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**Forum on Advancing Multi-Payer Delivery System Reforms at  
the State Level  
National Private Purchasers and State Reform Efforts  
Brookings Institution and National Academy for State Health  
Policy  
October 8, 2008**

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**JOHN BERTKO, F.S.A., M.A.A.A.:** Try to move this along nicely. We have a great panel here this morning. I would like to suggest that what we're hearing this morning is going to be a variety of discussions around a very large dinner table. So you've got one corner of the dinner table with the last panel, I think we had some great perspectives, I'd suggest now that we've got another part of the dinner table here with different stakeholders around here.

I've spent most of the last decade as the Chief Actuary for Humana, so I was part of the payer industry and bring that perspective. Like Joan, I'm hopefully tilting the focus a little bit westward and central in the country.

I live in Arizona these days and my experience over the last 10 years or so has been with the payment and delivery systems in the center of the country from Wisconsin on down to Florida over to Arizona. So it's a different perspective than the New England States. I think the county I live in bigger than Rhode Island, but that's not surprising either.

So I'd like to just make a few introductory comments and then briefly introduce our panel and get ready for their comments. Again, we're going to welcome questions along the way.

First thing I'd like to recognize is that there are a lot of opportunities for improvements in the health care

delivery system and the health care payer system. And then secondly, as we found demonstrated with the last panel, there is a lot of energy right now. In spite of what's going on in the financial markets, there's a lot of room for change, there's a lot of opportunities for change.

A few background comments, the private sector represented by payers and large employers typically, at least in my experience, represents about 50-percent of the cost for providers in most cases with Medicare and Medicaid making up most of the remainder.

And in market by market they're usually two or three dominant insurance company payers whether they're insurance payers or whether they're serving as administrative service organizations for large employers. And so there can be a concentration on efforts.

Another comment here is that working with multiple payer system brings some advantages. First, when we're going to try influence and make changes to the delivery system, it makes sense to have a lot of members or patients for each physician. If we're working only with 10 patients for an individual doctor, we're really not going to their attention. But if we're going together collectively work with a 100 or 200 of their patients we will get their attention.

Secondly, I am an Actuary so I have data for breakfast, lunch and dinner, and you need a lot of data in order to tell

what's going on. If you only have a small amount of data you really don't have anything that's statistically valid.

And then on the flip side for the provider's side, you have a lot of economies of scale. So if we expect physicians and hospitals to make changes, we really need to say, this is going to make sense for you for much of your panel. There have been lots of examples I think in the private sector and multiple payer side of what's going on, and I'll just name a couple of them.

One of the things you'll notice from the last panel is we're not doing much in describing these, we're really trying to draw lessons from what works and what doesn't work. But P for P and particularly in California where I use to live has been very active for a number of years. The medical home pilots we heard a little bit about, but there's a lot of activity beginning on those.

Electronic transactions, the company I was with was very active in Florida on a multiple payer basis in making life easier for patients and for physicians, and particularly being able to get things done right the physicians office with the swipe of a card.

And more recently, I've worked on a joint effort with the California Insurance Commissioner on enabling personal health records, and I think I've alerted Karen to maybe perhaps say a few things about that.

So, again to open up here, I'll now introduce the panel, but we're not looking again for descriptions of the pilots, we're trying to look at what lessons could be learned from things that have worked and almost as importantly, what lessons we should draw from things that have failed. And so with this, I'll make our introductions, again.

We're going to start off with some remarks from Karen Ignagni. I was one of Karen's member company people for much of the last seven or eight years, and Karen represents one of the best voices on the insurance industry and has been at it successfully for a number of years.

Reed Tuckson who I have a great admiration for as person, but I hated his company as a competitor. [Laughter] Over the year's very successful company, we'll look at what's worked there.

Steve Wojcik here represents clients. We serve some of his clients in the company that I was with representing the National Business Group on Health and the largest group of employers. Let me defend Steve ahead of time and say, employer's are a very diverse community. From the very largest ones, who frequently take a very active role in these things to the middle size companies who go along for the ride to the smallest employer's who would wish they were out of the business frequently.

And then Bob Margolis from Health Care Partners and I'll give a modest testimonial. Bob's on the provider's side, he's the managing partner and CEO of Health Care Partners and one of his sites in Florida was a partner of Humana's down in Florida, and I would describe it as a very effective, very efficient partner. So I think he's got some lessons here and reactions that we might get in response to the kind of discussions we're having today. And so with that, I'm going to ask Karen to start off.

**KAREN IGNAGNI:** Thank you John. Good morning everyone. I came into the room this morning with a piece of paper nicely organized and I started writing on it, and then I took another piece of paper and I wrote again. So now much in the chagrin of my colleague, Linda Henman, whose sitting in the back, I now have a new piece of paper which is always a frightening thought for people.

But, I was listening to Alan and the guests you had previously and I thought it was a very, very interesting discussion. But here's the question, in an effort not to try to be politically correct, but to stimulate discussion.

How do we get there from here? How do we look through the state lens and the marvelous people and the really innovative things going on across the country and say, well we have achieved what we need to do as a nation that we tried 100

years to do in this country, which is to achieve health care reform. So, how do you get there from here?

The question that Alan posed at the end is could a number of different states act together. I want to give you a window on it, and I think just picking up any major national newspaper today gives us a window on that. Great people in Europe trying to act together, but they're individually elected and they can't.

And so I think it gives us a window into asking whether individual Governors can be expected to act together without a national frame, number one.

Number two; we have had very significant movement on the part of the National Association of Insurance Commissioners in trying to respond to this issue that we brought to them several years ago. How can we achieve uniformity and processes? Leaving to the states that things that make sense for them to regulate, but how can we take some of the administrative costs down, agree on best practices, implement them exactly in the way I think everyone here would want to have implemented.

They rose to the challenge and did a number of things, but basically and they create compacts as many people know, but the large states traditionally say no to that. So, how do we address that? And they say no for reasons relating to the indigenous sic political situations in their state.

So how do we get around that? And I think we've been spending a great deal of time going around the country this summer meeting with a number of folks in different states. So, a very different perspective than I think we had at least a year ago at this time.

And there's significant work going on in the problems, but there is a significant lack of resources at the state level. We have to respond at the national level to help stimulate progress.

The second issue is a multiplicity of paths. And to what extent does that move us in a direction that in a search for innovation really doesn't allow us to create uniformity or best practice. The last discussion about do we take NCQA HEDIS Data and change it, or do we implement the data that the best experts say are best practices, is a strategic question that as a nation I think we need to finally answer affirmatively to. But that doesn't mean that states shouldn't have any innovation, and I want just work through that in a very quick way as a set of preliminary comments.

