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**FEDERAL AND STATE REGULATION OF MANAGED CARE**

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**DR. STUART ALTMAN:** We are moving into a new section of the discussion which we've touched on several points and that is that what extent is the future of managed care or that form, any form of insurance going to be influenced by, dictated by regulations both at the federal and state level. And clearly, the discussion we just had about Patient Bill of Rights and the ability to sue will have a very significant impact on the shape of our insurance market. And Congresswoman Johnson, I think, her discussion about the employers is nothing trivial because it is quite possible that if that ability to sue was translated to them and they began to be sued, you would see employers really figuring out a way to getting out of this business.

Okay. So we asked two very astute analysts of our system to come and join us this afternoon. First is Tom Scully who I think you all know, who had a variety of jobs at federal level working as you said, for OMB and in the White House and for the past, I don't know, six, seven years, or eight years sort of represented our for-profit hospital and health care systems. And now is about to take on what some would say an unenviable job of running our Health Care Financing Administration, but we're all very pleased you're going to do it. But in the meantime, it will be interesting for us to get your perspective on this complicated world of regulations. Tom.

**MR. THOMAS SCULLY:** Thanks. First, one of the many things I haven't figured out is how to use HCFA laptop, so a boring laptop. But anyway, the main reason I really want to take the HCFA job is to hope that if I worked out at HCFA for a couple years, I could get all cued up for a really big budget like running Robert Wood Johnson or Kaiser or something like that, doing something really significant.

But anyway, for those of you who don't know me very well, a lot of you don't, even though I give him a hard time, Chris Jennings is, in fact, an old friend of mine. And we worked together for many years. I like to give him a hard time about being the (inaudible) manager. He was--he and Nancy Ann and Gary and many others, were very gracious to me the last eight years.

And I hope that's reciprocated the next four by other people in the Bush administration. I know it will be by many of my other colleagues, but anyway, I like to give them a hard time, but we go back as far as inventing Medicaid drug rebates that some people still haven't forgiven me for in 1990 in the middle of the budget deal.

But I'd also say a couple of quick comments. Nancy Johnson just to show you all she really doesn't want to leave and go home. She what? But I will say just to show how much--how lucky you are to have her, how much she cares about health care, she called me Wednesday night to say, Tom, can we get together on Friday and talk about your health care issues? And I said, well, I'd love to but I have to go to Princeton for this kind of policy.

And she said, oh, what is it, what is it?

And I told her and she said: Well, I want to go. So, there aren't too many members of Congress that care that much that would go do that kind of stuff and we're lucky that she--this mic is not working. Some people prefer not to hear me, so there, you're lucky. That's all right. I'll just hold it. This is working fine. This is good.

Anyway, a couple of other things. I would just, just a couple of comments to begin with. Nancy Ann is also--she hasn't left, she's also an old friend. Some of you may not realize that when we lost--when the good guy lost in '92, I'm just kidding, Nancy Ann took over my staff in 1992 and we got to be very good friends then and we've stayed good friends for a long time. So it will be interesting that now I'm kind of taking over her old staff.

So I agree with a lot of what she had to say. I missed most of her presentation, but I read all of it last night. And as you'll see at the end of my presentation, I agree with virtually all of it. But I also agree with something she mentioned which is not a topic of discussion for this conference but I think maybe would be a good one for the next is that everybody likes to beat up nursing homes and long-term care, but if there's any one focus--there are many focuses I'm going to have, but one that we probably should focus a lot more on is we've got an explosion of seniors coming our way. And everybody loves to hate system--living in long-term care and everything else. But there aren't too many great people out there providing it. And so I agree with Nancy and we ought to focus on it.

And I also I didn't see Paul's presentation this morning, but I read it while I was sitting next to him and I would say he's figured out more than most academics, that you'll also see from some of my presentation what I think is going on with managed care and what the intentions are that it is completely

and totally different than what's going on in the Medicare and Medicaid Programs.

And then finally, I'd just like to thank two people. First of all, I'm going to be in command at HCFA in the next three years. Don't call me; I just hired Peter Levin, who's up there in the back, who used to work for Connie Mack. So if you get really mad at anybody, Peter's number is--so call Peter and bitch at him. He's the first public--first semi-publicly, now publicly announced new HCFA political employee. There are others on the way.

And I also--there's one other person that's very helpful to me who's here, Kathy Buto. I would like to thank CBL as much as they get, you know, half of the sum of my comments. They have lent her to me for most of the last six weeks. She's been kind of my one-person transition team and she's not going to stay unfortunately, but she's terrific. So thank you very much for all your help.

