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One-Day Conference: Delivery Systems Matter! Improving Quality and Efficiency in Health Care: How Public and Private Policy Can Encourage Greater Integration & Adjourn

March 17, 2004

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MALE VOICE: Kaisernetwork.org.

ROBERT BERENSON: Uh, thank you John that was very kind. I'm a pinch hitter today, Glen Hackbarth [ph?] was to be in this role, some of you knew that in a prior sort of pre-agenda and Glen, who most of you know, is the Chair of MedPac and, uh, spent a number of years at HICVA [ph?] and also at the Harvard Community Health Plan, so he would have provided a very good perspective on this topic, was in a skiing accident and he's fine, but didn't want to make a trip across country and asked me to substitute, so, I actually had a nice discussion with Glen, we sort of see this issue similarly in a couple of places I will actually refer to what he might have said, although as I guess the normal disclaimer is all these remarks are mine and I cannot ascribe them to MedPac or to anybody else.

Um, I, as the prerogative of pinch hitter, you know, after you ground out to second, you can go to the showers and go home, uh, I will leave a little bit early to catch a previously scheduled flight.

Uh, let me start with the sort of most memorable comment Glen made in the conversation we had, which was "you can't force people into systems they don't want to be in." And, sort of, he was looking back over some of the mistakes of,

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uh, where market competition went, focused on that issue in particular and I will be coming back to that, as well.

Uh, last week, uh, the Center for Setting Health System Change and Health Affairs put on a conference uh, drawing on a lead article, um, in this obscured journal called Health Affairs. Uh, our market force is strong enough to deliver efficient healthcare systems confidence is waning, by, uh, I was one of the co-authors. Uh, Glen Nichols [ph?] deserves credit for most of, of the work, but we all contributed. And we, one of our conclusions, based on, this is sort of work out of the Center for, Center for Studying Health Systems Change site visits for 12 communities, uh, including Indianapolis, interestingly, where we interview 80 people, providers, plans, purchasers, uh, government officials, etc. and there was an increasing sense that, um, was sort of encapsulated in this sentence "Major barriers to efficient market outcomes exist amid a growing willingness to consider renewed government interventions.

Now people were not articulating a desire for a single payer, double payer government system or for specific targeted government regulation, that was just sort of a sense that was left to its own, uh, there were no solutions out there and there was, needed to be a role for somebody. I think they were basically saying, and again, this was across all respondents

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from doctors to purchasers to brokers, uh, sort of a, what I think the WHO would call in it's reports, stewardship. A sense of the government of trying to facilitate or lead, um, activities to, uh, sort of deal with the system that, that seems not to, uh, be working very well. I'll, I'll be coming back to a recommended specific role for government as a purchaser.

In part of our analysis, uh, we identified four barriers to efficient health systems and the one obviously, that's relevant today is the second bullet here, uh, we observed that most of these sites, and one of them was Orange County, where there was still a vibrant, uh, multi-specialty capitated multi-specialty group culture, uh, but for most of the others, there was clearly, uh, no development, in fact, regression in development, so what most, what Steve would call an integrated delivery system, and that we would recognize as such. Uh, more sort of atomization of the health system.

Uh, in commenting on our paper at the conference last week, David Dranoff [ph?], who I'm sure many of you know, he's a professor of Health Industry Management at the Kellogg's School at Northwestern, um, observed, uh, partly tongue in cheek, but partly seriously, that, uh, the fact that people are not going to integrated delivery systems suggests not the failure of the market, but the success of the market. That is

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actually, people, if they don't want to be there, they didn't have to be. They were able to choose not to be. Now, I then asked the question from the floor, I think, uh, maybe the one that Allen might have posed, well if you, uh, subsidize people's choices, um, with taxpayer money the way the tax treatment of choices are made and without equal, uh, employer contributions, sure people would pick, uh, the more expensive, uh, alternative, and he agrees with that, clearly. But he was making a point, and he, which essentially, markets don't necessarily result in people picking the most economical or their, or the choice that policy elites, think they should pick, they pick SUVs. Um, now wants to talk about how much we subsidize gas, etc., but, uh, it was an important, I think, um, a discussion, that, in fact, what Allen has laid out, and does it again very well in, in the chapter in the book that I recommended, is not the, not the model that employers are following or consumers want at this moment. So I think that leads us to, re-thinking assumptions about where change can occur in our system.

Um, I think one assumption has been that private purchasing should be the focus of innovation and often people have dismissed Medicare as a commanding control operation that clearly can't be innovative. Assumption two has been that consumer choice should be accommodated at the choice of

insurance product rather than at the point of service. And here I make a, a distinction which we don't need to get into now, between people when they function as patients and the people when they're functioning as consumers. Um, but, I guess what I'm suggesting is that a broad choice plan, can, uh, accommodate, should accommodate consumer choices for how they want to get their care. Not about a clinical illness, when they're, when they got it, but do they want to go to a prepaid practice, not necessarily, as in a, as a choice once a year in an open season in enrollment, but perhaps, during the year, uh, and then, uh, you know, in a point of service kind of operation.

Um, and I would take, uh, Dranoff's comments to another place, where, which was, uh, in, in talking about where change can occur, um, if we do not, in fact, have a model, that produces consumer consciousness because, uh, cost consciousness, because they're somewhat protected from the real costs of their decisions, why not policy elites make decisions. At least to try and steer their decisions. We do not have the kind of, uh, market that many would call for the Allen explicitly calls for, so let's recognize that at this point and look for what the role would be of the sponsor or purchaser, in trying to organize choices for the protected consumer that might, in fact, promote, um, better care for them. Somewhat a

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paternalistic, but that's what I guess what I'm suggesting.

So, in, in line with that, uh, I'm gonna suggest the possibility of Medicare, for one, being in the role of the strategic purchaser, um, and, clearly other government agencies, uh, that have been referred to, like the B.A., uh, and others are doing very innovative things, but here I'm thinking, uh, about, um, Bob Margolis' point this morning about CMS is, is the big payer's, CMS can move markets and I think we should recognize that realty.