We have a strategic choice I think in Washington and John asked us to talk a little about the climate for reform, and this very much relates to last discussion. We can take the position in D.C. and we'll all be part of this discussion post November that it's too difficult, it's too expensive, nothing can happen in the context of what's just happened, which is

going to be \$800 billion before it's all said and done, or we can take the position that health care is a stimulus to the economy. It's the most production investment we can make and as stakeholders we ought to line up to try to get people educated to agree to that.

If government at the federal level were to act then I think that the question is where you put the fulcrum between state and the federal government? And let me share a couple of ideas that John asked us to talk about.

I think first, the question is what would then the federal government have to do? The federal government would probably if it puts resources on the table which it must for states. Develop a phasing plan. How long will take us to get everybody in and everybody covered, number one?

Number two, what are the deliverables at the state level? What are the standards that have to be met? Number three; how do we do subsidies and if we're going to do it through the IRS Code it makes sense to ask that question in D.C. and then the question is, do we give states a little room to respond in innovative ways?

I would answer yes to that question. I think the first panel put forth the best rationale to turn to folks who are very close to the ground to figure out delivery systems, to get resources to people in terms of refundable tax incentives and things of that sort.

But I do think we need guidelines. If you talk to small business people they definitely need to have some certainty about, there's a basic package of coverage that would be available across the country. We need to have some consensus across the country on continuity of care.

Third, it makes no sense I think from the standpoint of people who depend upon safety net programs to have a different level in one state verses the other. So we could get consensus if there were national action resources. External review; we've got 44, 45 depending upon how you count different systems. Surely we could agree on a best practice.

Privacy; we have HIPPA. Privacy standards, we have 50 states acting. Surely, from an administrative cost perspective we could agree on a frame for that. And security we haven't really done as a nation that much about, but we'll have to put that on the list.

Quality; we've tried to attack the quality issue as John said in a couple of different ways. We have many, many different local coalitions doing things, we have states doing things. Doctors are frustrated and have asked to work with us which we've responded to, to try to get consensus on what is measured to have all of the health plans agree on this consensus process. We set up an organization to do, it's [aqaalliance.org](http://aqaalliance.org), and it's on the web.

We're working specialty society by specialty society to get that consensus. So from there, we can aggregate data with physicians, with employer's, with consumers at the table with transparent standards. Aggregate data, we can do it locally, we can roll it up nationally, but again, the basic standards are the same across the country. Does that mean there can never be any state innovation, no?

But it does mean that if we agree; if the best people believe that there is a standard we ought to be hitting in terms of best practice then we have to be serious about implementing that. So you'll hear much more as John said from us about aggregating data, but we're doing it not individually, not working alone, with the provider community, with consumer community and with the employer community.

Similarly on PHR's, personal health records, the physician community came to us and said, how can we get some uniformity in terms of expectation of what should be on personal health records? We responded, got the plans altogether, we worked with the Blue Cross Blue Shield Association. We've now turned our template over to a standard setting organization because we're not in the business of standard setting. But we did the hard work of getting everybody to agree this we can create some uniformity.

So, we're trying to do our part. I know states are working very hard to do their part, but the striking thing you

see around the country today, great people at the state level, you saw a wonderful example of that in the previous panel led by Alan, but without resources to actually do what they need to do ultimately, which is to get everybody in.

I think the federal government needs to put resources on the table. I think it makes economic sense, we all agree on the social sense. It makes economic sense to do it. The most expensive thing to do is to do nothing at all, but the private sector we've developed a very clear window into our responsibilities too, in terms of achieving this uniformity.

A final thing before I surrender the microphone. In terms of medical homes, it's a very exciting discussion, but I hope in our panel having lived through patient protection 10 years ago, medical homes were called capitation then. And we have some of the same issues that will surface in the context of medical homes, and we've had this discussion where the family physician's and the ACP about how do we anticipate some of the concerns that were raised 10 years ago, surfacing again on the part of the specialty community and how can we take this idea of risks, this idea of responsibility and in addition to the primary care physicians think about the specialists as well.

So you'll hear a lot more from us in terms of innovative relationships and partnerships, but I just wanted to put that out since it was such a subject of really exciting

discussion in the last panel. But I think there's a lot to learn from 10 years ago, and very few people step back and really go through that calculus and I think it's essential if we're going to finally take a movement toward real coordinated care. Thank you.

**JOHN BERTKO, F.S.A., M.A.A.A.:** Thanks Karen. Reed, can I ask you to go up next?

**REED TUCKSON, M.D.:** Good, let me, very little time and lots of points to make. Let me above all, emphasize one critical point. We all want the same thing; I think we're all passionately desirous a fundamental change in the system. So the question and I want to make sure that I don't do in being asked to bring some of the lessons learned.

I want to make sure that I do not reinforce a false or unnecessary tension between what national health plans do for example, and the extraordinary importance of local innovations. So please, I'm asked to comment, but don't let my comments be something that drives an artificial wedge between people of common interests.

So, first let me just say that we as a national plan, we're involved in commercial insurance in all 50 states, we're involved with most of the states in Medicaid and SCHIP and state employee programs. We've touched 650,000 physicians, we are involved with the large employer's, the small employer's,

the middle market employer's, and we've got all those interests.

And let me tell you, we get it when it comes to the need for reform. What we also get is that the extraordinary escalation in health care costs, which we are trying to ratchet down through quality related initiatives must also be attended to through the administrative costs associated with implementing things. So we must not only do right we have to do right intelligently and that becomes extremely important for us.

Our experience teaches us that there are these real challenges in balancing local innovation with national level scale. Let's start with performance assessment. This point that Karen makes is extremely important in terms of performance measures. What are the measures that physicians are going to be evaluated by? We are seeing a multiplicity of well meaning initiatives that all have different measures. Why should physicians get whipsawed by multiple different sorts of scales of what they should be doing and not doing?

Remember that physicians get their education through specialty societies, which are national. So it is very difficult to reach physicians, help them to do the things they're suppose to do if they're having, well then there's this rule for this employer coalition, there are these for this state initiative, there are these for this health plan, there

are these for that. So you've really got to understand the terrible impact of multiple competing performance measures that whipsaw people.

Methodology of how performance assessment is going to occur is key. Someone on the earlier used the word, trust. Trust is absolutely important. Physicians have to believe that the methodology of how this evaluation that helps them to be better doctors is going to work is trustworthy.