Anyway, what I was going to do and most of this is plagiarized from very good HCFA briefings I've gotten in my last month as a consultant. And I guess hopefully since Julie's the only reporter here, this is kind of off the record, I might be the first unconfirmed, but nominated HCFA administrator I'm aware of, although Drew came close at one time. You did it.

Anyway, what were the goals of the Balanced Budget Act of 1997? You can look at these and say we pretty arguably bombed out on all of them - continued program expansion, means of extra benefits for beneficiaries, long term efficiency, more accurate payments, introducing new models, attracting rural plans, beneficiary education. You could argue beneficiary education; maybe we've done a little more of, but virtually every other goal of the '97 Medicare Plus Choice Plan legislation has pretty thoroughly bombed out and for some unpredictable reason.

Where are we now? We've still got 15 percent of all beneficiaries, Democrat or Republican, I think the estimates from CBO was anywhere depending on when you asked them, 25 to 30 percent is what we expected by 2002 in the '97 bill. That clearly hasn't happened. It peaked at 15 percent and has regressed, as you'll see in a few minutes. Only 63-1/2 percent of beneficiaries are in a county where a plan is available. All these new MSA's, PSO's, that's been a lot of fuel of some comments from people in this room including Cathy who negotiated it. Figuring out how to make PSO's for my hospital is a really new vibrant option in Medicare. And I'm still--I think there's one that's kind of dying in New Mexico and outside of that, it was a fun six months though. Wasn't it?

But there isn't—not much has happened. Sterling, which I think, I don't know anything about Sterling except that they're smart, there's a ton money for better or worse, people might not like the policy, but in the short term when we threw all that money in rural areas, some people and until the world adapts are going to make a lot of money in rural areas. And whoever they are, they certainly have figured out the code and are doing well in the short term, which we probably have a long debate about where whether that's good or bad as well.

If you look at the five top Medicare Plus Choice plans, all of these, except Kaiser, are publicly traded. I don't think any of these guys have been having much fun in the last couple of years. Certainly have been following the publicly traded companies, none of them has done well. The Centra Care has had a disastrous time, so virtually anybody that's been very committed to the Medicare Plus Choice program in the last three years has suffered enormously, which is not good if you want to get people to think of the government as a trustworthy contract partner.

The non-renewal activity is enormous - 1.6 million Medicare beneficiaries have bailed out in the last couple of years. And you can read through this and see, but obviously overall, Medicare Plus Choice, instead of being enhanced by '97, then the BVA in '99 and 2000 has, in fact, not been doing very well.

This chart, where you can where the numbers are coming down. I'm just going to whip through some of these. And it's pretty self-evident. I don't think I need to go through these today hopefully. But clearly, all the intentions, both Democrat and Republic in '97 to gradually phase in more people into a Medicare private risk plans just have not worked out in the least. The percent of Medicare population with access to at least one Medicare risk plan has dropped from 74 percent to 63 percent. I expect that's going to drop again this summer unfortunately.

Distribution of the population - 23 percent of Medicare beneficiaries live in an area with five or more options. That's down from 54 percent in '98. That's a pretty shocking number, I thought. And 20 percent live in an area with only one Medicare Plus Choice organization. These are pretty big numbers as far as the changes go. And again, all these are from the HCFA briefing I had coming in and I only picked out about a third of the slides they showed me. But a lot of these hit me as pretty surprising.

In rural areas, we've pumped a ton of money as you probably know into rural areas and managed care. And what's happened with rural access to managed care? A 33 percent drop. Pretty big in urban areas, but if you look

at where the distribution of the money was, the idea was drag all this money in the rural areas, jack up Medicare Plus Choice in rural areas. And no matter how much money we throw in them, it hasn't worked. They're still dropping out and there's no access. And I'm actually not sure if this number includes Sterling or not, but I think it does. And if you count--does it? Okay. I'm sorry. It does not include Sterling. You see, I've not been at HCFA that long; I'm just figuring this out.

And then access to plans by type of rural areas by type of coverage, if you look at the right, plans with drug coverage which is obviously what a lot of people are after given what our discussions are this year, 19 percent to 8 percent is the fall off in two years in rural areas. I doubt that Senator Baucus, who knows a lot of staff here or Senator Grassley or anybody else, who cared about rural health care and was pushing for those changes in the formulas, was expecting that kind of result in the last couple of years. I know I certainly wasn't.

