and so why they have both been very successful in some locations and some forms of organizations in some instances and have been miserable failures in other context, in other times. I am going to share a few questions or comments of my own in that but I am first going to start by introducing the panel that we've got today which are fortunately the 2 people in this country that are going to answer all these questions for us. The first is Bob Margolis, Dr. Marolis is an internist, hematologist I believe, and for our purposes most importantly the founder, CEO, and managing partner of HealthCare Partners Medical Group which is a large multi specialty group practice in the Los Angeles area with over 300 physicians in the

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

salariied component and another 1,000 as part of a rather large IPA division as well. It's mostly prepaid group practice yet it also gets, also treats patients through PPO's and other fee for service arrangements as well. Bob is a leader in the physician community nationally also past president of the Unified Medical Group Association, the American Medical Group Association, on the NCQA board and he does a lot of other fun stuff. The second person is of course, (inaudible) known to all of you as the pioneer in the principals of managed competition which have really lead both the intellectual discussion and many of the marketplace experimental, among purchasers as well as among delivery systems over the past 30 years, Alan, needs no introduction of course, but for those of you that, he is for many years a distinguished professor at Stanford university, which for those of you that don't know, that's a college about 50 miles south of Berkley, okay. So, what we want to do, they're going to do most of the talking here, I just want to point out some of

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

the very obvious facts, that it is, it can not but strike as someone ironic that as the institute of medicine has shown the light and caused all of us to think coherently about systems of care and what as the needed foundation or chase for new high quality, high performance health care system precisely at that moment, that the many of the physicians organizations and different types of delivery systems have gone through so much turmoil, if you have been watching what has been going on in the past 5 years in the marketplace at all, you will be quite aware of what I am talking about. The number of organizations, which have either shrunk, or disappeared all together, has been frightening. The number of these were of course, just hastily thrown together organizations that didn't deserve the way the name of a physician organization but some of them have been very good organizations which in their locals, were strong leaders, I'm thinking of the Thomas Davis Clinic in Tuscon, I'm thinking of the Nall Clinic in Charlotte, North

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Carolina, I'm thinking of the Permanente Clinics in North Carolina and the northeast, I'm thinking of the, a variety of smaller entities that have, that are no longer with us in various different ways. So, what we have to have in our heads is if the, if group practice, physician organizations so strong, first of all, why have some of these failed, why hasn't this worked across the country and in answer to that question we want to keep in mind the fact that there's not going to be easy answers to this because if you look at the problems we've faced, they aren't of just one type, they're not just in one geographic area for example. It's not like it's just in the ones in California or where there's a lot of group practice or just in New York where there is very little group practice, it's not just multi specialty groups, but also single specialty groups, it's not just that the IPA's have had problems and the groups have been strong, we've had integrated groups have problems and we've had IPA's have had problems. It's not just which sponsor,

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

there's some of the entities that went down that were sponsored by (inaudible) Management Companies but some of them that have had troubles were sponsored by hospitals, some of them were sponsored by HMO's such as AETNA and Cigna with their staff model components and some of them were sponsored by Kaiser Permanente in various markets such as Kansas City. So, when you think about the challenges, you've got to be able to think across this country. Of course the flip of that, the second point is that during that exact same period, there's been a variety of successes crossing all of those regions, and all of those models. We can think of successful group practices in a variety of different geographies, a variety of different sizes, we can think of very successful IPA's as well as group practices, we can think of very successful plans linked to health plans as well as groups linked to health plans as well as independent etc. So, what I want to do then is turn this over, starting off, we'll start with Bob, who is the living embodiment of group practice actually having

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

founded HealthCare partners bring, starting from just a handful of doctors growing it through both organically and through merges with other medical groups in the Los Angeles area to it's current size as one of the leading physician entity in the Los Angeles county. So, Bob.

Bob Margolis: Thank you Jamie, pleasure to be here. I noted, not in the introduction was I did all my training at Duke, Alan is from Stanford. This is March Madness and at the end of the day we will see how this turns out. I hope you'll excuse a little of enthusiasm that I feel for this subject, those of us that spend much to much time on the road on panels such as this as seen ourselves just as involved for years debating whether a \$5 co-payment was better than a small coinsurance or a benefit design that included or excluded mental health was going to drive the American health care system to a ultimately excellent outcome and I just want to congratulate Jay and the other folks that put this together, I really feel excited, we're finally talking about the delivery system where

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

patients actually receive care and my personal belief is if we as folks that work in this industry and policy makers that need to understand health care in order to improve our system finally focus on delivery system and recognize the delivery system matters, we'll get a whole lot further in this conversation that we will around consumer directed health care conversations.

