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HEALTH INSURANCE MODELS OF THE FUTURE

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DR. STUART ALTMAN: We're about to enter that part of the agenda to really begin to think about the future. We've been doing a pretty good job of analyzing where we've been and why we got there and why we shouldn't have gotten there, but it's about time we sort of say okay, we are where we are and now it's time to sort of think about as we move forward. And as we thought about moving to this stage of the agenda, we said we need someone who has been in the past and is part of the present, but is hopefully going to be part of the future. And I said I thought about last year if many of you were here at our Princeton Conference and we were talking about the complicated issue of prescription drugs and I learned something then that I didn't know and that was I didn't realize that FDA had to seek the drug companies' approval before a drug went over the counter. I always thought this was some kind of a morphs move. And I was educated to the fact that, in fact, this was a not a law but it was sort of FDA just procedure and Carl indicated that at WellPoint, they were very concerned about the fact that certain drugs in the market were over the counter in many other countries, but were not over the counter here and they were going to do something about it. And, of course, people appropriately sure, right, someone's going to tell FDA what to do. Well, it's not over yet and I don't want to judge how it's going to work out, but I really am impressed that WellPoint was successful in sort of at least moving the ball forward and saying that it's not always the drug companies that decide which drugs go on over the counter. I think it was an important forward move and I think it's indicative of the kind of President and CEO Len Schaeffer has been when it comes to WellPoint.

So, Len's been an old and dear friend of mine for a very long time. We worked together in Washington and I'm just so pleased that he has been part of the Princeton Conference for many years, has been a faithful participant and was willing to join us tonight and give us his sense of where he sees the future of managed care, so I'd like to introduce to all of you Len Schaeffer, President and CEO of WellPoint.

MR. LEONARD SCHAEFFER: Well, thank you very much, Stuart, and I am extremely pleased to be here and I was puzzled as to why I had been selected and now I understand. I am one of the few people that have been in the past. When I reflect on it, I don't know about the rest of you guys but most of my life has been spent in the past, maybe we can compare.

Actually, and this reminds me of the party that was--is this thing working? Right. That's really way back in the past. This reminds me of a party that was given by the Mayor of New York for the people who were involved in what was then called the Brooklyn Jewish matter. This was an attempt, yes, those of you who remember, this was an attempt to close down a hospital what is generally considered to be an unnatural act, and the hospital, this was my past, if you were there you get your speech, you tell your past. And we failed and what we found was that you can't shut down a hospital, not because it's a hospital, because it employs so many people. And Brooklyn Jewish later merged and is now St., yes, St. Jewish I think is what it's called, yes. In any case, the Mayor gave a party and the party occurred after I had left government, but he still was very nice and he invited me and I was in attendance. And as I was talking to someone, two people walked by and one pointed me out to the other one and said, "that used to be Leonard Schaeffer," so I got a past and it is causing me great anxiety. This building is a very scary place to be if you are a, were a Princeton undergraduate.

When I was an undergraduate this was back when everything was in black and white. When I was an undergraduate, you never entered this building because it was the home of the President of the University and there are only two reasons you came to this building. The first was to be informed that you had won the pine prize, which is the highest prize, I mean an undergraduate can win for academic and general all around wonderfulness, or you were brought here and told that you had been screwing around and that you had to buck up or you were going to be asked to leave. I have been to this place three times and the first guy who asked me if I won the pine prize is in big trouble.

Okay, you are all academics and erudites and read only the finest magazines and publications, so I think you know a little bit about what Stuart mentioned and I will cover that briefly in my talk, but we've had a lot of coverage recently, our company. We were—"Fortune Magazine" has rated us as the most admired health care company for three years in a row. I was told that that is an oxy moron, but it is true. We also were rated by "Working Women Magazine", one of the top 25 companies for executive women for the past two years, we're number nine on that list and there have been a number of other honors that I could spend more time talking to you about.

However, there recently was an article in the "Business Week" about our company that I have to mention simply to make several clarifications. I trust most of you didn't see it because you're reading better stuff, but this was two weeks ago and there were a number of inaccuracies and I really want to take a minute to comment on them. The first can be dealt with simply and that is that I am much taller than I look. The second is that I never, ever said that Tom Cruise is even shorter than I am. That would be rude, demeaning and insensitive. What I said was that I had met Tom Cruise at the Oscars and that I was very pleased to report that I am exactly a half an inch taller than he. Anyhow, those of you who read "Business Week" probably don't sink all the way down and read "People Magazine" because if you read "People Magazine" what you'd know is that Tom Cruise is an extremely litigious individual and he sues anyone that is critical in any way. So two further clarifications: the first is that I think Tom Cruise is exactly the right height to be a movie star and the second is that I can say from personal experience that no matter what the issue, Tom and I see eye to eye.