Decline in Medicare Plus Choice enrollees with zero premium plans, which is obviously the draw for a lot of low income people, which is something I actually care a lot about think this is a good option, was 68 percent to 45 percent. Kind of hard to find any good news in any of these numbers if you're in the Medicare Plus Choice business.

And then obviously the thing that draws most people into this is the drugs in the basic plan. And in 1999, you had 78 percent--I'm sorry, 84 percent of drugs in the basic plan. And on the right, you look and it's down to 70 percent, if you can read that, drugs are the basic premium is 35.1 percent, 34.9 for enrollees of drugs in the zero premium. So fewer people are getting drugs and they're paying a lot more for it. And that is very predictably going to affect the number of people that want to stay in these programs.

So what are the other statutory changes we've made in the BVRA? Five percent reentry bonus, that didn't really work very much. Hasn't seemed to draw anybody in. Decreased the amount of user fees, that might have make Karen happy, I guess. It probably offset some of the membership dues, I don't know. But the--but other than that, it didn't do a hell of a lot. Risk adjustment, we can probably spend the whole time on, but none of this really seems to have done much as far as encouraging and incentivizing more people into the plan.

And if you look at what it really did and this is really what happened is a lot of the money gets put in the rural areas. If you look at 1997 in Wisconsin for instance, surprising that HCFA did this for Wisconsin, I wonder why they did that. But anyway, yeah. New governor from Wisconsin is if you look at

Wisconsin basically from 1997 to 2002, Milwaukee didn't go up that much. Vernon and Lorea (?) went up a lot. There probably aren't that many people in Vernon, but there's a hell lot of more money thrown into Vernon.

And if you look in Florida where Miami, Dade went up not very much and Jefferson went up a ton, there probably aren't many new enrollees in Jefferson.

So the places where people want managed care and the places where people want to sign up for Medicare Plus Choice and the places where it was popular because it was drawing people and where--I forget who it was, Paul or somebody argued the market share can actually make a difference in the delivery system are not the places where the money was put. And I understand again, I've got Senator Baucus' staff which I don't want them to rat on me and go back and tell him, I understand the intention and the frustration with the floors and everything that went on in the last couple Bills, but most of the money went into rural areas and it has not changed behavior at all. In fact, it's made it worse. And the places where managed care, where Medicare Plus Choice actually worked have arguably been starved I think which is a point some people made this morning.

So basically the legislation's been almost nothing. I'm going to come back to this in a minute, but one of my other pet peeves of managed care is how beneficiaries learn about Medicare Plus Choice plans. And the bottom line is they have to be--go on the Internet site, which I know at least one of every two million seniors I know knows how to get on the Internet or call the 1-800 number for Medicare which is pretty good, but basically it's a marketing problem. Marketing these plans is done generally front porch to front porch, senior to senior, which is a lot more difficult than selling true plans to employers.

So--and I'm going to talk quick and then wrap this up. What are my conclusions for this--Nancy even left I guess before I could put this up. Is that right? Is she here? Oh, there she is. Good. With the baby and I still didn't see her. I read her paper on the lecture and this—I'm ending at the tail end of hers and she is a good friend. So I do agree with almost everything that she said in her paper when I was reading it last night, which actually shows that I wrote this whole thing up on the train, so I guess you had to figure that out, too.

The major goal of the BVA was saving money. And when you're trying to save money and come up with 103 billion or 260 billion, whichever number you believe in the BVA, trying to incentivize more people in the Medicare Plus Program and get them going that direction, the intentions might have

been good in 1997, but it just, you know, the math didn't work and it just didn't make sense.

As I said, the 1999 add backs for folks for (inaudible). There really isn't much traction there in Medicare Plus Choice. I think it was probably a valiant effort to get more people in there, but the money probably isn't being spent, number one, and it's just not really going to a place where people are that interested in these plans.

The draw for seniors, the 20 percent additional benefits, is really for prescriptions drugs, other additional benefits that got seniors into it, as those other charts showed, those were largely wiped out. And as a result, what you got is one PSO into Mexico and they weren't even a member of one of the trade organizations, so it didn't do any good. And Sterling, which I still haven't quite figured out, but certainly they've not the most popular guys in HCFA's staff what I've seen so far.

And as some other people mentioned this morning, the simultaneous fraud acceleration scared everybody. Everybody was scared - hospitals, doctors, health plans. And so if you're looking at the government and some of you know, I've been on the board of Oxford Health Plans until this week for eight years and I can--and they're one of the major people who bailed out of Medicare Plus Choice.