Not that those are unimportant, not that it's not critically important that we all be transparent in our results and that the consumer ultimately has good information on which to make choices because to answer an earlier question about what's negative about HMO's I think that the question really could have been answered or perhaps, a different answer might have been that the HMO bashing occurred because employers forced people into HMO's as opposed to a system in which you, consumers get good information about the cost difference and the quality difference and the service differences among the different choices that oppose and they make voluntary and explicit choices about where

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

and how they want to receive their healthcare and if we can move into that direction based on a platform of a delivery system of excellence it needs to be refined and improved and developed but which I believe, as Jay and others, comes from a basis of organized systems of care, I think we can move away from that tarnished period of the '80's and '90's, anti-managed care, anti-HMO, into an era where Americans can actually chose healthcare based on service, quality, and other measurable outcomes. So, I am enthusiastic, I'm actually rather optimistic which is unusual in these forums as well so I'll try to explain in a few minutes why. Let me just give you the bottom line from my perspective, we're starting on a road but until we build what I would call a consistent business case for quality, for efficiency, for effectiveness, for timeliness, for patients (inaudible), for equity, until we build that business case which is in many regards a financial business case, we won't get their. But we are on that way and I'd like to explain a little bit of

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

that, of how we are on that path. But first let me start by saying I'm honored to be between to incredibly well known and world class economists who've spent their entire careers trying to prove in theory what all of us know already exists in reality. And they've done a hell of a job trying to prove it too. So, let me just start before I get into some group slides here with a short and true story. It's a friend of a friend, so some of the facts might be off, but I think in generally it's true and here we have, in Los Angeles, we have an attractive 30ish year old female working in the entertainment industry as many folks out there do, that's strike one. She had full PPO coverage, that was strike two, and she was seeking care in Beverly Hills, strike three. She complained of several weeks of headaches and stuffed head and saw her family practitioner, who after a brief workup quickly referred her to an allergist who did a bunch of desensitization tests, a variety of x-rays and actually ordered a sinus MRI. None of that proved very fruitful

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

and so she was then sent to an EMT physician who spoke to her repeatedly and offered a variety of medications that didn't seem to help. Her headaches had persisted, this was after about 3 weeks, she then went on to a neurologist who felt that the first MRI was ineffective and ordered a second MRI. Most of these physicians had several follow up visits and waived the coinsurance because it was getting expensive for her so out of pocket was essentially nothing and at the end of about 6 weeks, if you add it up her ELB she had incurred about \$10,500 or so of expenses and she was engaged to a good friend of mine who offered up some of generic Sudafed which seemed to solve the problems and that generic prescription, I would say was priceless. So, that's unfortunately the disintegrated American system of care for too many Americans and, I think we all know that based on those kinds of perhaps extreme examples that the delivery system really does matter. In my view there is really two ways to influence the delivery system, one is to regulate it and create rules around

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

it, I would posit that would not be a successful way to get the delivery system organized and the other is to create incentives or behaviors to move the delivery system in the right direction and I would posit that that not only can but will be effective ultimately in moving us towards the vision of the IOM studies. So, let's take a quick vision, a quick journey about organized systems of care, I differ a bit from Jay in that my environment, my world, involves a lot of IPA and network growth and development. Molded on as it is as Jamie described and I will (inaudible) brief second, our organization, a large multi specialty for medical group which we call our RND arm for the IPA and in such my enthusiasm and actually the role we had today was how can we replicate some of the successes that organized systems of care or organized multi-specialty groups have done across the country and I didn't really honestly believe that we can do it despite Jay's pretty map, where was Kaiser, Colorado on their, it was sort of missing, but doesn't that qualify as an organized

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

group, Jay? Colorado was vacant on that map, but I don't believe we can fill up the entire map with large organized multi specialty medical groups but I believe that we can create incentives that link physicians together with the technology and the clinical decision support that is necessary to deliver a better quality of care across America and in every community across America there are physicians that can be linked into teams and to care giving coordinated teams of care that can make a difference. So, let's look a little brief journey on how OSC's work. I probably should have asked how this works but let me try that here. OK good. Very briefly Healthcare Partners, a mixed group, an IPA in southern California, 25,000 of our physicians are in our IPA network, 400 of our physicians are full time employed and we take care of a population of about a half a million patients. Albeit we are 90% globally capitated, that means that we do take full risk for everything that we do, very different than most of America admittedly and very similar to the way

