

## **News Briefing on Initial Findings from HSC's Fifth Round of Site Visits to 12 Communities August 24, 2005**

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**PAUL GINSBURG, Ph.D.:** Okay, I'd like to thank you all for joining us today to hear about the initial findings from the fifth round of HSC site visits. Before I get into the substance of the briefing, I'd like to introduce the panelists. Closest to me is Dr. Mai Pham, who is a senior researcher at HSC; Carmela Coyle, senior vice president for policy at the American Hospital Association; Don Fisher, the president and CEO of the American Medical Group Association; and Karen Ignagni, president and CEO of America's Health Insurance Plans. I also want to thank the Robert Wood Johnson Foundation, HSC's principal funder and the sole funder of the site visit project for making possible the fifth round of HSC site visits. We have gone, as we have gone in past rounds, to Boston; Cleveland; Greenville, South Carolina; Indianapolis; Lansing, Michigan; Little Rock; Miami; northern New Jersey; Orange County, California; Phoenix; Seattle; and Syracuse, New York. I also want to thank kaisernetwork.org, which will be webcasting this briefing first thing tomorrow morning.

The 12 communities that we track intensively through site visits vary a lot, as you can imagine from their names. But taken as a whole, these 12 sites are nationally and geographically representative of metropolitan areas with populations above 200,000 people in the United States. As I said, this is the fifth time we've been to these communities,

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and we know these markets; we know where they've been. We were first there in 1996, and we have a sense of where they're headed. What we found shows a lot of common trends throughout these 12 communities.

As we're beginning at this point in our project analysis of data from almost a thousand interviews with executives of various segments of the healthcare system in these communities, we are beginning to identify cross-site findings, and the ones that appear to be most important, most significant are what comprises the publication that we're releasing today, *Issue Brief 97*, which we call our initial findings. Indeed, we have 25 to 30 additional publications—either HSC issue briefs or journal articles—that will follow this issue brief of the initial findings, the things that struck us as most significant.

One of the bottom lines is that most of these trends are pointing towards higher costs and growing gaps in access, particularly by income and geographic location. The most striking developments in the 12 healthcare markets tracked by HSC is the ongoing building boom and rapid expansion of both inpatient and outpatient capacity. Whether meeting or creating new demands, the capacity expansions are destined to lead to higher rates of use of services and higher costs. Continuing high-cost trends are threatening the affordability of health insurance, especially for low-wage workers, and those who work

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for small firms, increasing the likelihood that the number of uninsured Americans will continue to rise. As many of you know, the Census Bureau next week will be releasing its estimate of uninsured Americans in 2004. I expect that we will see, despite an improving economy, an increase in the number of persons who are uninsured. The reason is going to be higher premiums.

Before I turn the briefing over to Mai for more details about the site visit findings, I want to leave you with this closing thought: I don't see any silver bullet out there that's going to alter the trajectory of our healthcare system, and that trajectory is one of spending more and more to care for fewer and fewer people. Looking forward, policy makers, the public, and industry stakeholders will have to more explicitly address the problems underlying these trends, and either revisit solutions that have been discarded, get serious about developing new ones, or accept the ramifications of a continuing status quo. Now I'd like to turn to Dr. Pham.

**HOANGMAI PHAM, M.D.:** Good morning. I want to talk to you about the major findings that we've identified during our recently completed site visits, which, as a physician, I find particularly troubling. I will first make three main points, and then talk about them in more detail.

First, to reiterate what Paul said, we've noticed fierce competition among hospitals and physicians for

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profitable specialty services, especially cardiac, orthopedic, and cancer care, and that this is driving costly inpatient and outpatient expansions. Second, the competitive fallout from this ongoing medical arms race certainly will result in higher costs than already is influencing the availability of certain services and affecting patients' access to care. Lastly, if current trends continue unabated, communities are likely to face growing number of uninsured people and increasing disparities in access to care by both income and geographic location.