If you're looking for the government as a really boring government contractor, solid source of revenue, it's scary. You're not getting a--you're losing beneficiaries, the margins stink, and they're anything but a boring low return, low risk partner. So anybody that's--I sat through many board meetings and I've sat through years of Oxford board meetings trying to convince them not to bail out of Medicare and I usually lost. And as it turns out, I was wrong. They were much smarter to get out.

But it's just not a good business for a lot of people to get into. So we can have a philosophical debate about whether you like Medicare Plus Choice or you don't like Medicare Plus Choice, but if you're a rational businessperson, either in a non-profit entity or a for-profit entity, you're pretty stupid if you've been increasing your role in this. And it has not been a very good business to be in.

And I also think the prescription drug increases which obviously only affect these plans and as mentioned in Nancy Ann's paper, which I agree with, the cumulative psychological irritation and frustration has basically gotten to the point where most managed care plans just don't really have any desire unless you're Pacific Care who obviously bit the ranch a long time ago and

was so far in, they couldn't get out, or Kaiser who I think has a philosophy that's consistent with what they were doing. Most people have been getting out pretty quick.

So additional random thoughts for me beyond what Nancy Ann said and I don't think she mentioned as much in the paper, I think and you guys probably could have had lunch for half an hour and skipped my speech. The whole discussion before lunch was with my very strong held views which is you can't compare managed care and fee for service. They're totally different entities. And I'm not being pro managed care or anti fee for service either way, but you know, the money, when Medicare was growing at 10-15 percent in the mid-90's and all the managed care guys in the product sector were heroes for having 1-2 percent growth, the reason was the hospitals and I know a lot about hospitals, were generally pretty fat, dumb and happy in the mid-90's and their margins were great.

So they were getting much better--there was a lot more leverage for the managed care plans to come in and drive down the marginal—for the extra marginal bed they were filling with hospitals in the mid-90's because the Medicare payment rates were great and the margins were great. And if you're a hospital, my hospitals, my old guys, where 45-50 percent of their revenues were Medicare. And they wanted to get the marginal patients from managed care so they were happy to cut deals.

When Medicaid came back in 1997, they had huge cuts in the providers, the Medicare rates all of the sudden weren't so great. And they were in big, big trouble. And they had no option but to turn around and I saw it on both sides. I saw it sitting at Oxford board meetings, watching what the New York hospitals were doing to them, and I saw it listening to my hospital members seeing what they were doing about how they were going to survive the BVA.

They went back, all the providers, I think hospitals more than anybody else went back and pushed back on the private side. So when Medicare is 40 to 50 percent of the market and they come and, you know, when you're the government, you want to come in and just ratchet down payments, all they had is one big balloon and it's pretty predictable what's going to happen.

So I've heard a lot of people say, well, you know, Medicare shrunk one percent in 1999 and the providers of all Medicare went down one percent, and those lucky HMO's got a two percent increase. It's pretty obvious what was happening. I mean, the air just got pushed around in the balloon. The HMO's had one percent increases when Medicare was going up to ten, Medicare took the inflation down to one, and the HMO's went up to ten,

heightened by the fact that they have to deal with the increasing prescription drug revenue as well.

So I don't say that to be pro managed care or pro fee for service, it's just I think too many people like to sit down and look at the numbers and say, well, this is an apples-to-apples comparison. And to me, and this is the discussion you had before lunch, it clearly is not. The government has the ability for better or worse to set prices, and they can set them high and let the other end of the balloon get low prices or they can sell low and push it back on the private side.

And I think for people not to--I think people in the business community in health care see that every day and just assume that policymakers see it. And what I see frequently in Washington is people--there's a complete disconnect. They just understand that. And maybe I have a really unique view having sat on both ends of it, on an HMO board and on the hospital side. And it was pretty clear to me that was going on.

So I just think it's not apples-to-apples. Medicare, you know, you can have an argument philosophically about whether we're better off with a Medicare for everybody or whether we should have private sector health care. But trying to compare the rates and compare the costs year-to-year, I think is fruitless exercise. Whatever happens in the private sector is a direct result of the push back that happens with Medicare.

So what can we do to solve this? I personally don't think and maybe I'm wrong, but since there's no press here but Julie and she's sworn to let me off the hook, I don't think there's going to be a BVA give back bill this year. I'd be surprised if there's any money put back in the system. There may be a little bit at the end of the year. Maybe Jonathan, maybe the rural hospitals or something due to the change in structure towards Iowa and Montana might get something started at the end of the year, but I wouldn't hold your breath.