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Permanent works. Why did organized systems of care, OSC's, stands for organized systems of care work somewhat better in California than they did in others, that's not to exclude George, for instance, worked beautifully in Minneapolis as well, mostly because populations were being prepaid and the incentives and capations helped to drive the development and the predominance of organized systems of care. The outcome of that was that California has and still has today, the lowest commercial HMO premiums, commercial premiums for insurance in the country, which is tied directly to the utilization patterns of these organized systems of care. It actually turns out in California that there's, the Department of Managed Care measures organizations based on whether they take capitalational risk and there is 180 risk bearing organizations in the state of California at this time, so organized systems of care actually do predominate across populations in even rural areas of the state. The OSC's developed in specific response to these market forces mainly

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

capitation and more lately, as I'll describe in a little bit, the activity around paying for performance and all of the systems of care that, and care management and registry and other processes that Steve Shortell and Larry Casillino pointed out, are very effective ways of making sure that outcomes can be more predictably managed and monitored. One of the things that has worked, and let me just spend a couple of moments on it, is that California, I believe, leads the way in pay for performance initiative and I'll (inaudible) at the end that paying for outcomes not necessarily specific (inaudible) quality parameters but paying for outcomes is really the nidus of the change that needs to occur in the American health care financing system in order to create organized systems of care and to create the kinds of outcomes that we want so their very active work tied to a true business case for quality, in California, is just an example. There is about \$150-200 million being paid out in 2004 to these organized groups based on specific criteria of

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

measurable quality improvement, that's by scale hundred's and hundreds of times larger than even with the excellence project and some of the other projects across the country relative to the amount of money focused on specific organizations to improve quality and measurable outcomes. It's really a program in it's infancy and during the discussion, I'd be happy to talk more about it but I think it's an exciting tipping point that's changing and moving towards a business taste for quality that's been lacking for so long in American health care. Successful organized systems and this is a little bit repetitive from some of Jay's is that they are self selective, physicians that choose to work in teams and work in organized systems and coordinated systems are different than physicians that say I want to be a purely autonomist captain of my ship. Now, in an IPA by definition, the I stands for independent, so we're dealing with thousands of captains of his or hers ships that have for reasons specific to the financing of health care, the access of

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

patients, and now to the performance measurements, have now been able to be molded away from pure autonomy to recognizing that there is a benefit, a specific benefit to coordination and teamwork, as a methodology of getting number one access to patients and number two payment for performance. So, I think, that again, I would call that an early but significant tipping point, there's clearly group think that goes on within physician organizations relative to hallway consultations, working with your partners, and more specifically the coordination of teams, which is very, very significant and predominant in organized groups. We talked about capitation incentives but those capitation incentives turn into specific measurable returns on investments for the things that just do not occur in disaggregated systems of care and for that matter, in many deeper service multi specialty groups such as, significant investments in care management, disease state management, the technology info structure and connectivity, the hospitalist programs and urgent

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

care programs to name a few. Our group for instance has 26 hospitals across southern California that we admit out patients to and we have 70 full time hospitalists, we get paid nothing for hospitalist care in a capitated system but the return on investment is profound because we take risk for hospital utilization so just a quick and dirty example of how RLI works in a capitated system. Vertical and our horizontal strategic relationships meaning that we have very significant critical (inaudible) the integration of payer across boundaries, we have very significant requirements that we relate to nursing homes, hospitals, to home health as well as vertical meaning that we have very strategic and structured relations with our health plans. We will talk probably in the discussion period about one of the greatest barriers to continuing a model of successful integrated care and that is the lack of risk adjustment and move, I'm sure Alan and Jamie will oppose these questions, but the move towards more PPO and to skinny benefit products or

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

high deductible products is creating a significant market segmentation of health care risk and the lack of risk adjustment is one of the great barriers, I think, to the successful implementation of this model into the future. Capital and leadership, I think are self-explanatory. Quickly into the lessons, you can through technology, through eligibility, referral (inaudible), clinical informatics, and pharmaceutical management across electronic boundaries have successful integrated IPA's that integrate very much with very similar results to a organized group. You need significant regulatory reforms, certainly in California, relative to the PPO regulation versus the health plan regulation and I think there's just great opportunity in paying for performance. So, with that, I'll leave that open now and turn it over to Alain, and happy to answer questions in the discussion period.