Okay, we're now going to do this technology thing, we're going to talk about health insurance and I'm going to briefly cover these five topics and my hope is that you've all had enough to drink so this will appear to be a very insightful presentation. We've been through a period of time we can describe as the evolution of health insurance in the good old days. From the 40s through the 70s, [we had] insurance products, no networks and [were] focused on paying claims basically. We've entered the era of managed care that I think gave everybody things to write about and talk about. It was pre-paid health care and was going to be more comprehensive benefits, first about our coverage network based products and a focus on cost control and preventive care. And I guess the reason we're here tonight is to figure out what comes next and you guessed it, I know what comes next, but you [have] got to see a lot of slides before you get there.

To come to any conclusion about the next phase, I think we do have to take a look at two things. First, you know what's happening now. And then second, what customers want, what do customers want? In terms of what's happening now, I want to cover just three things because there are lots of things that are going on. We've already talked a little bit about some of these things, but consolidation is a very important phenomenon and it's happening not just in terms of health care plans, but in terms of everything else. In terms of health plan consolidation, this just shows you that since 1994, 32 independent plans have come down to six, so we've really seen a lot of consolidation on that end of things. In terms of hospitals, it's been even more dramatic. In California, these 27 standalone hospitals are now

parts of four large systems and this chart does not include Catholic Health Care West, which all by itself during the same period, consolidated 22 hospitals into their system. Medical groups too have consolidated and this is kind of sad because these 31 medical groups consolidated into the six groups you see on that chart and as of today, only one is left. One of them went bankrupt and one of them just went away. So, the net effect is we have bigger, stronger forces on all sides of the equation. There is a phenomenon though that we could talk about if anybody's interested during the Q & A period, which I call the big dog syndrome and it's probably worth talking about because as you become larger, certain other things begin to happen and many of the hospital folks, and certainly the doctors, didn't realize that was going to occur. But that's not the purpose of this speech. We can talk about it later.

What I'd like to talk about now is what else is going on and what's going on right now is odd things with premiums and costs. This shows you where the consumer price index has been through the past decade and except for the first year, it's been flat in between 3 and 4 percent. Medical inflation came down from a high of 9.6 percent to a low of 3.5 in 96 and is going back up. That doesn't tell you what the cost of health care to the people who are insured has been. This is a chart from the Bureau of Labor Statistics and what it shows you is what happened in the beginning of the decade, we had premiums going up at an annual increased rate of 12 percent or more. And this was the time when the Clintons came into power and the deal was we've got to do something about the health care crisis. For whatever reason, the people of this country decided it wasn't going to be a government solution, they're going to hand it over to a private sector. And I think you would have to say that private sector did one hell of a good job reducing the rate of increase from a positive 12.2 percent, down to a negative three tenths of one percent. The problem is, not that it was done, but how it was done. This process managed to anger everybody in the equation. Doctors are unhappy, patients are unhappy, employers are unhappy, and frankly, health plans were unhappy. So what you see now is some corrective action and the problem is that corrective action is going in a very eerie direction.

I was not only a graduate of this institution which is a cause for great embarrassment for all of the people who are at Princeton, but I'm a graduate of the Economics Department, which is why Uwe is way in the back of the room covering his head. This is every embarrassing. Okay? But we all know that the difference between the curve, the yellow curve and the blue curve should have been good news for health plans, and the difference between the yellow curb and the blue curb when it goes negative is bad news. So what we had was a good period, a really bad period and now we're going to have a very aggressive catch up period and what we're seeing

is, if you look carefully, the costs were pretty flat between '96 and '97. Between '97 and 2000 we went from 0 to 7.6 percent rate of increase. And earlier somebody today said that costs are going to go up. They are going to explode and this is really something unusual and we have got to be very careful and try and understand what's going on.

I want to talk about the key cost drivers very briefly. There are many more than these, but these are the ones I want to talk about because it's my speech. Hey, the first issue is not about whether mandates are good or bad. The point here is very simple, mandates cost money and they result in coverage going down and the number of jobs going down. According to the Lewin Group for every 1 percent increase in premiums, 200,000 to 400,000 people lose coverage nationally. In 1998, we had a big issue in California about a whole bunch of mandates and it was costed out by the Barrens Group that a 10 percent increase in premiums across the state would result in a loss of 800,000 jobs over 5 years and a cost to employers of the people who stayed around was \$12.6 billion. This is serious stuff and we ought to take a very close look at it. Oddly enough, states keep passing mandates. The average state has 28 mandates, two to three new ones pass each year and as you can see, some of these states have an awful lot going on. In addition to mandates though, we have our favorite whipping boy, which is technology. According to Project Hope as you can see, they project costs going up in the next five years and they say that 25 to 33 percent of those costs are going to be a function of new technology. I'm not going to comment on this other than to say that the health care industry is interesting and that the introduction of new technology uniquely seems to result in an increase of labor content and every other business, every other industry you reduce labor content. The other thing is old technology never goes away. So what we have is increased labor costs and duplication. But as I said, I'm not going to talk much about this because I don't have a strong opinion one way or the other.