The IOM 2003, I'm not sure if Harvey had this on his list, but I thought it was a very interesting report on coordinating government roles and improving healthcare quality with a long list of places where government, spec, Medicare, and all other government agencies, as well, in the areas of, uh, quality expectations, financial rewards, standardized measures and data sharing, uh, enabling active consumer participation, information technology.

I think another very telling, uh, view was the open letter in health affairs in November, December where healthcare leaders across the political spectrum, providers, uh, professors, all, signed on to the idea that Medicare, should take the lead, now, in paying for performance, by getting in at the large payer, um, and to try to sort out the confusion.

So, let me go back then, to sort of challenging the

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notion, that at least some have, that Medicare can only be sort of a commanding control timeless payer of claims.

The World Health Organization, uh, defines strategic purchasing as a continuous search for the best interventions to purchase, the best providers to purchase from and the best payment mechanisms and contracting arrangements to pay for such interventions. Um, I think this attitude, which is sort of new, I mean, basically, well, let me back up a second, this is, there is now an active discussion going on in European social health insurance and other developed countries, social health insurance systems, about having those systems convert from being passive payers of claims, to following this kind of precept, identifying best providers, developing best payment mechanisms, etc. Another words, it is viewed as acceptable, within a social insurance construct, to be an active purchaser and try to promote, uh, best practices and try to direct, uh, patients, consumers, to those places. This is not a reflection of mindless Soviet-style price controls in my opinion.

Um, and notice also that the focus here is on providers, and not plans or European content, sickness funds, and it is on payment policy as a major emphasis, here. And this is somewhat in contrast to the work in the U.S. on value-based purchasing, which, um, has focused on Medicaid and what some purchaser coalitions on purchasing from health plans, and

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the key role of the contract, um, at least in this, in this construct, strategic purchasing can involve the creative use of payment policy.

Medicare as any willing provider care program, but, I would argue that consistent with open access, uh, which is sort of a, I mean, I think that's what we have at any willing provider open choice program, traditional Medicare might employ payment differentials, paper performance, beneficiary incentives to effect choices, uh, robust set of performance measures, active education to patients and consumers about how to make choices and there's a long list. Uh, um, and I'd summarize this by saying that Medicare cannot restrict beneficiary choices, but it should be allowed to more actively try to influence them, consistent with what I said before is, is the use of policy elites, if we're not gonna have a system that really does put the consumer, uh, on the line with their own personal marginal dollars.

There's been some successes in the past, the heart bypass demonstration is one. Uh, where these kinds of, uh, tools were used. Um, and I will take a minute or two here to talk about, um, the, what I would say is the ignored use of payment policy as a tool of change.

Uh, I had an experience last year of interviewing a medical director of a, u, car, large cardiology group that was

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building their own heart hospital, um, and, uh, this person was waxing eloquent as clearly red Regina Hertzlinger [ph?] and could quote me about the fact, the focus factories and all the wonders of a heart hospital, so after we got through that discussion, I asked what they were doing for managing their congestive heart failure patients to try and keep them out of the hospital and he looked at me like I was from another planet. Uh, that wasn't anything, and this was a very large group, this wasn't anything they were doing. I mean, use the term disease management, he'd had never heard of it before. Um, the engine of change, I mean the engine of behavior for this group was basic payment policy. The fact that, uh, paying for proce, cardiac procedures, was a winner and if you were able to set up your own hospital on cherry pick who the, uh, insured people are, it could even be a bigger winner.

Um, and so, in discussions about paying for performance, I think we sometimes miss the relationship to sort of the basic engine of a healthcare, of, of, of, payment and where that does drive the system. Um, and so, in terms of that, I think we need to spend more time figuring out whether we're recalibrating DRG's correctly basing them on sort uncharged to cost ratios. It may well be there's, more charge distortions then, uh, then there should be and giving signals for how physicians respond.

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Um, Mark Chassel [ph?] I know has commented that, uh, while interested in payment for performance, he notes that, it's hard to identify quality measures for overuse, uh, in a fee for service system that basically rewards overuse. Um, so to really align paper performance, for that whole sector of quality activities, I think you need to sort of deal with basic payment policies. Consistent with what Jamie said in his chapter in the book, uh, pointing to the failure of pure capitation and the need to consider blended payments, uh, there's not gonna be a lot of time in my presentation because I'm already going over time to talk much about Section 21 of the Medicare Monitorization Act, which was brought up, uh, briefly by Ed Wagner, and others in the previous, uh, point, but I, in previous session, but I wanna make like one point and it is really targeted to, uh, disease management companies, I am hopeful that there will be medical groups, that uh, such as those that Don Fisher represents, that will be able to qualify, uh, that this is not purely a program to give money to vendors and not involve physicians. I mean, it is striking that we have a major problem of chronic care, and a lack of attention to his, and yet there's nothing in this legislation specifically to incentivize physicians to be involved. To me it would be like, back in 1983, recognizing that we had the wrong incentives for hospitals, through cost plus reimbursement

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and instead of moving to DRG's, we would keep the cost reimbursement, but just hire utilization review managers to try to get people out of the hospital.

You'd be to involve physicians in chronic care management and so I think, uh, the section 2721 goes part way, but, uh, has ignored physician payment policies. I am hopeful that the physician group practice demonstration, that a lot of people in CMS are interesting in promoting, but the administration more broadly, doesn't seem entirely interested in, uh, does sort of, this is the kind of initiative that I think will promote group practice. That's too complicated to talk about, but ultimately, it is using payment policy in traditional Medicare to try to incentivize behavior and ultimately direct payments to, uh, medical groups that can manage costs.