As Paul said earlier, the most striking development in our 12 healthcare markets is the ongoing building boom and rapid expansion of inpatient and outpatient capacity. Most of this building is taking place in more affluent areas with well-insured populations, and more diagnostic and surgical services are shifting at the same time from hospitals to physician offices and physician-owned ambulatory centers. One great example is that in Greenville, there are two major hospital systems in the adjoining towns of Greenville and Spartanburg, which are competing to renovate and expand inpatient beds and outpatient centers in what they call the "DMZ - the Demilitarized Zone." That includes wealthy suburbs in between the two towns. And in Northern New Jersey, the financially health suburban Atlantic and St. Barnabas Hospital systems are spending several hundred millions of dollars to expand and

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build cardiovascular, neurology and cancer centers, as well as ED facilities, while at the same time, public hospitals serving lower-income populations are closing. Facing stagnant growth in professional fees and pressure from growing malpractice premiums and other practice expenses, physicians have increasingly sought facility fees as an important new revenue source. Marked disparities in the relative profitability of certain services under both Medicare and private plan reimbursements appear to be the major driving force behind this competition.

I don't want to get down into the weeds of the Stark Self-Referral Law, but generally, we've also noticed that in-office ancillary services provided by physicians are exempt from these prohibitions and the level of physician entrepreneurialism in response has been startling in some cases. One extreme example is of the medical group in Phoenix that added a PET-scanner to its practice in order to increase revenue from Medicare. More typically, as in Northern New Jersey, we were told that most non-invasive cardiovascular testing is now done in physicians' offices.

In many communities, hospitals view the growth of physician-owned facilities as their most serious competitive threat, not that from other hospitals. For example, two hospital systems in Miami reported dramatic declines in the volume of endoscopy procedures as a result of staff

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gastroenterologists opening competing endoscopy centers. In particular, ten NHCA hospitals reported a 50 percent drop in their endoscopy procedures as a result of a competing physician-owned endoscopy suite.

Many hospitals across the 12 communities have responded by forming joint ventures with physicians to retain at least some of this revenue. In other cases, they've responded by opening facilities separate from their main campuses to directly compete with physicians for the lucrative services. What are the consequences for local healthcare markets? Well, whether meeting or creating new demand, the capacity expansions are destined to lead to higher rates of care use and cost. Some of this additional use will no doubt provide increased access to beneficial care, but as always, there are concerns that physicians face strong financial incentives to recommend more services when they have an ownership interest in a facility and that this could potentially lead to unnecessary care, or at least care that adds little value or benefit for patients.

The intense competition for profitable services also potentially can influence the availability of healthcare services and patients' access to care. How? While many hospitals are expanding ED capacity, increasingly, hospitals, especially those serving uninsured patients, are struggling to get physician specialists to provide on-call coverage for

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emergency department evaluations and trauma care. More and more, hospitals have to pay physicians to provide on-call emergency coverage, historically a part of physicians' obligation in return for maintaining hospital privileges. And some hospitals have resorted to adopting the new strategy of outright employing specialists to guarantee their availability, particularly in Miami, Little Rock, Phoenix and Seattle. As specialists provide more services in their own practices or in other facilities where they have an ownership interest, they become less and less dependent for revenue from their privileges at general hospitals, potentially diminishing access to specialty care for some patients. This staffing strain is particularly evident in the sites that I mentioned, as well as Phoenix and Indianapolis. One Phoenix hospital system now pays each of its neurosurgical groups \$10,000 per week to see trauma patients in addition to their regular per patient reimbursement.

The movement of profitable services out of hospitals and into physician practices and physician-owned facilities poses a real threat to some hospitals' ability to subsidize care for less profitable services, and for low-income patients. And as hospitals expand lucrative services, some are cutting back on less-profitable ones, such as in-patient psychiatric care, that are no less critical, placing more pressure on safety-net hospitals to provide this care. Moreover, the

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buildup of specialty services is occurring at the same time that many inner-city hospitals, caring for large numbers of uninsured patients continue to struggle financially.