Okay, prescription drugs. All of you, I hope, read the NIHCM Study and all of the coverage that it got, but prescription drugs are killing us. A 19 percent increase last year. What is interesting to note is that 36 percent of that was a shift from one drug to another drug that cost more, not clear that it really does a better job, but that it cost more and 22 percent was a function of price increases. It's interesting to note that in all of this kind of arm waving we forget that the so-called good guys where costs were under control, are also seeing their costs go up, but we're seeing their costs go out. This is a HCFA document and it says that in 1999, hospital services went up 4 percent, a little higher than inflation, physician services 5.3 percent and their projection for this year is much higher than inflation. So just about everything is going up.

But this is the real killer, which is, or the lack of killers, this is the aging population. What's happening in the United States is the baby boomers are moving through and the good news for human beings is more people are living longer, that is a big win for those people, it just costs a lot of money because each one of those people will fall prey to an almost predictable series of chronic conditions and there are drugs and therapies that will be used for each of those conditions and all of them will live longer and consume more health care services. And I'm not talking about the last year of life being the most expensive year. I'm just saying with that number of people, living as long as they are going to live, and I hope to be among them, what we're going to see is costs sky rocket. We haven't seen anything like what it's going to be over the next couple of decades.

Now we saw today, we heard today, a lot of interesting statistics most of which look to me like political polling. What we do is polling to try to understand what consumers want and what their views of the world are and we spent a lot of time trying to understand the baby boomers and basically they want three things. First, they want to look good. Second, they want to feel good. And third, they want to live forever. You want to take a vote, you know?

The baby boomers have changed every single institution in our society as they move through it. They are going to change health care and we're going to see ourselves spending money on things we never thought of as health care. And as the definition of health care and what is insurable broadens, costs are going to go up again. My guess is once again, very good for human beings, but very, very expensive. When I was in HCFA, I used to say that given enough time, you know, the HCFA budget would be bigger than the Department of Defense. I now believe that the reason we can't find the Inca civilization, the Egyptian civilization, is they went through a single payer national health insurance and it destroyed them and it will destroy us. Okay?

Moving along, what do consumers want? We do a lot of consumer, or customer research. I'm just going to talk about two. We consider employers customers and we consider consumers customers, and we're not going to use our research because it's proprietary and I don't want to tell you what we know. So this first chart comes from Price Waterhouse and they call this the ABCs. These guys make all of this money for charts like this, I love it. This is, Price Waterhouse Coopers explaining to all of us what employers want. Okay? The A is for administrative ease. Now it's important to note here is that the bigger the employer, the more important this is. And I think it is safe to say that the really big employers, the

national employers of so called jumbo accounts, care more about administrative ease than anything else. In a good economy. But this worm is going to turn, it's going to turn hard, but a lot of our time as a health plan is spent trying to make it easy for a company to do business with us and trying to make it the easiest for their employees to be covered by our plans.

B is budgetability, I love this term, I don't know what it means. Underneath it are four things. First, what employers want is predictability, their budgeting this year, next year and the year after so they want a predictable set of increases. They do not like what happened in health care, a negative 0.3 percent, that doesn't help if next year or three years later it's going to be a positive 7.6. So they want predictability, they want affordability and they expect health plans to control costs and if the current techniques aren't working, they want us to develop more aggressive techniques. Many of you are going to say that's not consistent with what we've heard, that's not consistent with what people are saying. Well, I have a source that will knock your socks off. Again, I cannot share any of our research, but [instead] bring to you the highest form that I know of academic research. See down there?

Stuart Altman presented this chart at the WellPoint and USC Symposium last year and as you can see, there's no source, Stuart made this up, but it doesn't matter, it doesn't matter because it makes my point right in the middle. What do employers want? And this is at least a year, a year and a half old: 29 percent want plans to use a more aggressive form of managed care. I would bet if you did this this year, Stuart, that is to say, you know, go into your bathroom and make up another chart, that number would be closer to 60 or 70 percent because they are very scared. What is happening is the CFOs are coming out of their offices, they're saying what's going on here? All of the raw materials are going up maybe 3 to 4 percent, labor is going up 4 percent, you guys are coming here with this cockamamie 7, 8, 9, 10, 11, 12 percent, not going to happen. Let me talk to that guy in HR, let's fire the people in benefits and let's get this thing under control. And that happens very quickly and it's very ugly.