Um, I'm over time so I'm not gonna go through this right now, uh, but this would be the kind of an approach, um, three tiered approach to using payment policy to promote chronic care management, um, we can get back to it. So, let me finish with this slide, um. What I'm really suggesting is that the private payers have flexibility to innovate, they are quicker and more [inaudible]. Fundamentally, employers are not dedicated to reforming health delivery, they are interested in selling whatever product they have or services that they have

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and they cannot easily move markets. Uh, the public and I'm speaking mostly of Medicare, some of this applies to Medicaid and others, but not all of it, has an obligation to fairness and transparency. It is a dom, the dominant payer, it is dedicated to mission, has expertise, but it is under resourced, some of its decision making is ossified, partly because of, uh, the tough rule making environment, which requires three years from announcing a proposed rule to actually getting it out the door. Uh, too much of the decision making is political and congressional, and there may be too much market power in some cases for the government. So, I think where we need to go to promote this notion, which I highly endorse for integrated care, is, a collaboration between private and public, with Medicare playing a large role. Thank you very much.

[Applause]

PATRICIA NAZEMETZ: Uh, thank you, that's a good transition Bob, um, let me just see, do I, what I need to do here. Uh, there we go.

So, um, okay, you need to do it up, there, well, while we're, uh, we're waiting to get my slides cued up, uh, just let me say, I am going to change the lens a little bit here, um, and, I realized as I was sitting out there this morning, why I don't do these things very often anymore. That's because there's always, uh, such a great group of thinkers with such,

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um, high powered ideas out there, I'm encouraged that you're still out there working those ideas, but I'm going to take us down a whole bunch of feet, uh, to maybe, uh, um, a more practical view, very practice view of, um, from my perch. Um, which is buying healthcare, uh, for retirees and, uh, active employees, uh, in the United States, uh, primarily, I'll keep my comments focused there.

Uh, for about, um, there are about 60,000 or 70,000 people, uh, employees and retirees and their dependents for whom we purchase healthcare, we spend about $350 million a year, that's a lot of money. Uh, particularly since that money, those dollars grow a lot faster than just about any other part of our business. Uh, certainly, in recent times.

So, um, I will start by saying, it's kind of, from my perspective, it's pretty messy out there. Uh, the concept of integration, I think has taken a couple of giant steps backward over the last decade and, uh, form where we were pushing the system, two organized systems of care, back in 1988 and 89 where we first started down the, uh, the path of, um, of really our own version of, uh, of managed competition, and its pretty much unraveled at this point, uh, in time, so what I want to, uh, talk about today is not how bad it is out there, but some thoughts about how we might make it better in the short term, uh, with a view to longer term integration.

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Uh, and, uh, going, uh, going to try to keep it fairly simple, you're probably looking at the graph and thinking, uh, there are nine pieces there, uh, but, we're, I think you get the general idea. Um, let me just, uh, start with, uh, a couple of things that, uh, again, don't necessarily talk about the system, uh, the way it's been talked about for most of the day, but that do, uh, talk about things that we can and should be doing that kind of get in the way of us moving forward. Um, at least, again, from a major employer perspective. And, some of it is our own doing, some of it, we can certainly use some help in getting things corrected from, uh, many of you in the audience.

Uh, the first, uh, is in the flavor of tax code changes. Uh, and I know this is always, uh, um, a very, uh, loaded subject and one that everybody starts getting their calculators out and, um, scoring the, uh, the implications of anything in the tax code, but we're currently, uh, we currently have some provisions and there have been some other provisions, uh, added more recently around consumer directed health plans. But the concept of the use it or lose it, Section 125, is, uh, of the Revenue Code, the use it or lose it health spending accounts or flexible spending accounts and they go by a variety of names, uh, the, they have never really, I believe, reached anywhere near their potential because people, um, essentially

are concerned about losing their money. It is their money and if they set it aside in these spending accounts, uh, and realize that they lose it if they don't use it by the end of the year, uh, in some cases, it takes some fairly, um, unnatural turns as people strive to use any money that they've set aside.

Um, why we don't just simply move to something in, um, attend to, spend it or save it, as you set it aside, and why is the society, with the healthcare crisis that we have today, and as I said in the beginning, we're spending $350 million a year, our costs are moving somewhere in the 8% or 9% area, which is a huge, uh, a huge improvement over the 16% or 17% just a couple of years ago, but in an economy that is essentially flat, 8% or 9% is not a good news message. We project that our costs will double, uh, if we just stay on the, uh, the same trend or track over the next ten years. And, while I, you can never say never, and I can't absolutely project or predict what will be, where we'll be in ten years, um, I will say that if we have to make those decisions any time in the next couple of years, unless a nature of miracles happen within our own business, and we've climbed out of some pretty big holes in recent times and we're on, much more solid ground now, but certainly not in an area where we're about to commit another $350 million a year, uh, for, uh, for healthcare spending, we just won't spend it.

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Uh, so, uh, to the extend that we're not going to spend another $350 million, a significant piece of that turns back to our employees, uh, and, um, at our retirees, and that means it come a the expense of wages, which it essentially does now, anyway, or, uh, a discretionary spending dollars that they might put somewhere else.

So, uh, we got what we think is, uh, you know, uh, we're pretty much in crisis mode, uh, right now, and we think we've pushed the boundaries of, uh, employee cost sharing as about as far as, um, as we can. So the idea of allowing people to save some money, to set some money aside for their current year expenses, or to save it for future years spending, seems to be a very prudent policy decision from our perspective. And, uh, I think that one that might appear to, to cost some money, you know, from government perspective in the short term, I believe will, will, uh, avert some significant crisis in the future, if we all put our minds to doing something like that now.

Uh, the next is, um, again, in the flavor of tax codes change, this, uh, the concept of premiums being tax qualified or tax preferred if we pay them through an employer system versus individuals, uh, actually spend their own money to buy, uh, buy those benefits, doesn't, seems to be, un, a difference, a distinction without much difference and, uh, we would suggest

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that, uh, we shouldn't, there shouldn't be that sort of artificial distinction out there. That anything that I'll refer to as a qualifying, um, health plan, one that needs some standards of reasonability, um, efficiency effectiveness, should qualify for tax effective, uh, premium contributions regardless of the source of those, uh, of those contributions.