Unfortunately, there's been little resistance to this buildup in capacity. Employers and health plans have launched few initiatives to control rising costs beyond increasing patient cost sharing. Indeed, in many markets, we were told that health plans were eager to contract with physician-owned facilities for outpatient diagnostic and surgical services, because their facility fees are often lower than those at general hospitals. Plans largely have focused on new product designs aimed at engaging consumers to make more cost-conscious decisions about service use and choice of providers, but enrollment to date is limited. So in the absence of significant innovation to control healthcare spending growth, plans and employers have continued to focus primarily on shifting costs to consumers as their key response to rising premiums.

One result of these rising premiums has been more people becoming uninsured. Some small employers reportedly are dropping health benefits while in other cases, increased premium contribution from employees have led to lower rates of takeup of insurance. In Northern New Jersey, the state has taken a novel approach by passing several controversial tax assessments of sources of funds to shore up its uncompensated

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care fund. These include a 3.5 percent gross revenue tax on privately owned ambulatory surgical centers, and a 6 percent gross receipts tax on cosmetic procedures, the first of the kind in the country that we know of. But this really was a rare example of public sector intervention.

Meanwhile, the safety net is truly becoming stretched. While healthcare costs continue to rise and health insurance becomes less affordable, the public sector has fewer and fewer resources to respond to the growing needs for coverage or subsidized care. Ongoing state budget constraints and a general unwillingness to raise taxes and federal budget pressures have all left state and local governments hard pressed to keep up with the growing need for coverage and care.

The one bright spot in this landscape is that hospitals have increased attention to quality improvement over the past two years. Many hospitals that we spoke with expect payor demand for demonstrated quality to increase, and therefore, view these activities as important investments to be able to compete in the future. While information technology investment has also increased, the scope is more limited than some policy makers and industry proponents would suggest.

And finally, to reiterate Paul's conclusion, unfortunately, we see no silver bullet on the horizon. Overall, the promise of quality improvement initiatives and IT investments pale in comparison to the scope of the cost and

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access problems confronting the healthcare system. In the final analysis, we're getting exactly what we pay for, and not getting what we don't pay for.

**PAUL GINSBURG, Ph.D.:** Carmela?

**CARMELA COYLE, Ph.D.:** Thank you very much. Paul and the Center for Studying Health Systems Change have invited me to join you here this morning. The work of the Center is so important to a clearer understanding of the healthcare system in the United States, and the problems and ways in which we deal with them, so we thank you very much for your work.

Dr. Pham just referred to a healthcare safety net that is stretched in America, and I think America's healthcare system in fact, is frayed and torn. We've got 45 million people who have no healthcare coverage whatsoever, millions more who are uninsured who are unable to access or afford the healthcare that they need. I think as this morning's study notes, the gaps between those who have access to adequate healthcare and those who don't are growing.

The study also shows that the costs of healthcare are rising and continue to rise in the United States, and employers and plans are shifting some of those costs to consumers through new benefit plan designs. But higher premiums and higher copayments, cost sharing on the part of consumers, can again, lead for further reduce people's access to care.

Today, the American Hospital Association is also

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releasing a new study that looks at factors that are driving increased spending in at least one aspect of our healthcare tab, and that's hospital care. Key among the factors and some troubling trends included there, looking over a five-year period from 1998 to 2003, more than half of the increase in spending on hospital care is due to rising costs for the goods and services that hospitals have to buy to provide that care. That means, the cost of the things that hospitals have to use to provide care to you and me are on the rise. Most of that—three-quarters of it—due to rising wages; that's driven by workforce shortages and the federal government is now projecting that the shortage of registered nurses will actually exceed one million by the year 2020.

The other half of the increase is due to increased demand for hospital care and increased intensity of hospital care. What does that mean? People are using more hospital services, and we are able to provide medical miracles every day, advanced technologies that allow us to do more things for more people, but we also have a growing population, an aging population, and a growing burden of chronic illness. So, we will be spending more, but investment in healthcare is a good thing if it leads to more productive lives.