It's interesting that only 13 percent want plans to use a less aggressive form of managed care and only 18 percent want more plans. What they want is cost control and we're going to see that tremendous push back. Now what do human beings want? Because these are the people, this is where most of the money comes from, but the people who want to be satisfied are the employers or the consumers. And they want four important things. First, they want information. Really half of online consumers access the Internet for health care information and I'm proud to tell you that in health care now, there are more health care sites today than there are on pornography that

was a big breakthrough. We've paid a lot for that [information] too, but I can't share that with you.

Second, consumers want to be involved in decision-making and this is something that's hard for physicians and hard for many people but they are dead serious about it. 78 percent that they want to have to have a say in the treatment, 72 percent say they feel uncomfortable if they are not consulted.

Consumers also want help. And this is where health plans, and I'll talk about it in a minute, I think are going to have the big opportunity. Our health care system is so complex, they want assistance in winding their way through that system and they are more likely to stay with the plan, 82 percent, if it offers tools to do that. But they don't want just a health plan. If you do enough of this consumer research, you come to the conclusion that it's close to what we heard from the Harris Poll guys today.

As Stuart Altman pointed out, Americans are feeling anxious about the future and it isn't about the health plan they have today. Most of them are okay with today's health plan. What they are worried about is will they have access to quality care at an affordable price over a long period of time and what they want is security about that. In the good old days, you know, Prudential was solid as a rock, okay nothing is solid as a rock, everything's changing and people are very, very worried. Now the two things that are important about this. The first one is they're looking for the future and the second one is about HMOs, PPOs, deductibles, that does not matter to most Americans. They don't know what kind of a plan they're in and they don't care. What they want is to make sure they're going to be okay and their families are going to be okay and they think they have a right to get that.

They also believe in the market economy, most Americans are not health care experts, but they understand their rights and privileges as consumers and want to exercise those rights in a way they're use to doing in the rest of the market economy to assure that that will happen. This not about health policy, it's not about the government. It's about what consumers want for themselves and how they want to exercise those rights. Well how does all of this add up? I'm sorry, this says consumers want to feel secure, but I didn't underline that strongly enough.

Well, I want to talk about what I think health plans will look like in the new millennium given all of the stuff we've already covered. I think and by the way, I was supposed to say what's going to happen in the future. I haven't the vaguest idea what's going to happen in the future. What I'm going to talk about is what we're going to do where I work and you can either

generalize from there or not. We believe that success in the future requires a different model, not a health insurance model, not a managed care model, but a health security model. We think administrative cost and bureaucratic abrasion has to be reduced and we think that we have to be involved with you and others in the development of policy changes over time. In other words, the next generation is going to be health security. Consumer oriented products offering choice, multiple network options and focus on member assistance and service by getting information, providing disease management and case management which are very powerful tools if they're done the right way and of course, you'll learn about that in a minute.

So success in the future will be to those institutions we can call health security companies. Those are organizations with the financial, technical and intellectual capital to assure their customers that health care services and information will be available and affordable to those customers over a life long relationship. A mouth full. Let's talk about what that means.

The first thing, the first part of health security has to do with products. We have to offer choice. Americans are very resentful of the whole HMO movement and justifiably so. I'll show you some statistics, but basically, the classic HMO model is built to frustrate people, right? There's a gatekeeper model and there's a limited network. The classic letter you get is I've been a member of your HMO for three years, my wife wants to go to the dermatologist and you guys say I've got to go back to our primary care doc. Okay, who says he or she can handle it, okay, it's a red spot, you know rub it, it will go away, that's not what I want. I want to see a dermatologist. As you'll see in a few minutes, it doesn't cost very much to let that patient see a dermatologist. It costs an awful lot to force them back to the primary care doc and to start this fight. And you saw on the chart today about the number of people that had bad experiences and how many of them were significant versus the ones who were insignificant, that's what this abrasion is. It's irritation, I'm paying the bill I'm in charge, I want what I want, why are you giving me a hard time? So, I think we're going to see more companies offering more choice. It is administratively quite complex to do that and we'll see who can make it happen.

Hybrid products, you take pieces of HMO, pieces of PPO, pieces of EPO and put them together so they make sense to people. This whole religion of what is a classic HMO and what is a PPO is meaningless in the marketplace. Nobody cares; you got to get a product that works, not a product that fits somebody's definition. The contribution is coming, which we'll talk about it in a minute, is totally in my opinion, a function of the economy. If the economy continues to go south, you're going to see it in a very big way. It will, I believe, be trotted out as an opportunity for people to get better

coverage, not worse coverage, because people can buy out. And someone said there's a 10 to 12 percent of the population interested in doing that. Well we're all going to be offered that opportunity and personally I think Medicare is going to go that way, too.