So if you really do, I mean, one of my goals and I think it was one of Nancy Ann's, she made great efforts to try to keep people in the system, I think it's pretty obvious what's happened to the Medicare Plus Choice folks. I think Democrats and Republicans all wanted to get the number up above 15 percent. I think the number's going to drop again. My intention if I ever get confirmed which should be this next week is to try to find any reasonable way without doing anything really stupid policy-wise to convince the managed care players that we feel their pain, we'd like them to stay in, and we'll do anything we can within reason. I think HCFA reduced the regulatory burden to make their lives easier and smoother, to make the payment more

predictable, and convince them that they're going to have an open door to discuss their problems and try to become a more predictable, reliable partner.

That probably isn't going to be a lot of help to keeping them in since they're really more concerned about money than anything else and I'm not sure that's going to happen any time soon. Provide greater flexibility and plan designs. There's a lot of things that I think personally that some seniors would like to do that I don't think are widely available and maybe not even legal to do right now. I mean I think there are a lot of poor seniors, in my opinion in some parts of the country, that would much rather have a zero premium HMO that would have a tight network and a very limited drug benefit and get 50 bucks more in their Social Security check. A lot of them would rather have that for food or housing than to pay it for a part fee premium. And that's something that's not out there that I know of in the market right now.

But I think there are a lot of viable options that we're not giving. And generally what you're going to find, at least I've found in my experience, is in a lot of cases, the tight Medicare HMO's are most attractive to low income, poor people and it's a good option for them.

I really feel that the key to Medicare Plus Choice is educating seniors about choices which is why I've got one slide up there. I think HCFA's done a good job at educating people, but I don't think the average senior really understands any of their choices. My parents are pretty smart, pretty educated, but they have no idea. I've got to tell you, I got my dad a couple of years ago to switch to a Medicare Plus Choice product in Maryland and he spent half an hour trying to get me to explain to him why he wasn't going to have to pay Medigap plus Medicare Plus Choice. I mean that's a common thing among seniors. I don't think they understand the system that well.

So one of the things that I'm planning to do is really put a much, much bigger emphasis on promotion, on education, on educating seniors about their options, on expanding the 1-800 number to provide them with a lot more detailed information about what their alternatives are and, you know, if that helps them get in the private plans or Medicare Plus Choice or Medigap or fee for service, I mean, my view is a better educated senior, if they make the choice and only four percent want to go into Medicare private plans, great. But I think the more they understand it, the more likely they are to make the best choices.

And I personally believe that if seniors really understand their options and understand where their dollars are going, that you'll end up getting back to

the 25 to 30 percent of people in Medicare Plus Choice plans that people envisioned four or five years ago. I personally don't think absent massive legislative changes, you'll ever get much above that because fee for service is going to be around for the rest of my lifetime and I think Medicare Plus Choice on the margins is very good for some markets.

So just in conclusion, what will I really know? When Leonard Schaeffer gets back in the Medicare Plus Choice Program, I'll know that I've won. Leonard actually goes around the country actually giving some speeches and bragging that he's the smartest guy in the health care business because he never got into Medicare Plus Choice except for some of the people he's acquired and it's hard to keep track of every day by somebody else. So it's hard to keep on him. But he goes around saying he does, he has the best stock and he's the most successful guy on Wall Street because he was smart enough never to get into Medicare Plus Choice, which I think is a good and a very vivid picture of why this is not a good program to be into if you're a private contractor. He's done really well the last couple of years because he was smart enough to stay the hell out of it when it was a very unreliable program to get into. And when he decides it's a good business to get back into, then I would say we've probably succeeded in fixing Medicare Plus Choice.

Anyway, thank you very much.

**DR. ALTMAN:** Well, thank you, Tom. Next, I want to--we're going to turn to someone who has become well known to us in Washington and taken on a very challenging job and has done it extremely well, Karen Ignagni, who is the President of the American Association of Health Plans, and has had to deal with this complex change in the attitude of Americans towards managed care and as well as the government's role. So Karen has a fairly unique role in understanding and in trying to interpret if not change the complex web of state and federal regulations that weave around the industry she's part of. And she's going to try to help us understand that and hopefully give us a direction on maybe where we ought to go. So let me turn the program over to Karen Ignagni.

**MS. KAREN IGNAGNI:** Well, you can see how technologically proficient I am, still writing on legal pads and I can't use the mic. Other than that, everything's fine.