We now have, and someone mentioned the NCQA, we got three different NCQA standards that are operating on our business today. And one of those is because of a very well meaning, and I would applaud it, one state regulatory body that has been pushing very hard for the people of their state. So they have a set of standards of methodology.

We have a new set of standards that have come out of the patient charter with the National Consumer Disclosure Project. Meanwhile, NCQA just put us through a certification on methodology which we passed with distinction just six months ago. So you can imagine if you will the administrative burdens, the costs, the distraction, the confusion as we have those. And so we're going to need to make that make sense.

The physician's who participate in the methodology evaluation basically have their conversations through their national organization. And so, if they are state by state sort

of conversations about this, it makes it very difficult for physicians at the national level.

Number two; data aggregation. We've been charting it, we got almost well over 200 different data aggregation, HIE's, REO's and such that we are involved with. In the last year, 35 different ones have approached us to participate. Fourteen of them we are currently now doing in six different states, 14 six states, nearly 12 more we're negotiating with in 11 states. Of that 26, 14 are statewide, nine are intra states, small counties in states, and another three are interstate.

And so you can see again, that there is a great deal of complexity as we are being approached. And we love every one of them, and we love state, and we want to be right there with everybody. Each of them have a cost and that cost is significant to the people on whose behalf we organize health services.

The people who pay for health care, care about all of those costs, and many of the people on whose behalf we organize health services will be paying for that five, six, seven times. Do the math of what happens when you aggregate all of those costs. And remember, data costs money to collect. It cost money to refresh; it cost money to analyze it. It cost money year over year over year.

So, these are great ideas which we love. We're playing in 14 of them, but do the math. And I want you to do the math

in relationship to; we're trying to bring health care costs down. So we've got the good and we're doing good in a very complex way. And so this requires a certain sort of balance.

The data fields that we are being asked to contribute to are all over the board. The data extractions are all over the board. Now, if I'm a state, I'm going look, I can't solve the world's problems, I can only take care of what's happening where I live. The rest of that is somebody else's problem. And I understand that sort of frustration that you have.

I'm just giving you back when you look at it at scale, and especially if you start thinking about lab data and pharmacy data. Those are often really national level data that you get from. So now the national lab and pharmaceutical folk have got to give you individual state by state. This gets to be orders of magnitude of complexity, the medical home.

No question that you absolutely have to have local collaboration if you're going to get enough data, but also if you're going to get enough money for a primary care doctor to care about all these wonderful ideas. Because the docs are saying I need cash, that's what this ultimately is about for the poor primary care docs who don't get paid diddlysquat. So you got to aggregate across plans. So that is absolutely important.

There is therefore, a real need for the facilitator, broker, mediator, moderator at the state level and I think the

last panel gives you examples of people who have been exemplary in that regard. So we need that role. The problem with that role of course is and what they don't like is that it's slow. And so you've got real attentiveness to the governess mechanism, to conflict avoidance to being able to sort of to be able to figure out how do you determine roles and responsibilities.

There has to be consistency in the models. We can't have inconsistent models because again, how do you educate doctors? We're spending a lot our money with the American Academy of Family Physicians and the American College of Physicians to educate their members to be good at the model. If the models are different, you got problems.

Evaluation is one of the things that we have been struggling with the most. We're involved in these all over the country trying to actually develop an ROI that says there's a business case for this that you can say to the purchaser's of health care why you ought to get excited is very difficult because the models are so inconsistent you can't do aggregate rollup national ROI's. The methodology is also particularly important. We have been involved in leading and innovating in the patient attribution logic that underlines how this stuff works, but we need consistency just as we do in the ROI's.

Summary, we love innovation. [Laughter] We also understand that health care is absolutely local. What we

challenge ourselves and how we work with states, is there is a moral and ethical responsibility with 45.7 million uninsured people to don't screw up and drive up health care costs because of well meaning, good intentioned ideas. That is unacceptable and we have to be responsible players in that drama.

We have to make absolutely sure then that there are not additive and redundant costs. So I would urge you, number one; would you please, please, please get involved as you have been, but more involved would be NQF and the AQA, the Ambulatory Quality Alliance, but the NQF and let's get this standard set of measures and you commit to use them. And you need to be in there like heck fighting.

Number two; we have got to have the AHIC successor, and we've got to bring the AHIC successor along like tomorrow, it's just got to happen now. We have to have the rules for how data is going to be dumped in. I'm very pleased with what Karen Ignagni has said and I hope you will really go back in your spare time and look at what AHIP has done in terms of creating this national data aggregation model. We need to be very clear that people will send data in same ways and that we take out the administrative complexity of how we do these wonderful data aggregation things, we have to be very attentive to the standardization of performance methodology.

Please talk to your regulators if you're not one of them, and make dog gone sure that you don't reinvent yet a

fourth or fifth methodology around how this stuff works because you will drive everyone crazy, and finally please commit then, to not be dragged kicking and screaming, but by will and force of initiative to make sure that you are finding the way to be part of national level solutions, a national road map, and then good speed ahead on trying to do all the local stuff that we need to do.

**JOHN BERTKO, F.S.A., M.A.A.A.:** Thanks Reed. Okay, Steve from a totally different perspective now. The good guys who are paying for this. [Laughter]

**STEVE WOJCIK:** Well, John after the Medicare and the federal government, large employer's that the National Business Group on Health represents, and other employer groups represent, collectively we are the second largest payer of health care as you just said.

And we operate under ERISA which is a national uniform standard that has allowed employer's alone and working with our health plans to actually be sources of innovation and that is a critical contribution that the employer community has made in many areas to demonstrate for example, that targeted disease management targeted works, financial incentives for wellness and healthy lifestyles work. Again, if they're targeted, and evidence based benefits are key as well.

Lots of other things and prescription drug management for example, are innovations that came from the employer

community working with health plans. So we value the national scheme that large employer's and employer's generally operate under that ERISA force regulated by the Department of Labor, and that as Reed says has a lot of administrative simplicity, reduces the administrative costs.

We do also applaud the states, Colorado, Vermont, Rhode Island and North Carolina and other states that are looking at health care transformation which I think is the key, rather than health care reform and we applaud that you are focusing on what we believe really matters, which is, to focus on improving quality and take those costs drivers out of the system to reduce the growth, or hopefully control costs. And those are the types of things that employer's have been involved in and will look to be involved in at the state level.

North Carolina, Rhode Island had talked about the patient centered primary medical home pilots. We're involved in some of them. Some of our companies were part of the patient centered primary care collaborative, with other employer groups are encouraging our members to participate where it makes sense, and some of those things are some of the things that the previous panel mentioned.