Alain Enthoven: Thanks very much Bob. I'm sorry that I don't have slides, out there in the duke of the west; some of us are still computer challenged.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Sometimes I do show up with slides. If I just pick up quickly on a couple of questions that were raised before that I think are particularly important and Bob touched on them and I think he is absolutely right, on Marsha's question, how do we get there from here, how do we get the ball rolling, I might just say if it would all get going pretty fast if every American were in something like the Federal Employees Health Benefits program or Calpers, that is a model of wide, responsible, responsible meaning you get to save the money if you chose a less costly system individual choice and for example, I mean, Kaiser Permanente, their best customer in every region they serve is the Federal Employees Health Benefits program. At Stanford, if you count the POS plan, 86% of our group are in prepaid group practices, either (inaudible) or Kaiser Permanente. Then Bert Sideman's question which is also very important, and I participated in some research in the late '90's, I chaired a commission in California investigating managed care, what's wrong and

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

so forth, that, some research, and other people's research convinced me the main problem is that it was imposed on people, that is their put their without a choice, what the research shows is that the backlash, the dissatisfaction concentrated in the people that it was imposed upon. Meanwhile, we've had millions of people in prepaid practices for years who are perfectly happy with no backlash because they are there by choice. Now, some of what I had to say a little bit overlaps Bob's excellent remarks so I'll shorten that and just hit on a few points. First of all, I think it's important to understand that purchaser policies choose the delivery system, that is health insurance and health care organizations are shaped by public and private purchasing policies as well as tax policies and regulations so employers and government officials need to think about the incentives they create and how that leads to organization of health care. If we want high quality, cost effective, accountable, comprehensive care systems that innovate to improve value, including

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

built in incentives to restrain expenditure growth, etc., than we can expect to see them in some form of market if not others. Also, I think is very important is that, is to do with the formation of group practices and this links to what Jamie was saying and to some extent helps to answer his puzzle, I think that fee for service is a centrifugal force, if the doctors all being paid fee for service than each doctor knows what revenue from patients he or she is bringing in and it's very easy doing that balance, would I be better off on my own. It's very easy to slip away and make even more money if I'm in a solo practice, whereas, a capitation is a cohesive force, a centrifugal force, and if you have a competition to produce value for money, I think experience shows that capitation is associated with behaviors of physicians that provide more economical health care and if you have capitation than the physician gets his or her money from the group and not from the individual patients. So, that's a cohesive force. So, in an environment that is predominantly fee

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

for service, that will work against the formation of group practices and I think explains part of Jamie's problem, and an environment in which all employees have cost conscience choices in which is one employees will migrate to the most economical organizations, usually programs characterized by per capital prepayment. Where I live, I talked to some employers who offer a range of choices, we do at Stanford, Kaiser and a few other HMO's, and a PPO, the PPO costs a whole lot more and the employers pay the whole thing, or 80 or 90% of the whole thing, and the result is they are putting out every month hundreds of dollars more on behalf of families who chose fee for service, than on behalf of families who chose prepaid group practice. I try to point out to them you are shaping the deliver system, you know, and so if you wanted to reshape the deliver system, you ought to do what we do at Stanford, which is to say we offer the same 5 choices and University contributes a fixed dollar amount equal or in case of dependants, somewhat below price of the low price plan,

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

and the you if you want the PPO, God Bless you, go for it, it's your own money, not with the rest of our money. More along the same theme, how would this thing move forward, I think the first thing is to open the markets. It turns out that the employees of 77% of insured Americans are not even offered a choice of carrier, for a variety of reasons, the employer has decided to go with a single carrier. Sometimes I say to them, you know, if you all do single payer, than pretty soon the American people are going to wise up and say if single payer is a good idea, let's get a real single payer. So, the single payer policy shapes the market. If an employer has a single payer, it means it has to include virtually all providers, so that every employee can get to the doctors he knows and loves so in this model the carrier has little or no bargaining power or little of no opportunity to manage quality and it always means cheaper service incentives for more costly care. The only cost restraint is likely to be high deductibles and coinsurance. That

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

may sacrifice disease prevention and disease management services. I think these all-inclusive networks work against accountability for cost and quality so that would be an important thing. A prepaid group practices that link health insurance to a specific medical groups are of course bills suited to be a single source for a whole group because some people won't like it for one reason or another, won't want it or won't live near it, or whatever, so prepaid group practices are not good candidates for that. So, it's hard for prepaid group practices to break into the single carrier market, a very promising way to do this is opening up on the west coast, there is a company called Benu and a company called Auto Nation for example, Benu is an entrepreneur venture that has the software to do risk adjustment and management of the whole thing and for example up in Oregon they have teamed up with Kaiser Permanente and Cigna and they're offering to the employer who wants a single source, looks like a single source, because they just get one monthly bill and the employee though gets