You also have to have an environment of continuous innovation. The problem with health care is there is no answer, there is no equilibrium, there is no stability and we're never going to get there. Why? Because the critical things are always changing, the science space is changing, people's needs and expectations are changing; a change as we age as individuals, and a change dramatically as our family situation changes.

You know an 18-year-old white male in our society does not need health insurance unless he drinks and drives or takes drugs and drives and then he needs a lot of help. Okay? That same person in his middle 20s may meet a female if he hasn't been driving and drinking and behaving poorly who will spend some time with him. That female has had a relationship with a physician over time. It starts much earlier; women understand the health care system because there are some things that work very well for women. A pap smear is one of few preventive things that does work and we ought to have it done. But suddenly, if those two decide they want to either live together or get married, there is a relationship to the health care system. If we move through time and they decide to have children, there is a big relationship with the health care system because the mother is going to take good care of the children to the extent she can have a relationship with the pediatrician, with the OB doctor, with everything that's necessary to make that work.

Now, most men do not have a relationship with a physician until they are over 50 or so I have been told. When, when--it's my speech. Okay? When they begin to have problems, they realize they're not going to live forever. That's why I remember our three goals. So, you have to continuously develop new products. If the science space is always changing, if people are changing, if needs and expectations and family situations are changing, we've got to roll out new things. Remember technology dispersion, which used to be a problem, you know 10, 20 years ago, occurs instantaneously, it occurs on the 5:00 news, right. Consumers know about new stuff before physicians even hear about it in their journals. And they want it right then, and the health plan better have it or better have a reason for not giving it now, but giving it in the future.

We had an analyst from Wall Street come to visit us and he said you are not a health plan; you are a consumer products company. You're constantly focusing on developing new products. Well it turns out we are a health plan,

but the observation was appropriate. New products all of the time. We can talk about that later.

In addition, the plans of the future will have a very different approach to networks. They'll use segmented networks, it will really get this centers of excellence thing going and they will collaborate around the patients, with the physicians and hospitals around the patients that need and consume care.

This is a very sophisticated graphic of what segmented networks look like. Basically what's going to happen is that most health plans will continue to have relationships with as many primary care doctors as they can, but you will see a dramatic reduction in the number of specialists, sub specialists and hospitals because there are too many of them and they're too expensive and the quality is grotesquely uneven.

Centers of excellence, I think, will also mature. For major procedures and major problems, what you'll see is people being guided to the appropriate location by their health plan. What we found and this is a bit of a surprise, if you can provide meaningful information to a person who faces a big decision about a procedure or therapy and includes things like survival rates, complications rates, the number of cases that are done, the quality, the alleged quality of the team, people will make a reasonable decision.

You know, when somebody's got a real big problem they will sit down with their family, they will take a look at the data if it's made available, and you don't have to go to St. Mary's just because St. Mary's is around the corner. If there's a place that's better, I want to go there. Now sometimes those places are cheaper because they do more of it, sometimes they're not. The issue is not the cost for procedure; the issue is the cost for the whole episode because if you go to a place that knows what they're doing and you have better outcomes and have fewer complications, that's where you save the big money and that's what this is going to be all about. What are the quality outcomes for these complicated procedures?

There's also going to be a new focus on collaboration. As I said, everybody here is quite the academic and reads only the best journals. So, we all saw that "USA Today" article that said that the procedure you received is a function of where you live and that incidence of different procedures vary by a factor of seven across the United States. Now we've all known that and when we take a look at the money that's associated with that, it's pretty scary. So I think what we're going to see is the specialty societies and others, building national protocols and standards of care and the adoption of those things by health plans and by physicians because they are beginning

to realize that this is trouble as well. And I also think there will be rewards over time for physicians based on their clinical practices.

We're going to move into an era of medical management where plans are going to try to be a medical concierge as apposed to a gatekeeper. Instead of saying no, they're going to try to say here's what's best for you. They're going to try to provide treatment option information and targeted medical management. Now this is the take home slide, please refer to the far right. In any statistically significant, random group of folks, what you find is that 8 percent of the people in that group will consume 70 percent of the medical costs. And what's significant is 7 of the 8 percent can self identify, there are no big secrets here. The incidence of trauma and the onset of the surprise disease only accounts for 1 percent. So they know who they are and they know what they need. This is also the reason why people don't like HMOs. Because the remaining, 68 percent of the people, only consume 7 percent of the cost. Those are the ones that were forced to go back to the primary care doc and got beaten up about going to see a dermatologist. Okay? So we got to switch things around. We've got to say, how do we help those 8 percent get the most effective and appropriate care in the appropriate setting quickly, easily and hopefully better outcomes with reduced cost.