Now, against that backdrop of hospital and healthcare spending being on the rise, the Center for Studying Health System Change's study this morning identifies another

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contributing factor, referred to in this study as the fierce competition among hospitals and physicians, a situation that has the potential to harm, not help our healthcare system. But some economists argue in general that competition can lead to improved quality and access, better service and greater efficiency, but I think the HSC report indicates that the competition they're seeing appears to have the opposite effect, and in fact, we can say that that's happening in many communities beyond the five that are the subject of today's report. We're seeing this happening across the United States; whether it's Oklahoma or Arizona, South Dakota or Kansas, and many other places. The HSC study notes that the growth of physician-owned facilities—in particular, physician-owned hospitals, physician-owned ambulatory surgery centers—are raising issues about physician conflict of interest and about self-referral. These facilities do represent a growing and expanding capacity in terms of healthcare that may be unnecessary, raise costs, and further fragment a healthcare system that's already struggling to better coordinate and manage care. And the study also notes that these facilities are really syphoning off some of the most profitable services from hospitals, and the specialty physicians that in some cases are at the helm in ownership roles in these facilities are pulling back from providing on-call emergency coverage in the nation's healthcare system, again, fraying and tearing at our

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healthcare safety net. All of this really threatens the ability to continue to provide those less well-reimbursed services and services for lower-income and uninsured individuals. So, this morning's report, I think really confirms what other research has shown, that physician ownership of and self-referral to limited service facilities creates duplicative capacity, increases costs, and reduces access, adding, not subtracting from our nation's healthcare problems. So we thank you for inviting us to join you.

**PAUL GINSBURG, Ph.D.:** Thank you, Carmela. Let's turn to Don Fisher.

**DONALD FISHER, Ph.D., C.A.E.:** Thank you Paul, and I appreciate the invitation to be here, and I really congratulate the Center for the outstanding work that you're doing. It's just terrific. In the interest of time, I'll just cover four real quick points here. First, who is AMJ, for those of you who are not familiar? Second, what do we conclude from this report? Third, what is the problem? And while we don't believe there's a magic bullet either, there are some solutions that I think we ought to embrace that could change what's going on in healthcare today.

First, AMJ represents mostly large, integrated, multi-specialty group practices. These are the preeminent medical groups around the country. The ones that sit on my board are Mayo and Cleveland, Henry Ford and [Inaudible], and Palo Alto

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and Dean Health System, and Geisinger and so forth. We have about 70,000 physicians in 260 groups. More than a third of the members own and operate hospitals as part of the integrated delivery system.

What we conclude from this study is that it is clear that market forces really now are driving the business of healthcare in the United States. What my members are seeing every day is increased costs of delivering services against a declining reimbursement that makes survival a very difficult thing for them each and every day. If you just look at the Medicare program alone without a congressional intervention this fall, Medicare reimbursements will decline over 30 percent over the next five years, and all of you know that. Something needs to be done, because if you take 30 percent out of the reimbursement with increasing costs, there is going to be a greater access problem, and many of the facilities we now see out there providing healthcare in rural and urban communities will simply go away because they cannot sustain their business.

This is also against the backdrop of an increasing demand by providers to be more transparent and accountable in the care they're delivering, and the only way you can do that is to build an information technology system within your enterprise that can actually gather data, measure what's going on in the quality and cost side of the business, and actually report that. That requires huge investments on the part of

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these providers out of these declining reimbursements against the other technical increase in costs of healthcare.

So we do believe that the Center's report does absolutely identify that market forces are driving the business of healthcare. Competition is going to increase, and it's all about survival, and it's all about being able to care for those patients that walk in your door every day and provide the best care you can give.

Having said that, what the providers in this country need to continue to focus on is making sure that every day they provide the highest quality, most cost-efficient care they can deliver. When I look at the best healthcare in the United States, if any one of you decided today that you need to go to a healthcare facility, you're going to be looking for a facility that has a multi-disciplinary approach to your care, because everybody comes in with more than one problem today, especially the elderly. And you're gonna want to make sure that care is delivered, not only in a coordinated fashion, but by a team of providers. You're not going to be out there today looking for that solo practitioner who's out there with that limited ability to take care of your problems; you want a whole team of people to take care of you. So what we need to do is focus on what's going to make these kinds of enterprises thrive in the future.