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

a risk adjusted choice among at least one flavor of Kaiser and 2 to 3 flavors of Cigna. Up in Seattle the same thing with 2 or 3 flavors of group health and some flavors of Cigna. So, that is a method by which you could, prepaid practices could penetrate that market. I call it the two-carrier exchange but that takes, it does risk adjustment to take that issue off the table. Now the other thing is, to level the playing field and there are a number of things that need to be done here. First it's just a matter of equal dollar contributions, as I mentioned moments ago, one of the big problems is these employers out there, I won't name them, I know them and met with them and pleaded with them, to reconsider what they're doing, I won't name them cause they won't talk to me anymore if I did, who pay the whole thing or 90% of the whole thing and I think if the consumer doesn't get to keep the savings he's going to get, be a lot less motivated to limit his choices to a prepaid group practice than if the employee did get the savings. At Stanford where we do get the savings,

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

like Calpers, a few other models University of California is a distinguished model rather than a very high percent of people do join prepaid group practice or other HMO's. Next is that you need comparable benefits in all competitors. It would be very hard for prepaid group practice with first dollar coverage to compete effectively against PPO's that have very high deductibles and therefore lower premiums because among other things, the people who expect not to go to the doctor at all will be motivated to choose the less costly premiums and then get to keep the savings and the poor risk will go into the prepaid group practice and then in turn brings one to risk adjustment, which I think is really essential for several reasons for a properly functioning market, if you don't do risk adjustment, then you create powerful incentives for health care organizations of any sort not to acquire a reputation for being very good at diabetes or AIDS or something like that, and of course, the best way not to create such a reputation is not to be good at it, that

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

is don't hire the doctors that are good at it, so if you want to create the incentives to have excellence in chronic disease management, then the payers need to use risk adjustment and if it's, in order to compensate for that. Out in California now, the University of California uses risk adjustment payments for their carriers based on an age, sex, location, and drugs model. Wells Fargo Bank, Verizon Communications does, and I'm humiliated to say that Stanford is behind the University of California in this respect, but on the other hand we have a lot better basketball team. Finally, there is the regulatory environment, prepaid group practices and other HMO's are subject to costly, complex, state regulations that are not applied to their self-funded competitors. Moreover, HMO's are subject to state benefit (inaudible) self funded plans. So, it's understandable that a self-care organization that holds itself out is actually delivering the care has to be held to some standards to define what that means, to deliver on that. Still, if prepaid group

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

practices are going to prosper, it's necessary that the cost of this burden doesn't render them non-competitive with other forms of health insurance. I've looked at some situations where I think that the strategy for driving prepaid group practice out of the state included a legislature that loaded a whole lot of mandates on them to make them too expensive and not able to compete effectively with self funded, therefore, non-regulated plans.

Jamie Robinson: This is designed to be one of the more customer focused parts of the conference so, we're going to do Q & A from you all to the panel and, but this is going to be an exercise in short questions and short answers, ok. So, no speeches, think of a question and ask it to only one of the panelists, there's a good idea, so that we can actually have time for a whole bunch of you, hopefully, to cycle through there. Our general theme, which is what are the core elements organized systems that we can save and use across the country to help pursue the goals as

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

we all believe in as developed by the institute of
medicine. So, yes.

John Houghton: Hi, John Houghton from
Dockside, my question is for Alain, from an economic
perspective, how important is it, you hear about
hospitals not being able to share information,
technologies with doctors in the community because of
star clause, how important are the anti-trust
legislation out there in making the plans work well
with the (inaudible) with the hospitals, with the
individual doctors?

Alain Enthoven: That's a really good
question, I just don't know.

Jamie Robinson: Great, ok, next.

Alain Enthoven: Sorry. I apologize for
that.

Roseanne Calzetta: Hi Roseanne Calzetta from
Baltimore County, Maryland. We're a purchaser for
about 12,000 (inaudible). I'd like to know if there's
any evidence or anything that's happening in the

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

prepaid group practices to come back, the influence the pharmaceuticals we're now spending \$.30 on our \$1.00 for pharmaceuticals, and do integrated systems do a better job of that and if so how?

Alain Enthoven: I'm really glad you asked that excellent question because I've just finished editing a book that I hope you'll read in which there's an excellent chapter on that by Dr. Campbell of University of North Carolina, and Sharon Lavigne, who is here, and it explains what prepaid group practices do in order to integrate pharmacy benefit management with the rest of the care system. The key point, I think, is the doctors who are responsible participants in the whole thing, the docs who are treating the patients are the ones who decide, committees, study groups and so forth, which drugs to use and therefore, they've got the right kind of balanced incentives. They would never prescribe a ineffective because it's cheap because they know the next day the patient would be back in their office saying doctor you didn't cure my problem, now what are you going to do. So, they

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

want effective drugs, on the other hand they don't want drugs that are so expensive that they're rendered noncompetitive. Please read the chapter and that will explain it in greater length.