Well, it turns out that about 20 percent of our membership and we have about 9.7 million members, has one of these chronic conditions. And those chronic conditions amount to 90 percent of that 8 percent. So what we try to do is identify those people and reach out to them and help them in what could be called either case management or disease management. I have a very intricate slide that explains how we did it but Carl deleted it. Here is the result.

This is just diabetics, we do this for congestive heart failure and a number of other things. What you see here is a comparison of patients that are in that program are members and patients who are not, but the red are non-participants. Look at the number of admissions, look at the average number of days, the average length of stay, and look at that the average number of ER admissions, you do not want a diabetic to crash and have to go to ER, that is a terrible thing to have happen. So this is a very successful program. We have one other program for women with breast cancer and a similar tremendous impact of the [reducing] number of women who go to the ER after having a bad episode with chemotherapy. There's an awful lot that can be done.

The key to this thing when you talk about it in the Q & A, is not getting between the doctor and the patient, but doing the things that will help the patient be successful. Generally, physicians do the diagnosis; they do the

first counseling session. Generally, patients don't do what they're told, and so the nurse follows up. After a while, the nurse gets tired. What we try to do is extend what that nurse is doing in terms of trying to get the patient to make changes. One of the social issues I'll talk about later is what do you do with the non-compliant patient? And there are a lot of non-compliant patients; a lot of money is spent on [the ramifications of] that.

Plans for the future are also going to focus on administrative costs. I'm not going to spend a lot of time on this because everybody sort of knows about this stuff, two points: (a) it's not as easy as it looks and this is only about 10 percent of the cost. So this is more window dressing, I'm sorry take that back, this is more to make everybody realize that health plans share their pain, this is more about reducing abrasion. There isn't enough money here only 10 percent of the action may be 15 percent in some plans, but there's not enough money here to change, you know, the fate of the free world. But we've got to do it because everybody considers this to be wasteful.

I think there are more opportunities to bring more money out, let me back up, excuse me. This thing down here at the bottom, standardized transaction codes and procedures HIPAA, CAQH and a bunch of things, that is very important because most of the administrative costs involves the interaction between the physician or the hospital and the health plan. If we can get both those costs down, there is a big opportunity. Right now, everybody does it their own way. If we can standardize that, we can make some real progress.

We started an organization called CAQH, which I heard today, wasn't going to amount to anything. I will remember that and see you later! There were copies of the annual report of CAQH available over at the other venue. I'd ask you to take a quick peek at that because it was all about building trust and it's our feeling that the health plans have lost the trust of the American people and we did a lot of research about how you regain trust and the answer is: saying "trust me" isn't enough.

Advertising doesn't work either. What you have to do is set an agenda that's meaningful and achieve those things you say you're going to do. So if you read that, these are the things we say we are going to do. We're going to improve the health care experience, we're going to work with doctors and advocates on quality, we're going to research ways to make administration information dissemination easier.

I've been working with doctors and advocates on quality. The comment was made this morning and I think it's very important: health plans cannot be the lever to write the problems with errors. It will not work, physicians don't

trust health plans and frankly, members don't trust health plans to do that. What we can do is provide information; we can't assist physicians in improving quality. One very good example is this SAS project and that means save antibiotic strength. We're spending a lot of money to try to help turn around what is a crazy situation. 50 percent of the prescriptions for antibiotics are inappropriate, given to people that don't have the problems that an antibiotic can deal with, but that's the good news. The bad news is the result of those things, we are growing the fiercest bugs in human history and none of them can be defeated by the antibiotics, so we're creating a huge problem. And this CAQH organization is working with physicians and the CDC to try to turn this thing around.

This slide is mislabeled. This is [not] supposed to be industry collaboration, it's really involvement in policy change. This has to do with what Stuart mentioned, this is our FDA petition. The words from 1951 are actually from the Food and Drug Act and it says a drug can be made available without prescription if by following labeling, consumers can use it safely and effectively without professional guidance. Claritin is a great drug, full stop, it's very effective, it has no side effects, nada. The alternative to Claritin is Benadryl. Benadryl is available for \$4.50 over the counter, it makes you sleepy, you know the great joke line about do not operate heavy machinery comes from Benadryl. 10,000 people a year die in accidents involving Benadryl, 80,000 people are hurt. That you can get for \$4.50.