The next, uh, is, um, actually, one of my favorites and those of you who've, um, who've talked with me over the last, uh, well the Kaiser folks, will um, will, uh, this will sound very familiar, uh, to you, those of you who've talked with me, worked with me over the last decade or so, know that this is one, that uh, that has been a long standing, um, belief of mine, and, uh, to be very honest, we as a company, have moved away from it, uh, painfully, uh, to, uh, for short term, uh, economic purposes, but I think we've forsaken the longer term benefits of things like, com, my words, community responsive, uh, underwriting rules. Uh, whether it's truly community, the old community rating type system, or structure, which probably doesn't truly exist anywhere anymore, uh, or something that just comprehends the fact that, the community is the, is, uh, is the locus for healthcare, and that as each of us tries to carve out, his or her own experience pool, uh, we've actually fragmented, uh, the, um, the underwriting pools sufficiently that it no longer works and we're all paying a significant

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price there. So some rules that we need to agree upon around community responsive underwriting, and, a personal favorite of mine, and this is, uh, uh, I truly hope, that, uh, systems like Kaiser, uh, um, do prevail in the long term and that we do have truly integrated systems of care for all Americans to belong to. I especially hope that they come back to, West Chester County in New York, because, that's where I live, and, uh, having, uh, been a Kaiser member for a number of years, um, I am certainly disappointed that, I'm not able to participate in those kinds of plans any longer. Um, however, on a practical note, I think that we will have multiple kind of systems out there, and that even then, the great systems like Kaiser are not likely to be for everyone.

So, the concept of some sort of payment schedule, moving away from, the reasonable and customary and usual prevailing approach to setting, uh, setting payment, um, schedules and payment trends, which have been incredibly inflationary, and largely, not productive, um, is something that I think we need to reconsider. Whether it's truly the old payment schedule that, uh, Blue Cross/Blue Shield used to use, or something, uh, that just at least says, allows us to say to our, um, our people, this is what we're willing to pay for a particular service and this is what the system will pay for a particular service, you can get any service you want, anywhere

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you want, you have to pay, you have to pay the difference, is, uh, I think, uh, a relatively easy thing for us to achieve, and, uh, something I think that will help move us in the right direction.

Um, we've heard a lot about, uh, into the information, uh, age, uh, and a lot about, the need for information, um, as opposed to data, uh, from, particularly from the end user, or individual buyer perspective. And, I, uh, I won't say anything much more about that other than, I do believe we, we need to support, um, the development standards for the collection of data, and then for it's translation into usable information and dissemination, uh, to the end users, uh, because that's uh, those are the, will ultimately be the decision makers.

And, finally, uh, the technology factor, and, um, again, we've heard a lot about that, particularly with the last panel. Um, I believe that we need to, to get serious about, uh, what we're willing to pay for, from a technology perspective, and there's technology in the pervasive way, using it as an integrator, um, as a virtual integration device, but also to, for us to embrace, basic, um, technology and basic virtual opportunities, um, as an example, it seems to me that if we go to a payment schedule type of thing and we believe, that, um, that physician, an office visit or a primary first visit, uh, to a physician, should be worth $50. We should be

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paying $60, if it creates an electronic record, we should be paying $30 or $40 if it generates a stack of paper that goes into a little manila folder and gets stacked away, in the back office somewhere. Because until we are ready to, uh, to move to, uh, to pay for some of the technology, ah, and differential on the basis of the effective use of technology, it's unlikely to happen.

So let me just switch for, in the last minute or two to just, uh, talk about, the longer view, the bigger vision, where I hope we're able to drive the system from my perspective. Um, Bob said in his final comments, um, that from a large purchaser's standpoint, we're not in the business of healthcare, this is not a business we know a lot about, this is not a business we want to own, or run, and yet, anything that we spend $350 million for, we've got to take pretty seriously. Uh, my goal, my fervent hope is that someday, we'll be able to see our way, out of the healthcare system, that it will not need us to participate so actively in terms of, setting the standards and insuring the quality and driving all of these agendas forward. What I hope is that there will be integrators out there among you, who will pull together a system that might look something like this. That says, there's a core of services at the center that are, insurance-based if you will, I believe they always needs to be some cost sharing in every

element of the system for those who can afford it, because, um, otherwise, there is no, uh, there is no, um, financial decision making. Um, but we want to, um, provide, we want our people to be able to buy insurance, we want them to be able to buy subsidies so there will be a set of services that are subsidized out there, like prescription drugs for instance, or, wellness care or the like, preferentially priced services. If you think of this as sort of a club, you buy membership into the club, your premiums buy you membership, it may get you preferential prices for things like, uh, gyms, or fitness centers or diet advice, or programs or whatever and then, preferentially accessible services and that could even include things like, access to, uh, high end spas, or um, uh, or clubs, or whatever.

Um, that is, integrate all the services that the buyer, the end user wants, as the baby boomers and we've heard a little bit about this already, during the course of the day, as the baby boomers age, uh, we're spending a huge amount of money on discretionary health services. It's a multi, multi-billion industry out there that I believe those of you on the inside the healthcare system, are kind of leaving untapped. High margin businesses that can be integrated into the overall set of services, uh, in a way that allows the individual, who's your member, um, to choose whether they want those, those

services or not, and to buy them, through either tax referred dollars or out of their own pocket, as they're buying them today, but to buy them in a much more integrated, coordinated way.

So, I think what we're talking about a C change, I think we need to change our focus on, uh, from fragmentation to integration. I think we need to change our language. We need to, uh, focus on the user of the services, not the corporate purchasers, um, not the corporate payers, but those who actually use the services and we have to develop a buyer mind set, the buyer being, not me, but, my employees and my retirees. They're the ones who need to think of every healthcare encounter as, um, as a buying decision. And, uh, I realize, when we're into emergencies, people don't go through any sort of decisiontry as to what they want to purchase, or how they want to purchase it, but what is that suite of services that they want to buy up front and what are the integration that they want to buy up front, so when they do need the care, in an emergency, it's there for them.