Jamie Robinson: The chapter will also help you out on the quiz.

Katherine Kemps: Katherine Kemps with Health to Resources and I have a question to Alain as it relates to accountability, and the question of value and resource consumption and who becomes accountable or responsible for ensuring that, the front page of USA Today, (inaudible) \$763 I think for health care benefits for family coverage. So the question is how do you balance the question of value and resource consumption with ensuring that one receives quality care?

Jamie Robinson: I don't know if that's conclusive with the short question format we decided earlier.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Katherine Kemp: I can restate that as it perhaps relates to some of the issues of accountability.

Alain Enthoven: Well, let me just say, I think it's in the realm of informed consumer choice. That is, first of all if consumers had to pay the difference if they chose the more costly health care plan then they would do at least what my colleagues at Stanford do, is look carefully and say where is value for money, and then if you given them a lot of information about quality, you know, the performance indicators the specific group is developing, (inaudible) that sort of stuff, patient satisfaction, and performance on a lot measures and other measures like risk adjusted outcomes studies, then they can get a feel for the quality and they can make a judgment about value for money. I think that's the main reason.

Katherine Kemp: I know you want short questions, but as it related to integrated delivery

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

system, who becomes accountable or responsible for that reporting capability and information for consumers.

Alain Enthoven: Well, on the information for consumers about the quality, out where we are, it's the Pacific Business Group on Health that takes a leading position as well as NCQU which takes a very important position on that nationally and I would like to see NCQA go farther and faster and do more if it, you know, Brook & McGlin had a great article about failure of the health care system to deliver on generally agreed (inaudible) of medical care and a lot of potential in that research for even more indicators in how effectively the different care modalities perform.

Karen Milgate: I'm Karen Milgate, I work with the Medicare Payment Advisory Commission so my context of course is fee for service payment to individual settings of care and one issue that the commission is beginning to explore is how you create this virtual groupness that Dr. Margolis spoke about.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Some of the ideas of well do you use payment to create that kind of groupness, do you use quality measures, so I just wanted to ask you to expound a little bit more on what you meant by that virtual groupness.

Bob Margolis: I was asked earlier how do we actually implement this business case, create federal policy, and less is the answer. My personal belief is that until Medicare says that over some period of time, we're going to convert from a fee for service to perhaps 25-30% of your reimbursement will be based on measurable outcomes, a lot of work to be defined on which those are and certainly politically, a tough thing to do, but nevertheless, until we create that vision and get the expectation in the physician community that the system is gong to change and that we're going to pay based on performance and outcomes, we will not create that groupness. As soon as you do, in my view, as soon as you create a business case that says you're going to have to be able to collect and report across longitudinal and horizontal episodes of

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

care, you're going to have to be able to create reports and information on how well those patients are thriving in those settings, you don't have any of the glue that creates the reason for these people to communicate and develop teams and the technology and the info structure that starts to bring the information together. So, I believe the driver, again, as I started is the business case and the business case from a federal policy point of view and my view has to be (inaudible) transformation not just mentalism.

Alan Wilde: Alan Wilde, the Urban Institute, Dr. Margolis, you described having your organization vote employed physicians and an IPA model, I wondered if you could just spend a little more time on the implications of trying to bring those two together into one organization, differences across the two models within the organization, communication tension given the earlier question about how many physicians are likely to want to end up in the employer model. It seems like bringing these two together is, figuring out

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

how to and what the pitfalls of bringing them together is an important one. I'd just like to know more about how that works for you.

Bob Margolis: Trying to create a short answer to that will be difficult and Jaime will chastise me so let me just really quickly say the mental transformation for us was to stop believing that IPA's were groups in formation and start, in other words, they were on some journey that they hadn't yet figured out they wanted to be groups and to recognize that indeed, there are very different characteristics and if you learn how to treat and respect the fact that these physicians and consumers want the option of having one stop shopping in a large multi-specialty group or there local physician in his or her office, that's a consumer choice issue. Once you respect that and you start to build collegial relationships and conversations about the things you have in common, the measurement sets that are important to patient outcome and patient safety and patient quality, you can start to build that

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

bridge of communication. A lot of technology can assist that and it's a gradual process but again the driver in California was for IPA's to form was a mechanism of gaining patients through contracting with health plans, that doesn't always exist in the PPO world elsewhere, so I, my personal belief is that PPO's and the anti-trust laws have to change to allow PPO's to be negotiated in the same basis that the HMO's are negotiated between physician organizations, as oppose to individual physicians. (Inaudible) that conversation and so on has tilted well away from the physician at this point. That's a whole another conversation I'm sure.