But yet, Claritin with no side affects, [you] have to go to see a doctor which costs \$100 plus, then you have to pay for the prescription which costs \$65.00, it does not compute. Worse yet, same drug available over the counter in Canada for 12 bucks. So in July of 1998, we petitioned the FDA to convert the non-sedating antihistamines Claritin, Allegra, to over-the-counter status. We received a Dear John letter from the FDA and I received several death threats, it was very interesting. In the snap of an eyelash there, only what is that three years later, the FDA convened the advisory panel to address the petition and on the topic of Claritin they voted 19 to 4 to remove it from the prescription drug list. I think if it goes forward, a real victory, a very good drug and we wish the company Schering-Plough no ill will, we just think more people should get it. If you do the math, you take the drug out of the prescription formulary, you make it available from \$8 to \$10 over-the-counter, I think they're going to make more money, but for some reason they don't agree. So, what we're going to see is a movement to the point where well capitalized health plans are going to make investments and will be adding value. New techniques will replace old techniques, but health plans alone can't determine the future of health care. There needs to be some health policy changes and a need to face some

health policy issues. And we'll go through this pretty quickly. There are a zillion of them, [but] I want to cover three.

The first is the uninsured. In our target markets in these states, there's 6.5 million people who are uninsured and are in families with incomes over 200 percent of poverty. The question in our minds, why don't they have health insurance? A lot of research was done and in 75 percent of the cases, it's because health insurance costs too much, end of story. Okay, well, you want to spend more money on research, you can and what you find is that the people who are uninsured have a very skewed version of what health care costs and what they can afford. The blue bar is what they think it costs, the yellow bar is what they're willing to pay, so these folks aren't ever going to buy health insurance.

The last point: those two lines show the prices of plans we offer in California today. So, in almost every case, in every case, there's health plans these folks could afford if they knew it was out there. If we could speak their language, if they felt the health care services were culturally appropriate. It turns out these issues start out as financial issues, but become very, very complicated social issues. Anyhow, we're trying to get to those people. However, I note that in the beginning that these are people with over 200 percent incomes with over 200 percent of poverty, 43 percent of the uninsured are in that situation, where people under 200 percent of poverty, there's not much a health plan can do. We cannot offer care if somebody doesn't pay a premium. So we work together with Families USA on this proposal and I'm sure everybody here has appointed you on it, I'd just like to say we worked as hard as we could.

This is the conclusion that has to do with addressing social issues. I've done work in the United Kingdom and New Zealand and Germany and a little work here in the United States and it's obvious after you've been around health care systems that health care systems vary not as a function of the science base, or even the economy, but it's a function of social values. And we bump into these problems all of the time and some of the biggest ones we have are right here in terms of the future of health plans.

The first and I think the most important one concerns the baby boom generation; over the next 30 years what constitutes an insurable event? And we're going to see health care dramatically increase in terms of what people want it to cover. We were the first company to cover Viagra. That won front page coverage in the "New York Times." But what we said was we'd cover Viagra if there was a co-morbidity. That means if an individual had a diagnosed situation, one of whose symptoms was a erectile dysfunction, if you have that, you get your little blue pills. If, however, you

just want to have a hot Saturday night, that's up to you. We have never been sued, we've never been challenged, we've never had a problem with a patient or a doctor.

Now, the real question is not do I get the pills or not, but how many pills is a one month supply? Some of you may have heard me ask this question before because I did this for a year. I went around before Viagra came out and asked that question to people and it was fascinating, it tells you a lot about insurance and a lot about the problems we're going to face because the responses were always the same. What is a one month supply? Women in a group would say let's see 31 days, 4 Saturdays, 3 pills. Men would say let's see 31 days, 4 Saturdays, 35 pills. But clearly, how much of your insurance premium goes to the 35-a-month person versus how much goes to the 3-a-month person. It doesn't seem to me that that is a classic health care issue, although increasingly we're going to see those issues.

My other favorite recently is the one you see on television. There's a pretty strong drug called Paxil and Paxil is developed for people who are clinically shy, another great term. What is clinical shyness? I think it's people who literally can't leave their house, all that sort of thing. It has been marketed on television almost everyday, if you watch television enough, as the pill to relieve social anxiety. Clearly, who among us has not had at least one incident of social anxiety in the last month. Starting with me when I couldn't plug in the god damn computer! I mean right, so we pop a pill. Use that as an insurable event, use that as something we want to cover either from my health insurance or the government. What about clinically unproven therapies?