I apologize for arriving late. I had to do a meeting in Washington this morning, but I thank Stuart for inviting me to participate in the session. And I struggled with what to do because I didn't really want to take you over grounds that many of you are familiar with already. I didn't think that was

going to be terribly useful or a good use of your time. So I'm pushing the envelope a little and I wanted to try to change the conversation a little and tackle the question of whether the regulatory structure is going to be adequate for the future.

And as I begin, I also would be remiss if I didn't say that Tom did what I think is a very, very good job assessing the problems in Medicare Plus Choice and where we go in the future. And I do think it is a question of preserving safety nets that many members of Congress are going to want to take a hard look at this year. And we can talk more about that, both in that context and the HCFA context.

I want to begin by looking at the environment where we are now. A number of my colleagues are going to be participating - Leonard this evening and several of our CEO's tomorrow morning, about their perspective on what's next and what's in store for the delivery system. I wanted to take a different perspective. I'm going to yield to them to talk about what's on the horizon. I want to talk about the regulatory context.

And I'll tell you as I--when I get ready to put up the slide, I was looking at this last night and I had it out and I was kind of holding it up. And my son who's 13 said, hey that looks like a creature without a head. And I can't think of a better way to describe I think the regulatory structure we have now.

I want to--in terms of where we are and whether we're meeting the mark, the IOM now has issued two reports. The one I think is more interesting even and more problematic but also challenging than the first. And that was a blockbuster, the one that they released about six weeks ago which talked about the chasm, the quality chasm and that got almost no attention in the press. But it basically, the sub-text said that we're missing the boat in terms of the debate. They were kind enough not to go to assess the current regulatory structure, but I think if they had, they would have said there's no way with this to get from A to B. And I think that's an important wake up call for all of you who spend full-time assessing this, not only this industry but this field about where are we going and are we going to hit the mark in terms of providing the beacon in terms of new delivery systems and whether we'll be encouraging or discouraging them.

Their recommendations talked about coordinated care, talked about second centers of excellence, talked about evidenced base, sounded a lot about like managed care. They didn't use the words managed care, but many of the strategies that we've employed that have been very much at issue in the context of patient protection.

We've built a very extensive state regulatory structure. We are now in the process of building an equally extensive federal regulatory structure. Nowhere does anyone assess the opportunity cost. And as we get into, Tom's talked about HCFA, and he could equally, I suspect, give a very effective presentation about the amount of money either on a hospital, provider side, or a health plan side to comply with those regulations. And I suspect he'll have something to say about that very quickly. But you can make a similar and very compelling case on the private sector side, too.

So here's what it looks like from our vantage point. I hope you can see that. And this is no exaggeration. I can see hybrid cyst here. The 3-D effect here. Some people may say quickly oh, there's too much waste space on this chart, but this is what we have to--the entities with which we comply. I think you all have copies of this and if not, we'll make sure it gets handed out.

But I put this up because as we talk--thanks, Tom--as we talk in the Washington arena about more regulation, there is almost no assessment about what exists now, so everything is always additive. And that's the case in the HCFA context, that's the case in the private sector context. And you've got to look at this and as we look at the scientific advances coming down the pipe, we need to really I think stop. We've got an incomprehensible system but nowhere is there any consistency. There's no prioritization, there's no cost effectiveness analysis, no relationship with anything that we've created to the idea of assuring quality, and no evaluation or assessment.

And I think that that's the sort of thing, not to spend too much time on this, but to give you a sense of what folks are dealing with as they think about new product development. And as they think about innovation and responding to consumer challenges, this is very up close and personal. So I think--.

No, that's the next slide. You've already--you can see having been in this position, I see you're thinking ahead quite appropriately to that.

We're not dealing with evidenced based and we're not looking at improving quality. And I want to just use several examples.

The first example that I think is most compelling about the present, remember the case that kicked off the entire liability discussion was the case of Nolene Fox out in California with Health Net. It was an individual who had breast cancer and wanted ABMT. It was independently reviewed by

technical academic medical center experts suggesting that that particular procedure would put her more at risk and shorten her life. The trial lawyers went to court, \$78 million judgment, later negotiated down, settled. But that kicked off the entire liability debate. It also foreshadowed a number of mandates.

The reason I bring it up is because I think that we in the delivery system now have nowhere to assess how do we respond to pleas from the desperately ill, the ABMT pleas individually turned into mandates. OPM required it, a number of states did without any contilla of evidence about whether or not it was safe and effective. And how are we going to avoid as things develop in the future being in that situation again? And that's I think the major question.