I would suggest that we should be more inclusive instead of exclusive. And, frankly, what we've been doing, and I'll take the blame from a corporate stand point, we have disintegrated the system at every possible turn, and we've done it because each year, we go in and we see what can we take out

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so that we can reduce the costs, so we can take the trend from 14% and 15% to 8% or 9%. Uh, because we can shift less of that cost to our employees, we can absorb what we can afford to absorb. The result has been ugly, it has been dysfunctional and it's created, truly, a disintegrated, disassembled system and we really need to move toward, toward integration as, not just part of our language, but part of our overall goals and objectives. With that, I'm gonna stop and we can take some questions. Thank you.

[Applause]

JOHN IGLEHART: Bob has to leave, in uh, five minutes, so, if you would direct your questions first at him, uh, that would be helpful. Bob you made passing reference to the, uh, physicians group practice demonstration, uh, could you say a word?

ROBERT BERENSON: Yeah, it was something we were kicking around when I was at HICVA, then it become legislated in BIPA [ph?] in 2000 and then it, basically, it's a way of, uh, establishing financial incentives for, medical groups, the groups who are eligible to apply our 200 or more members. So we're talking about large groups, it doesn't require an individual to actually elect to get their care from the medical group, basically using claims data, uh, people, who, whose, whose majority of their E&M visits, evaluation and management

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visits were with members of that medical group or were assigned to that group for accounting purposes and, essentially through sort of a complicated risk adjustment, risk adjusted payment of what those people would have spent, uh, if the group can save, uh, they get some, they get to keep some of the savings, hit quality measures, is complicated, I know we have some CMS people here could talk about it in more detail. Uh, applications are in, they've been reviewed, it's just, as I understand it, a question of, of getting clearance to get this thing out. It strikes me as exactly the kind of demonstration the traditional program should be doing to promote the larger group practices.

Now, once the demonstration, if the demonstration findings are positive, that, in fact, that groups do well financially, save the government a little bit of money and hit the quality measures, uh, and patient satisfaction measures, it seems to be the next step that, and would be, not to require beneficiaries to join these groups, but to publicize the results, maybe even find some financial incentive somewhere. One of the problems, because people tend to have, uh, Medigap or retiree wrap arounds, it's hard to find easy financial incentives, like, forgoing your co-insurance, but it can be done. And so that's the kind of activity I think that traditional medical could be doing, sort of dealing on the

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Permanente side of the business, rather than the Kaiser side of the business, perhaps taking some liberties.

JOHN IGLEHART: Questions for Bob? Comments, criticisms, whatever. Adieu's. Bob there are wildly different estimates, uh, of how many, seniors would take advantage of Medicare advantage or would role in plans of contracted, uh, CMS under the new legislation. What would be your sense of it, are you closer to, uh, the more optimistic push. . .

ROBERT BERENSON: I'm formally right in the middle. The, uh, interestingly, uh, as I understand it, CBO originally estimated current trends, which was heading them down to 8% enrollment in Medicare Advantage, but in their new budget projects, their baseline, that's now up to 13% once they had a chance to revisit how much money was put into the program and, uh, CMS is up at 32% and it will be interesting whether we get to hear the reason why they estimated 32.

When I came into the program in 98, uh, when payments were pretty generous to plans, uh, about a million a year enrolled in Medicare Plus Choice plans and I think we would be going back towards, I think it would be increasing, not decreasing, and I think the, as I understand it, the major difference in estimates, is how, is over the PPO option. That CMO and CMS are not that far, the actuaries office, are not that far apart on Medicare Advantage, but how many people the

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PPO will attract, um, and, um, that's a whole discussion about, you know, PPO's that will come in more expensive than traditional Medicare in all likelihood because they are serving rural areas, in areas where they do not have a lot of negotiating leverage. Whether those PO's will be attractive to beneficiaries or not is the question. I would raise a more fundamental question is why we need PPO's in Medicare. Uh, since traditional Medicare is largely a PPO, uh. One could ask the question of why do we want to risk breaking up the, risk pool, for that option rather than focusing on what is really an alternative to traditional Medicare, and that's integrated delivery system, that's what we should be trying to promote as an alterative to the, sort of, the, the PPO style fee for service program. But, uh, the Congress, in it's wisdom, has decided for a broad choice, and so we will have, and so I think it remains to be seen how many people sign up in the PPO and what sort of, character given to the PPO to succeed. There's $10 billion amount in there to help PPO's. But why we want to spend it, I don't know.

JOHN IGLEHART: You mention, it speaks volume about the state of delivery system reform on Capital Hill.

[Laughter]

One last chance to ask Bob a question before he takes flight.

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ROBERT BERENSON: Could I just finish then, what I was . . .

JOHN IGLEHART: Sure

ROBERT BERENSON: . . .gonna do. Uh, I had to go through one slide real quickly which I did want to say. I, I've been somewhat critical of the, um, chronic care initiative, which is really written, targeted for disease management companies, I think, to sort of, uh, outside of the doctor's office, try to, um, do better with consumers. And I think disease management is fine and there is some success in the private sector, and, uh, and I'm all for testing it, it has a role, and I think that thee, as I understand it, the agency would like to find provider-based, uh, physician-based groups to be able to be eligible for that. Uh, but I suggested there needs to be a complimentary, uh, payment change to get physicians to want to interact with the disease management companies and I sort of had laid out, this is all conceptual at this point, it has been tested in Medicare anyway.

One would be just sort of giving a care management fee, based upon complex patients, if you're the physician who's taken care of those patients, you get, something to, to, uh, answer the following, when the disease management care calls or for you yourself, to proactively, uh, call your patient back. It doesn't have all of the good parts of the Wagner Chronic

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Care improvement model. It doesn't have a lot of it, but, uh, I think you can marginally change behavior by providing the incentive. But the real, uh, approach would be to define criteria that was in Steve Shortell's chapter, here's what an integrated delivery system is, if you're an organization that meets these criteria, you are eligible for a real PM, PM, care management fee, um, and there will be some objective measures of performance, uh, associated with that, where you now get paid, not just to see patients face to face, but actually to coordinate their care.