There was a [previous] reference to a autologous bone marrow transplantation for breast cancer. This is a very, very sad episode, but it turned out that the one, set of data that supposedly supported this was falsified. There is no evidence that it works. A lot of people, a lot of women, went through great agony. We're one of the few plans that covered it. We said we'll cover it, maybe it's good, maybe it's bad, we don't care we'll cover it, but we will tell you what other people wouldn't tell you which is 1 in 5 women will die from the treatments and did. But there are lots of other things out there that people in extreme situations want.

What about alternative therapies? Herbal medicine, aromatherapy, all of this sort of stuff. It does, some of it does work; some of it is quite dangerous. What are we going to do about it? We're going to [have to] insure it. There are bigger issues in a free society, but can we mandate coverage for individuals who can't afford it? In California, you can't drive if you don't have automobile insurance, you can get in an accident and not

have health insurance. Are we going to require compliance of medical protocols, either on the part of physicians or on the part of patients? This notion of compliance of patient compliance or the issue of patient compliance is a huge dirty little secret and something we have to address.

Who should fund experimental treatments? What should be the role of the legal system? Just a one cheap shot vis-à-vis the discussion earlier today. It's hard enough to run the Medicare program you know out of HCFA. It's impossible to run it if all the decisions are based on legislation because legislation is concrete and once it's there, it doesn't go away, even though the science base is changing and people are changing, particularly seniors [who are] living longer.

But the worst way through any kind of a health care plan is through litigation. It is almost always disruptive. You never know the outcome; everybody runs for cover, a lot of money is wasted. It is a very, very pernicious way to go.

Anyhow, I've got a big finish here and I've got to, I've got to do it with a little preamble because this comes out of my economics background. I am now going to explain the big problem in health care and refer to my many years of study. This is about simultaneous equations and whether they should be optimized or maximized. The difficulty I have is I can't remember the difference. So, trust me it was a great idea, no, this is it. You can look at health care many ways, but there are four key stake holders: the consumer, the patient, the purchaser, the providers, the physicians in hospitals and for this purpose because this is suppose to be about health plans, I threw in health plans. The classic tradeoffs are access, costs, and quality and the question is: can we optimize one where we have one winner and then three losers or really trying to maximize all four. And I think we are trying to maximize all four. And I have a series of equations that make this case, but there's a better way to try to grasp it.

You all, any of you saw a movie called "Diner" many years ago. There is a character [in the] movie called "Boogie" and it turned out he actually exists. And Boogie actually owns and manages a diner in Aspen and I was invited to a very fancy conference sponsored by a foundation in Aspen and went to Boogie's diner. And on the far wall, there was a huge sign that says Boogie's Diner; it says our food is fast, cheap and good. And in very small letters at the bottom it says: pick 2. So, I give you that in lieu of my simultaneous equations, but you could, you could take a look at what it says [about] stakeholder there. You could take a look at value or you could take a look at drivers, you could say, we've got the same problem with science, economics, social values and personal values. We cannot optimize one

because if we optimize one, we're going to end up sub optimizing the other. So we want to maximize all four, but in the process somebody is always going to be unhappy. We are never going to go to a conference without the emerging problem of them being unhappy about that because there isn't enough money on earth, or enough time or energy to do what everybody wants to do. However, everybody wants it. We confuse, I think, [due to] some of the political polling, the politics of health care as opposed to the way Americans view it. Our society is very unusual in that we really believe that science will solve our problems. You know in France when somebody dies, it's kind of the end of life right. In the United States when somebody dies, you call a lawyer right to sue someone because the person died. We really believe that given enough time and hard work, we go to the moon. Right? We were supposed to cure cancer and we'll get that, we can do whatever we want, well you can't. There are physical problems, there are problems of time and space and some things just don't yield to that sort of thing. However, people behave in health care debates as if it's out there and they want access to it. So, we've got an ironic situation, Americans have access to the best healthcare in the world and the best healthcare in history. The problem is we can't make it work for everybody, so these issues will be addressed and I think continually addressed in our market economy, which makes it very complex with a very complicated overlay of public policy debate, of legislation, regulation, media hype and the economic factors that act on this. I think that there is a role for everybody in this discussion. Clearly, you know if war is too important to be left to generals, you know healthcare is too important to be left to insurance executives or, you'll forgive my policy analysts, or you'll forgive me, the Congress of the United States. This is something that most Americans feel they have a personal stake in and they want to play in this game. The problem is no one, no stakeholder will be completely satisfied at any point in time, will never hit equilibrium. So what it means is we all have a very interesting and fascinating decade ahead, and we'll all get together again in 10 years and you know what, everybody will still be unhappy, but I will have retired and what the hell. Thank you.

DR. ALTMAN: I think we'll just kind of have dinner rather than ask questions, I think so.

UNIDENTIFIED MAN: How about a few questions.

DR. ALTMAN: Sure, how about a few questions.

END

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