So what is the problem? I think it's very, very

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simple. The problem is that we've got a reimbursement system today that pays on volume of services, that doesn't align the incentives for the care we want to get as patients. If I were to go into the hospital today and get a hospital-acquired infection, the physicians and the providers that take care of me will make more money as a result of their negligence and their mistake than if I don't get the hospital-acquired infection. That's just simply wrong. So what we've got to do is look at the problem, and the problem is, the incentives are not aligned. The more services I provide, the more money I make. Services are not equal in their payment mechanisms, so that if you have a scope or you've got some kind of a device you can use, you're going to make a lot more money by doing that service than if you're using cognitive skills to provide that level of service.

So what we have to look at in this country is how to come up with a reimbursement system that provides a reimbursement for the care we want as patients and a reimbursement system that's going to drive us as patients to those facilities that can provide the highest quality, transparent, accountable, efficient healthcare.

So what is the solution? I think the solution is to reform out entire healthcare reimbursement system to one that pays on results. And while I think pay-for-performance is an excellent first step in this process, we ought not get locked

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into a pay-for-performance mentality that says this will do it, this is the magic bullet, because it's clearly not. And I'll give you an example. If a patient admits to the emergency room and if in the first 30 minutes of their being in the emergency room with a presentation of chest pain, the protocol would say you give that patient an aspirin. So at the end of the month, when that physician gets their pay envelope, there'll be an extra dollar in there because they performed appropriately based on chest pains and gave an aspirin. But if that patient had a hiatal hernia, you've done more harm to that patient than good by giving an aspirin, but yet at the end of the day, while the patient was harmed by the medical intervention, the physician gets paid more. That's where pay-for-performance doesn't go far enough. It's a good first step. What we have to do in this country is begin to pay for results, outcomes. We've got to reward efficiency, quality, and patient safety, and we've got to move off the mentality of paying on a volume of service for everything that's done and have us competing as providers, whether it's hospitals against ambulatory care centers or what have you, for this volume of service. We ought to be forced to collaborate together to get the best outcome of that patient, and it ought to be transparent as to whether you're getting this in a hospital, or in an ambulatory care setting, because at the end of the day, what we want is the best care in the best place with the best results and the most

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efficient care that can be delivered.

So I thank you all for inviting me, and I look forward to questions.

**PAUL GINSBURG, Ph.D.:** Thanks Don. Next, turn to Karen Ignagni.

**KAREN IGNAGNI:** Thank you Paul. I too, appreciate the opportunity to present this morning, and appreciate being here with my colleagues. I think that we appreciate very much the deep dive that you all did in terms of what's going on in these particular communities.

It occurs to me that there are six large trends that you hint at but don't necessarily tease out. I think that one of the first things is we get our hands around rising costs and what can be done. The Rand Corporation data suggests that only 55 percent of what's being done in healthcare is best practice. In no other area of our economy would we tolerate that effectiveness rate, 55 percent, which means 45 percent is not best practice. We have an opportunity to have an organized approach diffusing clinical trial information into practice more efficiently and effectively and government should respond to that challenge, and a number of our organizations are working on that collaboratively.

Second, unfortunately, until recently, health plans have been the only entity to report any kind of data so it can track the kind of effectiveness, quality, et cetera; that's

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changing now, and that's a very positive thing. We need more transparency in the system, and that will allow us to get a sense of what's done under what circumstances, and what is the right thing to do, matched with the clinical trial information, diffused into practice.

Third, we need a 21<sup>st</sup>-century approach to technology assessment. You hinted at it, but we didn't exactly say it. I think the implication is clear, and Carmela talked about this as well. Where do we have a place where communities can talk about capacity, how much is enough? Where do we have a place where consumers and employers can come and participate in that conversation? Where do we have a place where we can assess the adequacy of new technology, whether it be pharmaceutical, bio or device, and talk about clinical effectiveness? Clearly, the structures we have in place now are not adequate to do that job.

Fourth, the issue of defensive medicine; and people feel very passionately about this issue, pro, con, whether it exists, et cetera. The government statistics indicate that ten cents of every healthcare dollar is going to defensive medicine, which I think is also driving this, because physicians are afraid to practice medicine today.