There has to be some kind of critical mass or big enough volume where it makes sense for the employer to get involved. For example, in the Mid-Hudson Valley Medical Home

pilot where IBM is a critical factor in that because it's obviously a big part of their market.

There are other things that also the panel mentioned. I think you're taking the smart approach which is to focus on evaluation, the return on investment, the focus on quality improvement which is part of the return as well. And I think one of the panelists mentioned that you can't mandate this, that there has to be an attractive business case that then employer's will say, yes this makes sense for us to be involved because we have a critical mass here. We do want to be involved in this.

Regarding the medical home pilots, I take what Karen said to heart because I think well there is evidence that a focus on primary care does improve quality as well as reduce costs. The verdict is still out on the medical homes and so that we don't want to put all our eggs in one basket and say that that's the primary care model, there maybe other models out there. But we do want to get the data and do the evaluation to find out whether this works.

One suggestion I might have, if you're looking for other stakeholders, and may you've already done this is to go to the state employee plan which is usually one of the largest players in the states and you can partner with them as well as private sector employer's who like I mention have a critical

mass in that state on how and have a vested interest in the local health care market.

I'm going to just briefly talk about Minnesota. Minnesota obviously is different, some people would say it's easy to do reform there because they're conditioned to work together and they've got a lower level of uninsured. But they did bring employers in right from the beginning in their Health Care Transformation Task Force and now the Health Care Reform Council. Key employers in the State of Minnesota have been involved from the beginning; they're at the table with all the other stakeholders. And I think that that's a good example where it makes sense for an employer to be involved.

Again, focusing on those things that will make expansion of access permanent and sustainable in the long-term, rather than an allusion until the health care, and affordability trend eats up whatever potential gains in access you may have with a program that's focused on expanding access.

I know I'll get to some other things later in the Q&A, so I'm happy to -

**JOHN BERTKO, F.S.A., M.A.A.A:** Great thanks. And now again, for a different perspective, Bob I'm asking you to represent physicians in the more broad provider community.

**BOB MARGOLIS, M.D.:** Thank you John and thank you everyone. Good morning. It's a pleasure to be here. I feel all pumped up after a great sermon from Reverend Tuckson,

[Laughter] and I'm always happy to be sort of the, I guess representative. I don't know how I get to be that of the actual physician's that take care of patients in the field. And along suffering primary care at that, so thank you for all the boost for primary care.

Lots of conversation this morning about NCQA, I've had the pleasure of being the Chair of the Board of NCQA over the last many years, and the standardization of data and the standardization of supporting and transparency I think is clearly in my view an absolute necessity if we're going to have a rational health care system.

Reed talked a lot about administrative costs. Clearly administrative costs is a big issue, but I'd like to take it from the perspective of leverage which we heard a lot about in the prior conversation. And that is 80-percent or more of the costs is in the delivery of care and a small change or percentage change in the way delivery of care is managed has much more of a leverage able affect on the cost care than all of the important administrative savings that we talked about.

Our organization, Health Care Partners has been an advocate and a participant in the much maligned common of capitation for 25 years. We take care of close to a million patients under a capitated system, 150,000 of those are Medicare Advantage patients. So when I look at reform from the

physician perspective, I have a few perhaps different ways of sort of feeling the elephant.

I must say I'm very depressed by the health care debate that's going on nationally and what we heard again last night, it's all about access. Access is very important, access in coverage. But we're missing where is the quality, and where is the efficiency, and we're not going to have a rational health care system until we get after quality and efficiency.

And I think the data is pretty clear, that quality and efficiency comes from the coordination of care across complex and multiple disease elements. We heard a lot about that in the prior conversation. It comes from an organized system of care, and I think the question that I think we as policy and people interested in policy and health care policy have to ask, is why aren't the politicians basically saying, it's the delivery system stupid, to use a prior phrase, because that's really where we need the health care reform in my humble estimation.

The core of that health care reform, I believe is management of populations, not the management of individual sick patients. While, that's important and obviously as physicians we're all trained, that's what we do. The question is how do we get physicians and medical homes is one piece of that, but how do we get physicians engaged and the whole system engaged in managing care for the population?

Clearly what we have now is a sick care system, not a health care system. How do we move that? Just an example, Kaiser who's a strong competitor of ours in California, Kaiser permeated in Northern California through coordination of care and disease management around cardiac care, has reduced the incidents of cardiac events in Northern California, over four million people since, no longer the primary leading cause of death in California in Northern California. It now has reduced itself below cancer as the population care across large elements in a coordinated delivery system can and will work.

I was asked to talk a little bit about how we tried to do that in California with the P for P Program. Multi Stakeholder Program, we got consumers health plans, providers together around the idiocy that Reed pointed out of physicians getting whipsawed by having multiple kinds of things they're being measured against. We got all the major health plans to agree on a set of metrics. We created a business case for quality by essentially taking pieces of the premium increases over time and paying them more and more for performance based metrics.

We started this some of us in the year 2000, the program has been up and running now for seven years. It pays between \$60 and \$80 million a year. It's a purely voluntary program, but essentially 95-percent of all physicians in the

State of California that take care of commercial HMO patients are involved.

The previous panel was asked about why isn't Medicare. We fought long and hard to get Medicare to participate on the Medicare Advantage side, we're in the same P for P Program. It escapes me as to why they haven't. They've talked about it, they want to keep it to a national standard and not deal state by state.

But nevertheless, this program creates the elements that are related to how do we reform the delivery system, and I'd like to just point that out, is once you create a business case for quality, on the delivery side you start to develop a set of factors that physician relate to.

Number one, the elements of what you're measuring need to be both consumer relevant and scientifically valid. If they don't meet those two simple criteria they're not going to be evaluated by patients as important or by physicians as worth measuring. But if you can create those two, and then you can create a business case around it, what happens? Physicians then say, well it's important to me to get the data. Well the data is not very clean, so it's important for me to clean up the data.

It's therefore, if you do administrative data, it's that important to adopt IT in technology to collect the data.

Then you get the fact that, well I don't deliver all the care,

some other specialists do, team members, nutritionists, home care workers. You get a team approach to how people start getting their data so that they can actually participate in these programs and what ultimately happens is you've created a culture of quality and a virtual coordinated care system, even when you don't have an organized medical group as a criteria.

I think that that is the benefit of P for P and what a incentive program of payment reform around quality outcomes and transparency will start to create and is the way to start to reform our delivery system. Thank you.

**JOHN BERTKO, F.S.A., M.A.A.A.:** Okay, thanks.

I'm going to lead off with a couple of questions and then open it up. We've got about a half an hour or so to go through these. And I'll start off by aiming at Karen and Reed.