I also want to go to privacy and confidentiality. There's nowhere to balance. The—without--it's very clear that everyone supports the goal of providing confidential assurances to individuals that their records will not be used against them. But at the same time, there's no way to balance or place the balance, whether or not we can actually carry out quality. We're in the process now being rip sawed by physicians around the country who are withholding data, patients data, Peggy, because in the name of the confidentiality rights. And that's not what people intended. We can go on and on, but I think we have these discontinuities that we need to think about as we look at regulation.

So my question is have we reached the tipping point? And I think in the HCFA arena with a cacophony of people now moving together from all sides of the health care world, I think that that becomes clear that there needs to be some major change. And Nancy Ann and her team to their credit, began this discussion fairly recently and right around the time that their tenure was ending. Tom I hope will pick it up, but I think there are tremendous opportunities to address some of these systemic issues in that context.

I also think that there needs to be some movement to assess this in the context of the private sector. And that's where people roll their eyes and it falls on deaf ears because we have so many things ahead of us in terms of the debate for the day. But I would argue strongly that the debates of the day now in Washington, in the states, have nothing to do with the IOM challenge. And I think that that is a real problem for us.

So what's next? I'll just share with you we've drawn out what happens in the context of Norwood-Dingell, and Ted Kennedy's basically the same framework. I won't bother making the chart stick, but you get the idea that

I'm not sure that that's the right direction, not only to achieve more accountability, but to achieve a better functioning health care system.

So again, no dispute about the concept of improving the functioning of the health care system. The question is what it means to the end. Now, it strikes me that we have a problem in the United States, maybe more than one, but the problem that I think is making it very difficult for us to get off dead center in this conversation is in Ann's case I think we think about the extremes and here are the couple that occurred to me and more will occur to you I'm sure. Competition versus regulation.

How many conferences did we all go to over the last 20 years about that? Public versus private. Now it's employer versus individual, state versus federal, micromanagement versus unfettered competition. We never really deal with the sub-text which was I think is the point to all of us a wake up call about how to begin having a conversation that improves the structure or the environment in which individuals operate.

We need to get to some transparency. If you look at the first slide, there is not transparency. People can't be sure that anything is being done to protect them, yet a number of things are being done but it's very hard to get a sense of that if you're a consumer. Therefore, there's very little confidence. Yet the more we do, I would argue that the confidence, there's an indirect relationship there.

We don't have any standard of workability. And most importantly and I think most problematically, there's no breathing space. For those of you who work on Capitol Hill, if you are besieged by a number of individuals who think that there should be a number of mandates put into the system, there's no place where you can go for dispassionate and effective analysis or evaluation. I think that becomes even more problematic as we go into the future.

So no breathing space, no process to assess new technology. So we get into the question of who draws the line between medical necessity and lifestyle? Who draws the line in terms of assessing technology? Is that to be done individually at a health plan level, at a hospital level? Where is it to be done? Do we need to begin to think about procedures as we go forward as we look at the explosion of possibility in the delivery system. And we haven't begun to confront this.

Even the tail in the water strategy in terms of synchronizing data, there are a number of data requirements both in federal programs, state programs and private sector programs, but there is very little consistency. The health

care forum is taking a crack at it. It's running into the very real world problems of will folks be willing to play by the same rules? That's also not only a direct economic impact in the system, but it's also a question of transparency and consumer confidence, if we can't move to a data system where people can do an assessment of what are we doing, how are we doing it and where is it going?

So I think that it's time to have a conversation about a cohesive regulatory framework. Can we ever get there from here is a major question. I think that there is an opportunity to talk about, although in the United States system, I think we don't often and we're not confident talking about trade offs and balancing, but how do we deal with access, how do we deal with affordability, how do we deal with quality, how do we deal with innovation, how do we balance all those issues? Where are we going to go to have that conversation?

I remember a number of years ago, Henry Aaron writing I think in Health Affairs that stuck with me and it's probably been a long time now, but I remember him writing that in the United States people go running from a crowded room when they hear the word rationing. It's akin to people calling the word fire in a crowded room.

But yet a number of these decisions are being made on an individual basis on plans in hospitals, in physicians offices, and it's time I think to begin to talk about this more broadly.

How do we incorporate scientific evidence? That's a very interesting question because we have been involved in a very passionate debate about utilization review. I was testifying a couple of weeks ago before the Senate Finance Committee, and folks on both sides of the aisle were very much anxious to learn about the techniques that have been used in the private sector to contain prescription drug costs.