Male Voice: We'll go on to the next question, I want to follow up this with a follow up question. In California, we have a very evocative notion of the medical group at an RMB arm for the IPA or the (inaudible). Obviously in California, a capitated environment, where you have IPA's (inaudible) Outside of California, you don't have that much and

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

with the anti-trust law being non-increasingly directed at non-risk bearing IPA's, do you see the potential, is that model applicable, the idea that integrated groups will maybe always get small percentage but they will develop the processes which will then be diffused across networks, how would those networks, what would be their functions?

Bob Margolis: Again, I'm trying to create a concise answer, the reason I said RND for the IPA is that a organized physician model is clearly one where you can develop processes, clinical flow, reengineering patient, flow reengineering, same day access appointments and so on and you can do it as a business proposition, it's your business, you make the rules, you create governments and work off of that. What you find is that some of those things are applicable, not all of them but some of are applicable and have real life vitality in an individual physicians office so within our, we have same day access for all patients, and primary care sites, I guess a couple years it was

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

working with IHI on doing that, it's a terrific program, a lot of the IPA physicians now recognize that's an enormous patient satisfier, let's get on with it and learn how to translate that, that kind of program. Its that kind of program, so, it won't necessarily have to have the RND arm of the physician group, I think that things like programs like IOM and others that produce best practice, AMGA conferences, IHI meetings, and so on to discuss best practices have an opportunity for migration to those best practices among organizations.

Bob Halins: Bob Halins from EI, this is a question for Dr. Margolis, again. Risk selection, I recently attended a meeting here in Washington where it was a collected up a group of the companies that are providing some variation of what people can consumer directed health care and all of those people went to a great deal of effort to say they are not seeing adverse selection there, some of them even presented a few numbers in that respect, if I heard you right, you're

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

asserting that in LA county, you're seeing evidence of risk selection and I wondered if you could tell us a little more on what basis you're getting that. Are those people looking under the lamp post or you or, I'm still in the dark. Thanks.

Bob Margolis: I would attribute my statement to a combination of some evidence, some real evidence meaning we've looked longitudinally over time at our, for instance, our number of diabetics per thousand members, our number of HIV per thousand members and so on and it's increasing. So, there is some true evidence in our organization and I know Permanente has had some of the same experience and I think George Halverson speaks pretty eloquently on the threat of adverse risk at Permanente. So, there is some of that evidence, some of it is antidotal, probably to be dismissed and some of it is intuitive and I think Alain referred to that, if you have a low cost, high deductible catastrophic like PPO product and you're a 25 years old health male, with a family that thinks

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

nothing is ever going to happen to them, it's very logical to buy that product as oppose to a much more expensive comprehensive one where as if you have chronic disease and you're going to be at the doctor every month and in the hospital once or twice in a year, a \$5 or \$10 co pay product looks a whole heck of a lot better, I mean, there's a joke in California that Len Schaeffer at WellPoint got rich by selling a \$60 a month high deductible PPO that had no benefits.

Jamie Robinson: You know, Blue Cross, was launched originally by selling for \$1.50/month a premium for 7 days of hospital care, they'll still sell you that product today. Yes.

Male Voice: I have a question, a little different, about how (inaudible) policy level, grocery strike in California was settled by providing any decent health care to the second generation, the new hires. It couldn't be afforded. A person that works for me at home, in Kaiser, I suspect most of the speakers are not. (inaudible) have to spend \$500 a

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

month now for her premium in Kaiser and so has deductibles and insurances have gone up dramatically and was thinking of giving up her health insurance because of it. It sounds like these integrated group models can't cope with what's happening with the technology and that all of them have to do fundamental change. Do you have any hope that you guys, whether it's the Kaisers of the world or the Caps of the world or the network IPO's of the world are going to produce a product that is affordable and that as a consensus of business will and the people will actually want to pay for it and I'm really worried, I saw the increase in premiums in California this year among the groups that are the people that we're trying to promote today.