Both of you gave some indications, some of the barriers and Reed I think your sermon there gave some of the possible solutions, but the audience you're preaching to today is a good one. It's the people that would listen and act on these. What do you think could be done to speed up the adoption of those standards to make the system more efficient?

**KAREN IGNAGNI:** Do you want me to start? I think one of the first things that can be done is an affirmation on the part of the employer community that they are robust enough to stop a lot of the, we talk about innovation when it comes to state activities, but there's a lot of important innovation and

learning on the employer side, but it's now I think important for all employer's to take a seat at the table to be serious about this issue of uniformity.

Now that the professional societies and the people who know what they're doing in this arena have come to the table and are working together. So I think it's not fair to aim the comments of, can't we get to uniformity and embracing that to the folks who are trying to work with very little resources at the state level. We also have to have that discussion; employers have to commit to that.

And I think consumers through their national organizations are already at the table and they've affirmed the idea of let's move together in this arena. But that's the next piece here, now that the health plans have agreed that they're going to act in a uniform fashion. There will be lots, as Bob said, there will be lots of opportunities to create competition in the system in terms of how you incent, but the similarity in baseline with respect to what constitutes quality care in a basic standard. That's got to be at the heart of all of this. And I think the other part that Reed talked about, I felt I was running out of time so I didn't say it. But the IT part is very, very important here.

Secretary Leavitt has talked very, very explicitly about agreeing to that years ago, we agreed as a country on the size of the train tracks. It's simple, but it's very powerful

as a metaphor. We have to do the same thing in IT, and so from that perspective every company that has a stake in the IT arena needs to come to the table and we have to get that kind of uniformity. And that's been frankly the barrier between getting from here to there, and I'm hoping that, I'm looking at Mark here as Brookings takes on this AHIC II, that's the challenge and to move expeditiously. So, I think that's the baseline.

**REED TUCKSON, M.D.:** My response, let me carry forward with where Karen just did it, and she talked about it as an organizational dynamics and that was the right answer. I love being a physician. I love being a part of what I consider to be the noblest profession in America, or industry in America, and that's health care. I love it.

I'm so frustrated with my industry. I'm so frustrated with my friends, myself and my colleagues. We all know each other. We go to the same meetings over and over again. We meet at the coffee bar, we talk at the breaks. We put on Hat A at Meeting A. We take that off and put on Hat B, I'm at the IOM this week, I'm at this place this week and we just keep.

The point being, and I think the genius of this meeting and I give you credit Mark and all the people at Brookings is because quite frankly, there are a lot of faces in this room who I don't see a lot, some I do. I see a bunch of people I see all the time. But some people I don't get to see enough.

So adding their faces to this conglomeration of everybody who knows everybody, and the point being is doggone it, when the history of this time is written, and we tell our kids why did we screw it up, I know every single one of the people who screwed it up, me included. And there's no excuse for it. This is a matter of personal leadership. This is a matter of people just deciding, got dam it, get it done.

If the organizational stuff is one thing, and we can get all kind of complexities, but we do not make the decisions. As people who lead organizations, to just sit in a room quietly and just make it so. And we see that in other industries. And I don't understand why. Anyway, that was just irritable comment from a curmudgeon [Laughter]

**JOHN BERTKO, F.S.A.,M.A.A.A.:** That's okay, I agree with those irritable comments representing a different point of the industry.

**STEVE WOJCIK:** I'd like to respond about the employer community. I think there is not a single employer who would not agree that we need uniform quality standards. We don't want to be paying physicians and hospitals for doing extra paperwork to satisfy the needs of different players, whether its health plans or employer groups.

There are some employer groups who do have their own initiatives. It's a free country and they choose to experiment. I think the larger employer community, most

employer's would prefer one set of national standards and we are glad to see that the physician community is coming to the table because I think that was the initial group that was largely missing from the table. We do participate in the AQA, and we do support the NQF and NCQA as well, so, national standard setting, national accrediting bodies.

Some of the state initiatives though, are focusing on changes in the delivery system, not necessarily just the quality measures. And like I mentioned some employer's will feel that they have a critical mass in a certain area, state or sub division of a state and they want to be part of one of the experiments, and it makes sense for them. There is some promise that the ROI will be there, they also potentially want to be a supportive part of the dialogue at the state level, especially if they're a big player in the state.

**JOHN BERTKO, F.S.A.,M.A.A.A.:** Karen, and then we're going to go to the audience.

**KAREN IGNAGNI:** Just a quick follow-up, I think Steve's made, what you're saying just to take the next step. I think we're approaching the tipping point. And I say that with a lot of enthusiasm, because I think you're right once the physician societies came to the table to participate in this dialogue it changes everything for employers.

And the reason I observed what I did about the employer community is that we're here talking about, can we get there

from here? And we've spoken a lot about sort of, it's great within a federal frame, I think we could have a lot of state innovation and it could make sense. More sense than it might without the federal frame. And the bargain would be providing valuable resources that the states need.

And I think Steve's making the point that we're probably, there's broader awareness now about from the employer perspective now that the efforts are getting robust enough, they can commit. And they can do the kinds of things that we've committed to in the health plan arena which is to say, it makes no sense to compete over the data. We have to have data that physicians find it acceptable, that they agree on, that's transparent to them.

They've had a major role in shaping, and then we can compete on the incentives. But that's a very different system and I think what Steve is saying is, we're approaching that from the standpoint of what the employer's need to turn this system over and to be sure that they're issues will be taken care of, and I think that's real progress.

**JOHN BERTKO, F.S.A., M.A.A.A:** Thank you.

**REED TUCKSON, M.D.:** And as you turn to the audience by the way I do want to underscore this idea of the physician's coming forward. I think that the ACP and AFP, I mean they're stepping up into the leadership role and have been extraordinary. And I will also say that I've been very

encouraged and I think we all have to pay careful note to people like Nancy Nielsen, the new President of the AMA. She is a singular force I think for bringing this forward as well. And I think we ought to give her some encouragement and support.

**JOHN BERTKO, F.S.A.,M.A.A.A.:** Yes, thanks. Questions. Yes, back there.

**RENEE CARTER:** Yes, Renee Carter [misspelled?] from Senate Finance. I had a question and this might be directed more to you Steve, but if any of the panelists want to answer it.

How do you reconcile, most of the physicians are also small business owners. So how do you reconcile their concerns as far as being providers, but also being business owners?