Fifth, we need to get away from the bipolar discussions we're having in Washington and the states about what the solutions are, whether they are public or private. Clearly, it

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needs to be a more nuanced approach. Everybody has to roll up their sleeves. That's easily said. It doesn't lend itself to the doing of that, or to sound bites, or to political speeches, but we need to get onto that.

In terms of the positive, what we see is that notwithstanding the study, and what you found in these communities, I think that there is some good news to report. If you look back over the last several years, health insurance premiums hit 20 percent in some categories, 15 percent for others. Hewitt just issued a report in June saying that in '06 we're going to see the lowest rate of increase in healthcare premiums in five years. The reason we're getting there is because health plans have driven down prescription drug increases from 20 percent per year, well below ten, to eight. You can plot a graph exactly; it looks like an X. As we've introduced these tools—tiering, encouraging generics—what's happened is a reduction in expenditures on the prescription side.

We're going to take these techniques and we're introducing them in the hospital arena, the physician arena, to encourage and reward quality performance.

We've initiated an effort of very broad efforts to participate with physician specialty groups. Don is involved in a number of other leading specialty societies to get onto the issue that you identified, which is how to adequately look

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at a physician practice where they may have a number of insurers. We're excited about that, and we're hoping that CMS is going to put its arms around that as it has in the hospital arena. That would be a very big step forward.

We've introduced disease management. The Medicare data suggests we're doing a much better job because of disease management in improving quality in health plans, and that's also something I know employers are taking a very hard look at, and Medicaid is taking a hard look at.

We're reintroducing techniques to do imaging review, because imaging, as you indicated in your study, quite appropriately, is on the rise, I think because physicians are concerned about defensive medicine. Again, appropriately, doctors talking to doctors about efficacy. That's where we want to be. We're providing more choices.

And then finally, in terms of consumer-directed, I think it's early. The regulations for HSA's were only passed a year ago this month. More than a million people are in this product, but we're going to see now, as large employers begin to offer these products, we'll have more experience. What we've been particularly encourage by, and we've been watching this very closely, in the individual market, 40 percent of people purchasing HSA's didn't have coverage before, so clearly, it's hitting a need. And 30 percent of small employers offering this coverage weren't offering coverage before.

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So I think that what I was particularly please about was the opportunity to participate in the discussion that was a nuanced discussion, designed to focus on how to work from a governmental perspective, a private sector perspective, and get away from the kinds of finger-pointing that went on in the 90s and really try to solve these problems. Thank you for the opportunity.

**PAUL GINSBURG, Ph.D.:** Thank all three of our commentators for really augmenting the substance of this discussion. Now I'd like to turn to you, the press, for your questions. We have some people on the phone, and we'll periodically work them in, but I'd like to start with someone in the room. Sure.

**FEMALE SPEAKER:** Hi. I was wondering if you could give us an example, as you did in some of the markets for the small employers dropping coverage, you know, something like you gave us for in Phoenix, they're paying \$10,000 to the specialty groups to be on-call. Do you have some examples of that from the markets of small employers dropping coverage?

**PAUL GINSBURG, Ph.D.:** Well, in the sense, a finding like that, small employers dropping coverage, obviously it doesn't come from interviewing small employers that say they're dropping their coverage, it really comes from people like brokers. We speak to brokers and benefit consultants in the sites, and it's really interviews with brokers telling us that

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some of their clients are dropping coverage, but they're not losing them to a competitive broker, they're dropping coverage. One thing I would say in the small employer market is that some of the big changes in the percent of small employers offering coverage come from whether small employers start offering coverage for the first time. One of the reason employers are hesitant about offering coverage is that dropping it is a big deal in the company, so when you see evidence that small employers are dropping coverage, that's really a troublesome sign. Marilyn?

**MARILYN:** Really, a two-part question. First of all, is there some way to quantify? Are we technically at overcapacity? And is there some way to define that? And as a second part of the question, how much of this buildup of capacity is due to the new specialty hospitals, the new surgical centers? How much of it is that buildup of capacity, and the response of the hospitals to that as well? Is that really the whole of it, or is there something beyond that?