And the third leg of this, which, I'm not sure about, but I would throw out is, would be, if you're an organization that is capable of taking financial risk, we can consider throwing in some Part V services, some actual dollars from Part V and have a quasai [ph?], uh, capitated arrangement, uh, and I would think that only a few organizations would qualify or want to do that, and ultimately, would you want to throw Part A in, in which case, you're really talking about a Medicare Advantage plans. Uh, but I don't know why, instead of just having a one size fits all RVRBS [ph?] payment system, which has perverse incentives, doesn't reward physicians for actually coordinating care, why we wouldn't want to test out, certain, different levels of, uh, of new payment systems. All this, I would do this all on a demonstration base. The

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criticism of it, of course, is throwing good money after bad. There's no accountability by just giving money to physicians to do good things. Uh, I think you can set up some criteria so you get some protections and in particular, you'd have your criteria of, and IDS's [ph?] would qualify and most other physician practices wouldn't.

Consistent with what I was saying, that's a role that, say, a purchaser should be taking, as distinguishing amongst, uh physician groups. You're not forcing any patients to go to that group, but you're providing a different payment system for that group, and I think that's what we should be considering and testing. And with that, I'm off the airport. Thank you very much.

JOHN IGLEHART: Thanks Bob.

[Applause]

I would just tell you, at least in my opinion, as Bob departs, that, uh, the medical community has no better advocates in Washington policy debates and dialogue than Bob Berenson.

[Laughter]

He doesn't pander to the AMA or any other group.

[Laughter]

But he, uh, he's smart, he involved and he's always looking for ways to not only involve the medical profession,

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but to improve, the quality. Uh, Marcia?

MARIA [LAST NAME UNKNOWN]: Yeah, um, sort of changing the subject, I, have, my question was to you Pat, so I was waiting, um, to give Bob a chance before, you talked about integration, and, I'm a little bit, I want to clarify something, or ask you a question. I think, if I understood you right, you could even integrate, you could integrate this delivery system or you could use the patient side to do it. If I looked at your five pieces on the puzzle, you, assuming, I think, that you really couldn't integrate the delivery system, or you couldn't start there and you're gonna use patient cost incentives to make people more aware and create some financial incentives. And what you were trying to do was integrate, coverage, not integrate the services and the system that people use to get, use that coverage. Is that right? Because we've been talking here about integrating delivery systems and when I looked at your concentric circles, you were really sort of integrating the coverage, where you wouldn't throw out a benefit, you'd just maybe have a 100% cost sharing, but a reduced fee, or something like that.

PATRICIA NAZEMETZ: Well, I, yeah, any new, very different from the, uh, the integrated, the totally integrated systems, because I'm, again, changing the lens and using it, this as an employer lens and we're not into developing systems,

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um, health systems at least, uh, but, the, the thought process is, as you look that those concentric circles on, and as we use some of the financial incentives to get people to be more intelligent buyers of, of, of, a series of services and products that they, uh, hat they want to, uh, to purchase through healthcare. Uh, that, we need somebody out there, not the company, somebody, ideally, within the health system to really be an integrator.

So, how do we get, organizations or entities interested in integrating in a much loser configuration, if that's more, uh, more appealing in terms of a business model, pulling together the various pieces that would say, and could be an insurance company as an example, that says, here's a set of services that we're providing and that we're underwriting and insuring with these underwriting principles at the core on a subsidized basis, and then partnering potentially, with other parts of differ, even places out the traditional health system, uh, to pull those services together virtually, so, uh, that, so, uh, think of it as a club membership. Uh, that our employees, then would have access to, a whole array of things that are, even tangentially associated with the health system. So that from their perspective, from our employee's perspective, buying into this bigger club, or this richer club, uh, enables them to have access to things that they, they may

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be buying in other places, but then would make the whole value proposition more attractive to them.

MARIA ?: Could I come back Bob, or John, is that okay?

JOHN IGLEHART: Yeah, go ahead.

MARCIA ?: I guess the question I have, I'm sort of playing that out, sort of, in a fact, it assumes the system do whatever it does, there's no real incentive for that club they're buying into to have one piece of it talk to the other or anything else, and it seems like, if I was a patient, I'd have access to that, but I'm, you're sort of assuming the cost is gonna go up whatever they go up, so I'm just gonna end up being able to buy less if the system won't change. In other words, the stuff is all there, but it doesn't really affect how much it costs, it just lets me approach it differently. It doesn't change anything underlying. And I'm not saying as an employer that that should be your job to change the system, I'm not sure that it is, but, it sounds like you've given up on changing the system and you're just gonna let the chips falls where they may.

PATRICIA NAZEMETZ: Well, what I think, if you, if you take that sort of, almost back to an old Blue Cross/Blue Shield model of, you know, there are sort of participating players in there, who would, you know, if you use a particular set of providers, I, the system, or the insurer, if you will, would

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reimburse 90%, 95% of that costs and you would just have to pay a small co-ins, a small amount of co-insurance, if you used any provider that you chose, uh, you might have to, if that provider matched the fee, that's fine, if they didn't, then, uh, it would spill out, uh, you would have to pay for it. Our experience has been that individuals, individual consumers or purchasers can be a very powerful force in, armed with actual information. This is what my plan will pay, uh, in negotiating those rates or fees with, um, with their provider. Not again with, you know, the extreme emergencies, or whatever, but I just, we've seen it in dental plans, over time that if you, you say we'll pay anything that's reasonable, the dentist says, this is reasonable, they expect you pay it, if you say we'll pay $25 for this particular service, and the doctor, and the dentist says I'm charging 50, um, at least our employees will argue with the case, and uh, attempt to either find somebody who will charge them less, or negotiate that fee down.

So, ultimately, we're hoping that that also helps to keep, sort of keep a lid on the costs, because, we want to do just the opposite, we want the dollars that we're spending to actually buy more in terms of what employees actually need and value in the form of healthcare.