**STEVE WOJCIK:** Well they probably have good first hand knowledge of the difficulties of our health care system on both sides, from the payer side as well as the provider side. So we do sympathize with them. I always say that I have the luxury of being part of a group that represents large employers, so generally they have enough resources to provide health care and it's a growing part of their resources that they're spending on health care.

So they're kind of in a different situation, but we do have great sympathy for the small employer and the situation

their in and that's why I think the state's focusing on changes that will improve quality and safety, and control costs.

Minnesota has a pretty ambitious goal by 2011 I believe, to reduce, not just control their growth and costs, reduce costs by 20-percent, and you can argue that they're starting at a good place in terms of how much they spend on health care and the quality of their health care system. But you can also argue that it's going to be harder for them to find 20-percent, so it'll be interesting to see what they do there in Minnesota.

**JOHN BERTKO, F.S.A., M.A.A.A.:** Thanks.

**REED TUCKSON, M.D.:** The challenge that you have in addition to the health insurance as part of their perspective is, and it's very difficult to think about physicians as business owners because of the professionalism that is so important for what they do.

But we also have the issue in terms of the agenda that is on the table in front of us here, is how will physicians offices be prepared to finance the capital investments that will allow them to participate in these activities? Now what the MBGH and other business folk who are not in health care will say and may well say to those physicians are; we have to invest always in our capital infrastructure, our computer systems that allow us to stay in business.

Some physicians are suggesting that the only way they can participate in this drama that we've talked about is if they get a subsidy for the capital investment that allows them to participate, and they want that built in as part of the costs associated with playing.

I'm not going to try to signal whether that's good, bad, right. I'm just saying it's a reality that is germane to this discussion and the question becomes is, how we handle that as a part of the formula for going forward?

**JOHN BERTKO, F.S.A., M.A.A.A:** Bob.

**BOB MARGOLIS, M.D.:** If there's an outcome where physicians believe there's actually payment for quality as oppose to payment for volume, the incentive to invest in these systems becomes very strong.

Our experience is that we have hundreds of independent affiliated physicians that have adopted these systems in California and now in Nevada and Florida and our other areas because they incentive starts to change.

So really the payment incentive and changing the incentive to pay for something other than volume is really the key to the infrastructure investment.

**REED TUCKSON, M.D.:** And so what's so important here though, is so that for example. In some of the pilots that we have been involved in, we have gambled and frontloaded

guaranteed payments, even without knowing whether the ROI is going to work, so we're at risk for a whole bunch to do that.

Because I think this is a key point that he's making, is that do you at the end of the day, can you guarantee to that doc that they're going to recoup their investment. Similarly, this is why the AHIC's successor is so important. If the certification commission and the health information technology is not able to absolutely guarantee that the interoperable medical records and so forth are going to be interoperable and are going to work and that the product they buy is going to work, they aren't going to be investing the \$20,000 in that system upfront.

So there's going to be a very strong need to guarantee. So these sorts of guarantees are key, and these poor docs who are not making very much or having a hard time are going to need those kinds of controls.

**JOHN BERTKO, F.S.A., M.A.A.A.:** So let me ask a clarifying question I think, because Bob I know some of your sites are mostly capitation sites as you said earlier. Is capitation a requirement or Reed when you talked about guaranteeing that, are you doing that in a fee for service environment? And I guess I'd ask both of you to comment.

**BOB MARGOLIS, M.D.:** A couple of points following on Reed. Number one; we've centered this part of the conversation around quality improvement. It think it's absolutely critical

to understand and improving the quality of health care in America is going to actually cost more, rather than save money in the short-term. There are so many people that are under treated and are not part of the system now that bringing them into the system, treating them to the RAND Study Compliance with best practice medicine is going to actually increase costs.

So, let's not have this conversation around this is the way to reduce costs, that's on the quality side. You can also build the same pay for performance or pay for outcomes around efficiency measures. Is capitation the best way to do it? In my view it is because you then focus on wellness and prevention as a way to avoid future costs. Someone early in the earlier panel talked about the turnover and how would someone invest because someone else will get the benefit.

At least in the physician organization where patients move from plan to plan to plan as their employer's do, they stay with the same physicians. So we have the ability to invest and amortize that cost of prevention over these patients' lives, even though they're moving from one plan to the next. So that's one feature.

And I think the opportunity then to change the payment system not necessarily to capitation, and I would advocate that we seriously look at that nationally, is to just have an

increasing portion of the payment related to some kind of quality outcome metrics that we can agree on.

My belief is that over time if we could get to 25-percent of physician compensation tied to outcomes, we would get there. Don't underestimate the incredible power of transparency and physicians always want to compete and be the best and if we can get a transparent system with some appropriate reward and incentive tied to it, you will see in my view physicians marching towards that improved outcome on both efficiency and quality.

**REED TUCKSON, M.D.:** Fee for service is what we're doing now and I take, whenever Karen puts cautions up like she did in her introductory comments, I pay close attention.

[Laughter]

**JOHN BERTKO, F.S.A., M.A.A.A.:** Other questions from the audience?

**KAREN IGNAGNI:** John, can I just add something just following up with where Reed left off. I think that we in the policy community really need to, not sounding like a wet blanket, but devote significant discussion to this issue of accepting risks. What comes along with it, what the nation's expectations are? I can tell you that in the area of imaging for example.

Our health plans, the old model was clerk to physician, it wasn't accepted, physicians rejected it everybody knows the

history. Now it's physician to physician using specialty society guidelines, transparency. It's a very different model, but some of the same kinds of assessment tools, accountability, but done in a more transparent way.

But as a community, we really haven't had a national discussion about whether we're really able to accept this concept of cost containment. My cost containment maybe somebody else's livelihood, and we really have to have more discussion about how to achieve that, how to deal with the expectations.

You raised the question about small business. A number of the physicians in small businesses tell us they're really having difficulty offering health care coverage if they have four people that work for them. So, as part of all this, we've got to think about what it's going to take to do health care reform, are we serious about getting to costs containment and what does it mean for rank and file people, and are we ready to accept that and what are the processes we want to protect us. That's sort of number one.

Number two is, how do you smooth out those risks of those small business people so they're not worrying about somebody, two people ending up having bypasses, and increasing their costs significantly. You all will hear a lot from us. We have a number of new proposals that we've been working with a number of small businesses to understand what their issues

are and to forge and to offer them as we get post November to a health care discussion that, A, we hope will happen, B, we're going to work hard to work with others to facilitate, but we want to broaden it so the access issues, which are all important we must get everybody in.

But we can't do that nationally I think based on the 100 years of trying without dealing with the point that Bob made which is, it's got to be about the cost containment and the quality. We can't just say that, with having lived through what happened in the '90s, we drove health care costs down to zero, and the nation basically said that wasn't good enough because we don't want cost containment, we want more access, we want X, Y, Z.