**PAUL GINSBURG, Ph.D.:** Let me answer part of your question, and Mai might want to do the rest. When you talk about the specialty hospitals, which is what Washington has focused on, because there's been a moratorium in the Medicare Modernization Act, and discussions in congress about whether to extend that or let it lapse. Our sense from these visits is that specialty hospitals are just the tip of the iceberg.

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Quantitatively, it's physician-owned outpatient facilities and just equipment in physician offices, or physicians leasing portions of equipment in centers that, in a quantitative sense, that's where the big issue is. I think that's where the major competition is for community hospitals, where most of the buildup of capacity is coming. Mai, do you want to answer the rest of the question?

**HOANGMAI PHAM, M.D.:** Sure. Carmela can address the question of measuring overcapacity in more detail, but I would just point out that many of our markets are certificate-of-need markets, or they're in certificate-of-need states. Some are not. Indianapolis is not, so there is not local assessment there of need, and so, despite the fact that we know over that past ten, 15, 20 years, there has been a steady reduction in inpatient capacity, and that some of this is a response to that, in compensation for that longer trend. There are troubling signs that all of this capacity is not necessarily needed. The other troubling aspect about it is that the new capacity is not being built in the same area where the general hospitals have their traditional service populations. They're being built more often and with more concentrated resources in more affluent communities, often, but not always in suburbs, and sometimes at the expense of resources being invested in inner city and lower-income communities.

**CARMELA COYLE, Ph.D.:** I wonder if I may add, because I

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think your question is a difficult one to answer. It's in many respects one of those answers, you know it when you see it, and then onto the rest of that. But if you look at the Oklahoma City market as an example, I don't think anyone would take a look at the incredible growth in capacity in that market, even somebody who's not involved in healthcare, and not just say, "What is going on here?" I think one of the challenges is that much of the growth is what I'll call nine-to-five capacity. It's physician office capacity, ambulatory surgery center capacity that's available to well-insured individuals between the hours of nine to five, and that doesn't lessen the need for that 24/7 capacity that's available in local community hospitals, whether they be public or private facilities. So that's another piece of the challenge going on, much of that being driven by technological change that simply allows us to do more in different settings, but who's minding the store on overall capacity? What is that doing in terms of driving healthcare system costs, and how do we find a better way to manage that?

**MARILYN:** In terms then, of general hospital capacity, is there much change there? And is there overcapacity in any are that we're talking about?

**CARMELA COYLE, Ph.D.:** In terms of what I'll call community hospital capacity, there are market areas in the United States where you will find over-capacity. Much of that

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has to do with the tremendous shift we've seen over the last decade, and more now from inpatient capacity to outpatient capacity. If you look at the trend lines, again being driven by technology, much more being able to be done on an outpatient basis, better for consumers who can now come in, have some things done that used to be a two or three-day hospital stay in a day. But what that's meant for a full-service community hospital is reshaping their capacity - less inpatient, more outpatient. However, we've started to see that inpatient trend, as I talked about earlier, that's been dipping for so many years, on the increase again, being driven by a growing population and an aging population, requiring more inpatient care than we've seen in terms of trends in the past.

**PAUL GINSBURG, Ph.D.:** Don?

**DONALD FISHER, Ph.D., C.A.E.:** Can I just jump in on that? I think there are two capacity issues here. One is the facility capacity; the other is the provider capacity. What we're seeing across almost all specialties today is that there is inadequate supply of health manpower, whether it's at the physician, nursing, or even the allied health services level. When you put that up against the aging population and the fact that the Medicare beneficiaries of 2011 and beyond are going to be demanding a whole lot of services, I really question whether we have an overcapacity. I think the real truth is that we have an undercapacity in terms of providers support, and that

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the facility shift is probably appropriate in terms of where you get the best care.