MALE SPEAKER: Pat, you've made the point, in your opening remarks, Xerox simply could not afford to spend another

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$300, $350 million dollars, over the next decade, but, not to put too fine a point on it, but it sounds like, Xerox and perhaps other corporations are moving to a system where it's every man, woman and child for themselves. Uh, maybe that's an exaggeration, but, uh, educate me.

[Laughter]

PATRICIA NZAEMETZ: We, we hope we don't have to move to that, to that space, uh, we're just sort of turning employees um, out on a system that is not a system truly, that's just a collection of, uh, not even really competitive elements, but just, an insurance system that isn't based on any kind of insurance principles, frankly, however, there, again, there is just so many resources that we can put on this, so our goal is to put our, our attention, our money, our efforts, in those places, where, um, we hopefully can make a difference and encourage the system to take on that responsibility, so we create an intelligent marketplace in the long term. I recognize there are lot of people in this room who've been working, that, toward that a lot longer than I have, and there is a possibility that we'll never get there. Uh, but, if we never get there, I mean, the, the consequences of that, uh, whether we'll continue to buy healthcare on our employee's behalf, but we'll spend, you know, the equivalent of 3% or 4% more a year on our 350 million and there will be 200 or 300

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million that the employees will have to pick up is, is a fairly dire, um, set of circumstances, but a relatively real one.

And I'll give you just a real live example, I mean, 2000, going into 2001, I think it was, our healthcare costs went up by $40 million that year, and we said, those of you followed, I realize that you're not, hopefully you don't all remember how bad things were for Xerox in October 2000, but it was a fairly ugly time for us and we certainly didn't have an extra $40 million to put on anything, uh, so we literally shifted most of that cost, normally we would pick up 30 of the 40 and shift 10 to our employees and retirees, we shifted the whole 40 to, um, to our employees and it was painful across the board, it was ugly, it was at a time when we were, you know we've reduced our U.S. work force from something like 55,000 people to 35,000 during that same period of time, from 2001 through the present. Uh, so, it was necessary and it was an economic necessity, uh but we realized the pain that our employees went through to try and pick up those, those, to have to spend those extra dollars in a time when the whole economy was going soft, so, you know, I don't have the, the clear answer that says we're gonna do these things and only these things, uh, but I, you know, I think it just becomes evident that we're not gonna be able to, uh, continue to pay all of our profits in the form of healthcare, it's, it's not, and you

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know, as we were talking at lunch time with a couple of people, um, as we tell our retirees, you know, we have 25,000 retirees out there now, who rely on the health of our business for their future healthcare. Uh, if Xerox isn't there, there is no health, they have no retiree healthcare. Um, there's not a positive money sitting somewhere to buy that healthcare for the future. This is paid out of current year, current year earnings, so, if we're not there, um, we don't have, we don't have health benefits, uh, for the retirees, obviously we don't have jobs for employees, so that just sort of um, eliminates itself, so we're trying to do everything we can to say how can we make the system work as a system, as a competitive market place so that costs get abated and that we can continue to provide some financial support, but not necessarily all the organizing elements and efforts, because, I don't think we really have the ability to ad real value there in the long term.

JOHN IGLEHART: Burt, you have the last question, but please make it short, because we're a lot of

BURT [LAST NAME UNKNOWN]: It will be very short, it will be very short, I won't repeat what you said. But if you, if the, uh consumer, has to decide whether or not to, uh, pay for whatever element of healthcare is involved, that it seems to me, is gonna have a very serious effect on the possibilities

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of integrated care, uh, because that decision made by the consumer may not be the decision that would have been made by the doctor and if they, you've got a situation where you're using many specialties and so on, the whole thing seems to me, unravels.

PATRICIA NAZEMETZ: Well, if I could just, um, I've gone of done that, the goal here, in my concentric circles model there, is not to exclude or move away from integrated systems, it's just to think about the whole system, um, in, in that fashion, whether its truly integrated system or pieces, parts from another system that, or a lack of system, that needs to be pulled together from the, um, our employees' perspective or vantage point. I hope that over time, the power and the value of an integrated system has to be ease of use, it has to be exactly the opposite of what happened, and, uh, Burt, I think it was your comments, um, earlier, exactly the opposite of what happened in the 1990's, as the whole concept of organized systems in care kind of imploded and HMO's became, uh, the villain, rather than the savior of the health system, and we have to reverse that, but we have to do it in a compelling way so that, individuals, chose that option and not that we force them into it, because we know that doesn't work

JOHN IGLEHART: Thank you Pat. We will uh, turn it over to Jack Ebeler for his summary comments.

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[Applause]

JACK EBELER: Thank you everyone, when I first got this assignment, um, I thought this was the thanks and divide segment of the program, uh, it turns out I'm supposed to summarize what you just heard. Which is a little bit daunting, but, let me, am I supposed to do this Laura?

Um, let's take a quick, a quick crack at that, uh, we obviously start with this whole idea of the delivery system does matter, the IOM's view that trying harder will not work to changing systems of care, will, they really laid out that challenge and division under which we're all operating. Uh, we then look at multi-specialty group practices, um, really as a model to build on. This is a potential platform for the future, um, it is much more widely spread than had been anticipated, uh, however, since uh, Permanente prevention is one of my members, I'm not gonna get into this fight about whether or not there is a group in Colorado.

[Laughter]

I will support whatever decisions you all make.

[Laughter]

And, um, it is clearly, when you get dropped down underneath that, these are the types of organizations that have the special competencies and facilitators to achieve a lot of the objectives of quality [Inaudible].

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Um, the evidence, in a lot of the research hasn't honed in on differences by delivery type, um, it really tends to be more HMO versus fee for service, um, and when it has honed in, it has been mixed, the book gets into that in [Inaudible] article, but there is emerging evidence that Dr. Shortell laid out that if you hone in more on organized groups and health plans affiliated with those groups, um, that there is, in fact, statistically a better clinical effectiveness, um, we're used to evidence based healthcare management, um, and this, while this is an area that we clearly need more research, it is a promising set of findings that a lot of us are excited about.