I'm not arguing whether they were right and wrong, but nobody has assessed the impact of that. So now when businesses say that they can't afford it, people love to talk about health insurance premiums, guess what, health insurance premiums follow underline costs and nobody has an appetite for that.

So we really got to talk about coordinated care, we have to talk about risks, we got to talk about primary care and specialty all across the continuum and this is really hard. Nobody really wants to do it.

**JOHN BERTKO, F.S.A., M.A.A.A.:** Thanks. Have a question over here.

**DAVE KENDALL:** Dave Kendall with Progressive Policy Institute. Well we have the evidence that's on a regional level. If we eliminated the variation of care that occurs in the high cost areas, we could save tons of money, Right?

So and it seems like this is a great opportunity, we have regional problem, we use the states to attack all the problems that. It's great that Minnesota is doing a 20-percent reduction in its costs as part of its goal, but the reality is we just got to get the rest of the country to Minnesota's level already, we could do what we want, if we got to that point.

So, what is the responsibility of the national payers on this issue of regional variation and it shouldn't be more than just. Have uniform standards for measuring performance, but then work out the incentives, and isn't there a collective responsibility that you all have to reduce the regional variation to save us the money that we need to get everyone covered in this country?

**REED TUCKSON, M.D.:** I'm not sure, so I guess we have violent agreement, I guess. I'm not sure whether the economy is, yes. So the answer is yes. We are working at the state level, at the regional level, at the national level to do all the things that you're trying to do. So maybe what your question gets to is, should we as national health plans do more to work at regional levels to collaborate to get this done, and I agree with you completely. Yes.

**JOHN BERTKO, F.S.A., M.A.A.A.:** Let me add to that. My work as the Chief Actuary was finding those things. If you think of me I'm here sitting at the radar screen looking for the amounts of those variation. You need data to do that, one company generally isn't enough, you need cooperation from Medicare. Mark maybe will cue this up for our luncheon speaker. There's a lot to be done in just finding it before. You don't want to go around and take a blunt instrument to it.

**KAREN IGNAGNI:** Well I want to answer Dave's question in a different way. And again in an effort to be frank, not necessarily politically correct.

But take the perspective of an individual health plan. So you're asking the question whose going to Boston and New York to tell them they have to be like Mayo, in terms of numbers of days, in terms of numbers of procedures, in terms of intensity, in terms of really being serious about care coordination and continuity of care all the way through.

So, the question is can an individual health plan do it, having had experience with the individual health plans, trying to do that themselves. Absent a national conversation 10 years ago, yes we were very effective, we could do that again.

And a number of the tools that now have been reinvented and embedded and pay for performance, disease management, we learned from what didn't work 10 years ago. Having said that,

if we proceed down this road on our own again it's too easy for the institutions, for the caregivers who have a different way of practicing in those areas. I'm just going to pick on Massachusetts, Boston and New York, just for a second.

That there will be press, they'll be backlash, it'll be all about the health plans not getting it, not doing it right, not caring about the patients, et cetera, et cetera. Meanwhile, all the policy advocates are challenging us to get the costs under control, we can do that.

Now it's a question of how much the public really wants cost containment and the best way to do this is the way we're now doing it in laying down pay for performance programs that use uniform data that have been accepted and forged by physicians.

Dealing with imaging in ways that using specialty guidelines, doing it very transparently, that's just a couple of examples. But I think this really means a change of the dialogue, enlarging it, doing it more transparently and having a national discussion about the one thing that our country doesn't like to have. We're going to have a whole discussion about comparative effectiveness, should we do it, I hope, yes. We're strongly supported and virtually almost all stakeholders groups are now terrific.

We're going to have a major discussion and it's going to get very intense and very difficult about whether cost

should be included. How can you have comparative effectiveness if you don't at least have the best and the brightest, not using it for coverage decisions, but assessing costs. That gives you a window into how difficult this is.

**REED TUCKSON, M.D.:** There's no question that, and so if you take that and say, absolutely. A national health plan does not have enough clout with any of the local players to try to by themselves get attention. All you do is you get yelled at, and you get beat up, and it's ugly and they go to the newspaper and they say, you're horrible people and then it's just ugly.

So that's why I say that at the end of the day it's working together with regional leadership, like we see in Rhode Island, like we see across the board. As you work with them and so I thought that's what you were calling for is there any reason why we are not trying to be in common cause with other health plans across the board trying to solve these problems together. And that's how I got there and Karen gave you the granularity, because you can't do it by yourself.

That's why I think the other thing is that, I think you ought to go back and look at this data aggregation stuff that AHIP has pulled together which I think is the perfect model. It's where the health plans together now with multiple other stakeholders have said, look we will get their aggregation done. We know how important it is to stop talking about

getting it done, we will get it done, and that's what's happening now.

**JOHN BERTKO, F.S.A., M.A.A.A.:** Mark.

**MARK McCLELLAN:** Yes so thanks. I want to use the prerogative as one of the conference organizers to actually blend the first two panels. This has been an excellent discussion here, an excellent discussion earlier and there seems to be complete agreement on the goal, that if we're going to get costs and coverage more sustainable, we're going to have to find ways to actually improve quality, and then everybody is talking about getting measures, getting consistent systems, and then providing incentives in the financial support for doing that.

But I was wondering if I could put Joan and Alan and Chris and Craig on the spot a little bit to react to some of the issues, and let's maybe be frank about it. That there are tensions between the push at the local and state level to take action now, we're facing some really urgent challenges, and everybody agree these are urgent problems, verses the reliance and support from the kind of national data standards that AHIP and Brookings and other organizations have been working to collect.

Do you all see those were the same path, conversions where we can have some kind of national standards that we rely

on, but still some very important roles for states and how exactly would that work and how can we make it happen?

**JOAN HENNEBERRY:** Well I think it has to work, I mean the pressure on states in the absence of a federal solution only grows stronger. So, we almost don't have a choice whether we address this or not, your Governor can't possibly ignore what's happening with 25-percent of their state expenditures, even if they don't give a hoot about health care, they can't ignore it.

Now I just had so many reactions to this, and what I like about the notion of standards is that, as a representative for clients it makes no sense that you're treated the same client can go to one part of the state or one state and get treated one way and go to another state and get treated another way. There's no logic to that in my mind.

As a purchaser, it makes no sense that one health plan uses one set of standards and does one set of pay for performance to their providers and another health plan does another. And as a payer nothing about this is logical and it feels impossible to tackle as a state payer and purchaser.