Alain Enthoven: Well Bob, I think what's happening is somebody on the outside of this process is friends with some of the people inside is that the prepaid group practices are responding to market signals. I spoke about a week or so to the Board of the Pacific Business Group on health and I said imagine

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

you're kind of a fly on the wall in this high level Kaiser Permanente Committee in which they're deciding on a dues increase and the doctors are saying we want more doctors, the hospitals are saying we want better hospitals, lots of wonderful things to spend money on, so let's raise our dues \$1,000 and then somebody else says no we can't do that, make the unaffordable, then finally deciding person says look, the employers out there typically pay 80% of the premium so if we raise our premium by \$1,000 it will only cost the employee \$200 pretax and \$130 after tax so for \$130 our employee is getting \$1000 worth of wonderful new medical care and so in the interest of our employees, we've got to raise the premium. Now, I learned later on that day and I've been meaning to get together and talk with you, I should have done it privately but since you're up there, that a very respected econometrician for the RAND Corporation came up and said to me in effect, you know, at RAND we have all these wonderful choices and the employer pays the whole thing whatever you do, so I

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

think that if we employers would send the correct market signals which is that we only pay for the low price plan and you have to pay for the rest that more and more, the organizations prepaid group practices would face real price competition and would face some real marketplace reward that they don't face now for holding down the premium.

Male Voice: I hope you're right Alain and but I'm really concerned that, you already have I put 4 facts on the table, we have the lowest number of physicians (inaudible) than any developed country in the world right now. We've got the lowest number of hospital days of any developed country in the world, we're 26th in life expectancy, premiums are going up and the prepaid group practices by 20% whatever it is, calculate it as going up, and we probably spend 4% points more for GMP on a higher GMP than anyone else, I put those 5 facts together and I hope that these groups are up to the challenge of, and years from now, reversing all of those, and I hope you're right. I

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

would love to see convincing evidence that that Bob's, Jay's and everybody else in the world will actually get us there and that the reversal of the policy in Washington is not what's key.

Alain Enthoven: What I'm really concerned about now is the reversal in policy at the RAND Corporation.

Jamie Robinson: Well, I think you two gentlemen should take this outside and settle this the right way. Well, all right, we've got about one minute before (inaudible) cuts this thing off, so my last question is ok, this maybe all very good stuff but is it legal. Ok, now the anti-trust authorities are very concerned about consolidation of the delivery system, physician level at the hospital level and there is a trade off between clearly, the potential for economies of scale and scope integration as an advantage but there is also the problem of frankly, doctors are (inaudible) in order to raise the prices, raise their income, and fight off, and reduce the choices available

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

to the purchaser and the consumer because they're all now amalgamated so, once again, briefly, anti-trust law, is it a good thing for American medicine as it stands or does it need major overhaul incentives permitting more amalgamation.

Alain Enthoven: I think it needs a great increase in its vitality and vigor. I think that these huge hospital accommodations we're getting in California are . . .

Jamie Robinson: What about the physician side?

Alain Enthoven: The physician side, one that's particularly pernicious in a lot of communities is the single specialty group practice that in effect is a cartel to raise the bees in the particular specialty and it's a lot easier to do that in a single specialty group practice than in a multi specialty group practice where it's subjected to proper market forces.

Jamie Robinson: Dr. Margolis.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Bob Margolis: I think the FDC has an important role to play to make sure there's adequate competition in every market but within that I believe that there are incredible efficiencies that are being prohibited at this point relative to information sharing, technology, (inaudible) and the FDC would take a better look at some of the safe harbors that they have spoken about but not promoted, to allow clinical integration among physicians in order to then allow those physicians to work together and to actually negotiate but one has to follow the other, that that would be a positive step, than that's especially true in the PPO side if we're going to get out of this individualism that occurs across most of the country on the PPO side.

Jamie Robinson: Ok, well on that note, I think we're going to wrap up this panel, thank you two panelists and (clapping).

Laura Toland: Hi, I'm Laura Toland and I'm from Kaiser Permanente. Can you people hear me, can you hear me now? Hi, I'm Laura Toland with Kaiser Permanente and I know I'm the only thing standing

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

between you and lunch so I just wanted to say a few things quickly, first I want to add my own thanks to today's speakers, this is the only chance I'm going to get to do it publicly. We have really made them work very hard. Prior to today, making them work pretty hard today, I want to extend my thanks. A couple of logistics, we are now going to break for lunch, there are box lunches available in the great hall out here and you see the signs, food is not allowed in the auditorium, so we'll ask you to eat your lunch out there. We do, there is some very limited amount of seating for lunch, for the most part eat out your box, you can walk around and chat with each other. For those that really need to sit, there is in the member's room, which is if you go into the Great Hall and turn right continue down the hallway, you'll see a sign that will direct you to the members room. There's some seating in there as well as in Room 184, which is if you go in the Great hall and take a left go down the hallway there, there is some limited seating there. I

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

also wanted to mention that you have in your bags this green sheet which is an evaluation form for the meeting and we ask that you fill that out, did I say that it was green, it's yellow. It is St. Patrick's Day and Happy St. Patrick's Day to you all and there is no green beer in your lunch but clearly I've had one this morning and I'd ask you to be back here by 1:00.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.