**PAUL GINSBURG, Ph.D.:** And Karen?

**KAREN IGNAGNI:** Thank you. I think one of the other factors of this study also pointed out which is relevant, Marilyn, to your question is that legislating away the tools of utilization review in the 90s allowed an overcapacity to develop, because it wasn't being funded, and if there is no funding, there's not going to be building. So legislating away the tools from a federal as well as a state perspective allowed this explosion to happen. What we've been in the process of doing, and you see it in the health insurance premiums now reflecting this, is entirely reinventing the techniques to review. That's why I mentioned the imaging review. The paying for performance, rewarding quality will imbue into the system a whole new range of incentives that will provide a look at value, quality and safety in exactly the kind of way that I think consumers and employers will feel satisfied. So we can already see the initial results of that on the pharmaceutical side. We're going to be seeing it on the hospital and physician side.

I think it's going to have an effect, but, I think this study also raises the issue, do we need to have organized discussions about how much is too much at the community level, to talk about capacity, technology, assessment and comparative

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effectiveness. Frankly, in the political arena, when you raise these systemic, crosscutting issues, everyone goes running, because there are no simple answers to these, but they are very, very relevant questions to begin to develop a critical path to sustain a solution to these problems.

**PAUL GINSBURG, Ph.D.:** We have a reporter on the telephone.

**OPERATOR:** We do have a question for [Inaudible] Jeremy Steel, from [Inaudible] Interview. Please go ahead.

**JEREMY STEEL:** Good morning. I'm calling from Lansing, Michigan. Obviously we're a CON state here. I'm wondering what kind of differences you may have seen in the competition factor between your CON communities and your non-CON communities?

**HOANGMAI PHAM, M.D.:** I think where we've seen CON have the most impact is with ambulatory surgical centers. There are some markets where I think the interest is there among physician groups, but the opening of new ASCs has really been slowed by the CON process, and in other markets, that just is not the case, and they've exploded in number.

**PAUL GINSBURG, Ph.D.:** CON systems vary a lot, besides their political support, as to what they cover. I know in the State of Washington, CON is just limited to inpatient bed capacities expansion, so it misses everything else. There's no building boom in building new inpatient beds. The building

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boom is all on the specialty services, both within the hospital and in physician-owned facilities.

**CARMELA COYLE, Ph.D.:** I wonder if I might add, another trend that we're seeing, even in states that may have certain kinds of CON protections, of course those CON laws are state-based. We have so many healthcare market areas that cross state lines. In many communities, of which Kansas City is a great example, what you're seeing in some of these border communities is, even in states that have CON laws, competition occurring because of physician ownership of limited hospitals that may be across the state line where there are not CON laws or protections there. So even in a state where there may be CON laws, there may still be issues that arise because of newcomers.

**PAUL GINSBURG, Ph.D.:** The next question? Owen.

**FEMALE SPEAKER:** I just want to kind of [Inaudible] a bit of what Dr. Fisher says, which is our reimbursement system, and the point Dr. Pham made about "We get what we pay for," and, if you could just speak to that a little bit.

**PAUL GINSBURG, Ph.D.:** Sure. Actually, there's a paper in your folder called "The Price Isn't Right." It was published in Health Affairs two weeks ago: I'm the lead author. This paper goes into the fact that our reimbursement system puts out just the worst incentives that you can imagine, that it inadvertently pays more, and makes some services a lot more

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profitable than other services. I don't think this is new, but I think that historically, the medical care system didn't react very much to it. Hospitals say, "Okay, we get paid too much for cardiovascular services, we don't get paid enough for mental health. That's fine. We can keep doing our mission." But today, with this fragmentation, with competition, the medical care system is responding. I can recall an interview with a CEO of a major teaching hospital—I won't mention the city—and casually, when I asked about the shape of their investment programs, he said, "Oh, the services that are profitable, that's what we're investing in." He also said, "We never would have done this ten years ago." So, I think that the reimbursement system has really always had the limitation of fee-for-service, and that's what Don addressed so eloquently, about the need to pay for results, rather than just for what physicians or hospitals do. But just, in our flawed fee-for-service system, it probably is a lot more problematic because of these inadvertent imbalances and payment, and I think that really points to a short-term agenda for refining the reimbursement systems, and as the paper said, probably Medicare, CMS is best positioned to take the lead on that.

Well, I want to thank members of the press and our panelists, and my colleague, Mai Pham for joining us this morning.

[END RECORDING]

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