So, I think the conversations, it's not one of the other. We have to stay the course, keep plowing along at the community level, the state level, but we have to have these national conversations.

ALLEN DOBSON JR., M.D., FAAFP: Let me put two hats on, I'll put my physician hat on in saying, we do a lot about physician report cards, but on the other hand we talk how we need team care and systems of care.

And so we're saying to physicians we're going to measure you and do pay for performance, but it's not just about the physicians, it's about the health systems locally, so that's one point. And I would applaud any effort to get standardization because we're just paying for the same thing over and over again. It's like buying a computer system and then up with ultimate customization at every turn, and you just can't do that. And I think we can work with data locally if we can come with some standards and get it to us in a usable form.

Also an appeal, I've heard it discussed, the ROI. Who's going to take the risk for doing this? And that goes all the way down to the practice level. If we want to get fundamental change at the practice level, there has to be an ROI for the practices and the communities as well, which leads to this shared savings.

And I agree you just can't do quality, it has to be quality and efficiency and there has to be some stake in it for the people to make that transformation, not that I'm going to get paid less if I don't do it, but there has to be some real engagement that there is a shared savings and some shared incentives to make these transformations. And so I would

appeal that we look at ROI from the ground up verses the top down.

**CHRIS KOLLER:** Thanks. I would agree on the need in the points of national standards. I think it's a different world from 10 years ago. Our project in Rhode Island relies completely on national standards. We're using NCQA standards for medical homes; we're using NQF standards for the chronic care conditions that the docs are going self report on.

I think that Karen and Reed probably overstate the extent of local variation. I think you'll find that responsible local entities are pulling from the menu that's being created so I think the national role is to create a limited menu to find options and allow the locals to pull the ones that are most acceptable. We got to make sure the menu doesn't get to be too many pages, so that with the variations isn't too much. But I think we've made progress on that.

The point I want to bring out is, standards aren't enough, that if you look at the things that are, people say are going to focus on, it's the delivery system stupid and what's going to change the delivery system. I'll take the example of payment reform. And Joan's comment; a reform where everyone ends up no worse off than before isn't a reform.

And the reason why we are not getting changes, substantial changes in payment reform, we're nibbling at the margins around primary care and things like that, is because

the uncertainty and the fact that some people could end up worse off than before and if we're successful at limiting the costs trends, people probably will.

So, we at the locals, we should do a better job of taking the Dartmouth Atlas information and saying, where we differ from others in making data base decisions. But when we talk about trying to go towards episodes of care, and getting people to pay that way, the health plans keep telling me, it takes two to tango and even if they come to the table with the hospitals, that the hospitals don't want to dance, that conversation's done.

Reed walks away and says, I'll come back later on because I got to satisfy my customers. We're going to have break that dynamic, they're might be a role for Medicare, in terms of setting out the path and start giving the cover for locals to play.

I don't think there's much of a role for purchaser in it because you have to take a population based approach and purchasers don't represent enough of the local population. So that's something that doesn't lend itself to standards, and is really getting at the underline vest of what the machine that is driving this cost inflation.

**REED TUCKSON, M.D.:** Can I quick respond? There's one more person I think -

**CRAIG JONES, M.D.:** Just a quick comment. I think a move to national standards is good, we're seeing that the NCQA's standards for a patient center medical home, Preventative Services Task Force recommendations, these things are being adopted in these models. And I think it's a misleading to characterize it as though many, many different things are happening all over the place, and they're completely, they're so different that we can't handle the variability which is sort of what was embedded in some of the earlier comments that how can we do this if there's so many different measures, I'm not sure that's the case.

To Chris's point, I'll take it one step further. I think people are looking for guidance through national standards and they are adopting them when they're there.

Furthermore, I think it's the absence of leadership from the national plans that is causing people to fill in and for states to make a move. So, multi-paired data bases that you're seeing spring up around the country. These are strong efforts at getting aggregated data in common place so that we can begin to look at common measures at a state level.

So you're seeing in the absence of national leadership, whether it be at a government level or at a plan level. States and other entities locally begin to fill the gaps. And it's not that national standards won't be adopted, but if we waited for those standards.

**REED TUCKSON, M.D.:** Well, that was the point I made that if I were in your shoes I would be saying the same thing. So I don't think we have a major difference of opinion there. I think also, I would say Chris's point which is I think is important. We are at a moment in time. Unfortunately we're in this transition period. Things are distinct enough, whether you put it under the real brick of standards and/or inconsistency.

I will tell you that when you look at the economic costs for the people who have to do this everyday, if you look at the ROI conversation with your major customers. If you look at the economics that it costs us to be able to process that data and reply back. If you the cost it takes for us per member, per month cost to participate in 32, 40 different of these things, the economics of it, believe me, you look at your numbers. We don't play around with numbers, it's serious.

So, I would say to you, you may think it's overstated in terms of what this means. It is a serious consideration for people who are mature and have to deal in the real world.

Having said that, I will absolutely accept your premise, both of you and that things are moving forward as they should. That's why I made my comments early on that I don't want to reinforce a false dichotomy or create more tension where I think we are all sort of getting there.

The question is, is what do you in this hybrid zone? And it really gets down to the level of the ROI, that our good Doctor talked about, because if you look at where is the costs expenditure and the reimbursement, who wins with all of this, and we are in that zone now where that's really very unclear.

The position that we've had to take to try to show some leadership and cut through that, at least on some pilots that we're involved in, is that at the end of the day, whatever the cost savings is, 70-percent goes to the doc, 30-percent goes in decreasing premium for consumers, none for us. That's the only way we know to break through it. So we took ourselves out of the equation.

So, I think that that's part of how you start to get out of this no man's land. But at the end of it, there are economic costs that doctors are going to have pay on the front end, hopeful they'll get their return on the, and you can go through all that.

So conclusion, I appreciate the comments you're making. We are more moving forward than not. However, this is a very uncomfortable transition.

**JOHN BERTKO, F.S.A., M.A.A.A.:** I think that because we're standing between the panel and lunch, I'm going to call a conclusion.

I would just sum up with maybe three words or phrases. One, acknowledge the need for working on these standards.

Secondly, I think everybody has come up with a sense of urgency to get there as quickly as we can.

And then the last one, just as an example between the slashes is the need for discussion and collaboration between all sides, across the dinner table, rather than having a food fight.

So, first of all, thank you for the panel, your lunches should be in boxes just around the side and then I think I'd ask you to come back in and Mark will introduce our lunch speaker in a few moments.

Thank you again. [Applause]

[END RECORDING]