We get to the Jamie Robinson question of, um, if we're so smart, why aren't we rich, um, and I guess I would have to say that this is the one place that I think we need to hone in a little more. I'm not sure we really answered that as well as maybe the book did, I'm not sure we answered the [inaudible] question about what's really heading this up, we've identified a couple of things though, very difficult to build this culture, I think many of you have heard the expression culture from strategy every time, um, lack of incentives at the purchaser and group level, um, this whole idea that consumers being forced into something that they didn't personally choose inherently leaves the dissatisfaction, um clear needs for leadership, capital, different regularly environment and, I

think a couple folks pointed out that these types of organizations may be behind the curve in product design.

Uh, that in a market that is looking for more lower priced products, uh, and for total replacement in the self-insured markets [inaudible] organizations, um, may have to do a better job there.

Uh, future pathways, again, I think organized delivery, um clearly a platform, not everywhere, won't fill the map I think is the expression, um, that came up instead, maybe it will hopefully grow, be a model and I think in terms that Jamie used in the book, an incubator for a lot of good ideas. But we also need to envision new models among networks of physicians, and in addition, I think the discussion this afternoon, across communities, is another way we're, some of the more virtual, um integration may occur.

We clearly focus in on enhanced technology, uh, as essential for this overall vision. Both within a group, um, for virtual groupness, um, I think, this, well everybody is really stressing that, that whole focus needs to be patient centered, um, as the end user of the technology, um, talked about a little bit about communication exchange, I think there's, tension about whether the technology investments are enterprised based or community based, um, and I think the typically American way the answer will be yes.

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When we hone in on what's needed, um, purchaser policy changes are obviously important and Dr. Enthoven brought them to the floor again about choice, contribution policy, benefits, regulatory environment, and again, more creative product design. Um, I think Carolyn Clancy pointed out that we have a sense that the attributes for successful performance within multi-specialty groups are becoming clear, but we need a little more evidence about exactly what does it as Dr. Shortell's research gets into this, but as you pointed out, we don't have quasality yet, really need to more know about that, um, I think this is a field that is very willing to go through rigorous measurement disclosure and incentives in paper performance. I don't think anybody is saying, because one is a multi-specialty group, one should get more money, they are saying, let's have everybody rigorously disclose data, um, on what type paper performance and accountability, um, we're confident that this type of model will do well under that, but people may choose other things as well.

Um, we get into the whole standard of risk adjustment. I think on the data side, it is a pretty clear view that you need some federal role for operating standards, um, and them from payers, incentives for technology. I think this whole question about whether capitation is clearly helpful, but need to look beyond that, um, there's gonna be a lot of future

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service payments within healthcare, two multi-specialty groups that can work, um, depending on how the providers within, um, they group are paid.

Finally, I think there's a pretty compelling message here, uh, that we need a sense of urgency and I think Dr. Robinson said it, um, early on, we need to get to the future faster, um, there is a compelling need for leadership that was sited on almost every panel. Uh, we need to build on and adapt the platforms, both for the multi-specialty groups, for linking with other physicians and other communities. Um, I think implicit and explicit at some times today, we really need to reach. I mean the reality that excellence in healthcare is, is pretty average in this country as a lot of people said and we need t get to the point where excellence is truly excellent, the next [inaudible] study that shows that 65% of Americans on average are getting what they need, we shouldn't clap for that, we should strive a heck of a lot higher.

Um, and finally, execution. I think we started off with this, I don't quote the [inaudible] or even pronounce the name right probably, but you need to move from knowledge and will to applying and doing.

Through the policy agenda is critical, I was not able to update this slide because this panel was just speaking.

[Laughter]

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Um, but I think it's clear and um,

[Laughter]

And maybe symbolic, sort of this way, I think we've clearly, in Bob's view, you turn to Medicare with a purchaser to fill a lot of the incentive roles, laid out here, and in many ways, pass the discussion, reinforce that as the potential of the employer community, um, ceasing to try and use group purchasing cloud and turn more to individual incentives. Hopefully those will reinforce themselves, I think I, and Bob laid out a lot of opportunities ranging from encouragement of growth of multi-specialty groups as well as opportunities within the Medicare ability, particularly in the chronic care area. Um, to, to get their, encourage virtual groups in there and chronic group management care in there.

They're both talking about incentives for technology, um, I think there is still a spectrum within the room, probably, clearly standard for technology, um, I think there is a spectrum about whether one should be paid directly for implementing technology, um whether the incentive system should encourage outcomes that effectively require you to produce the technology and I think that will be a policy debate. Um, that will continue into the future.

Let me now swing to the thanks part of the program. All of our speakers and chapter authors, again you have a

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terrific book in that bag, to the National Academy for Hosting us, uh, to our co-sponsors whose logos are right here, I won't read them all, but it's speaking on behalf of this group, it's been enormously interesting to be part of planning this. These are the folks that are on the planning committee. I think you've heard from most of, if not all of them today, uh, and there's been a group of staff people who have been terrific here, Amelia and Danielle were very involved in the planning of this, and, um, Tony, Jessica, Jerry and Jennifer were orchestrating things today. The person who gave me this list is Laura Tolen [ph?]. She did not put her name on it. Um, but I think we have a special thanks to Laura, because quite frankly, she was the, the glue that held this together both, both the book that you got and this conference so thank you very much Laura.

[Applause]

And Laura, sitting here looking extremely uncomfortable, I apologize. Um, and finally, thanks to all of you, I think we all look forward to working with you to improve care, the delivery system does matter, um, and it's time to refocus on it and actually make it work. Uh, the presentations will be posted on the Kaiser Foundation's, the Kaiser Policy, Kaiser Permanente Institute for Health Policy website at that site in about 10 days I believe, um, so again, thank you very

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

much for coming.

[Applause]

And fill in your green or yellow evaluation

[END RECORDING]

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