At some point, I stepped back and I suggested you realize if you adopt even half of these techniques, you become--you are put exactly in the middle of the patient protection discussion. So how are we going to have a discussion about how to get a standard of scientific evidence? We've been talking a lot about patient protection. Virtually no discussion about whether there should be standards for reviewers, what those standards should be. We've just done a survey of a number of the independent review systems around the country, and while plans are very comfortable with the process, we're finding out that a number of the decisions are made based on past practice and if we continue that, I think that that is very problematic in terms of again, getting to those goals that the IOM has laid out.

I think the issue of assessment is very important. Nowhere are we assessing regulatory burden. People run under blankets when we talk about cost benefit analyses. Generally, people are opinionated, divided by party about those issues. But I think it's time to really look at a cost benefit test or at least a cost effectiveness type of analysis when we look at additional regulation and look at how do we address what we now have.

And finally, I think the problems for the system and problems for people who are trying to design products to meet demand is to what extent are we letting the court set policy. And this is quite before, as I said earlier, we have any action on patient protection or additional liability. There are a number of concerns I think arising throughout the states in looking at what courts are doing. And I think we need to look very carefully about that.

So for managed care, many of the questions involve how do all of you answer the previous question, can we ever get to level playing fields or are we destined to discuss these issues continuously in silos? There's been a great deal of discussion about managed care over the last five years, almost no discussion nationally about safety, almost no discussion nationally about quality, efficacy, no opportunity to do that and no real place to do it. And I think that again, we need to think very carefully about that.

And then how do we balance the responsibilities of the different sectors? What should public sector do? What should the private sector? How do we have this balance? Where do we put the fulcrum and who decides?

Those are very difficult and complicated questions and I think most of us given the plate before us, both in the regulatory arena as well as in the competitive or market arena, you know, we say well let's leave that to another day. But I think leaving this to another day has very real costs, both in terms of economic but also non-economic costs that really do threaten the ability of our system to continue to perform at a level that I think is desirable.

So to sum up, there's no argument about accountability. We need an accountable health care system, there's no question about that. The question is does liability and do the proposals to require additional liability, do they take us there? Do they give us any answer or does it shine any light on how to reach what the IOM says is the major problem in the health care system? And are there strategies that we can employ that actually will get us to solve those problems, will allow us to develop a regulatory structure that's more uniform, that's clear, that's consistent, that's equitable and fair, but allows the kind of innovation that each and every one of us as citizens

and as patients are going to expect as we age many of us in the baby boom generation, we move into our retirement years?

That's a tough order, a tall order. So I think that what not to do is fairly clear. What to do is not as clear as what not to do. But if you remember the concept of breathing space, if you remember the concept of trying to get to a more cohesive strategy, I think in ending, the only way we could describe the strategy we have now, whether we use the terms creatures without heads which has a nice ring to it, but I think more importantly, I would like to describe it sort of in the context of the Yogi Berra strategy. You come to a fork in the road and you take it. That's what we do. But that has a great deal of cost associated with it.

And I think it's time for us to begin to start asking some questions. It's time for us to deal with the sub-text so that we can create a structure that invites real competition, real innovation, and gives us the health care system that I think we'll need.

So I didn't intend to offer grand solutions to this group. I didn't come here trying to convince you that if you have certain views about managed care, you should change them. What I've tried to do is to give you a sense that I think the shades of gray that we've just pushed aside in the policy community, it needs some more research and it needs more analysis.

Thanks.

**DR. ALTMAN:** I'm going to sit here if it's okay. You know, Karen, some day you'll get over the slide makers of great--it would be interesting to see the following slide. And that is to first put down the regulations that exist if you're in the delivery business which most of the plans wind up having to deal with. And then super impose on them all the extra regulations that impose on a plan that aren't on a delivery system.

In other words, those regulations are probably a combination of both, aren't they?

**MS. IGNAGNI:** Yeah. I think that's right. In fact, I was going to show you a slide which we had some fun making. You know, it really doesn't matter if you're a chicken or the egg because--I had a little slide of a farmer shooting at both sorts of things. But I think that there are differences, but I think we're getting to the point now where it's not very only complicated, but it's very cumbersome. And one could make a very persuasive argument that we're not meeting the mark in terms of expectations at either place. I think

that that's fairly well established in the context of HCFA, but I think that it needs to be vetted in the context of the private sector as well.

**DR. ALTMAN:** People want to join in this discussion?

**MR. ED GROSSMAN:** Hi. Ed Grossman with Hess Representatives. This is a fast question for Tom. I was way back here and I'm not sure that I saw the slide correctly. What I understood was BVA, we were cutting back on the money so that money was a problem and that the drug increases took some of the positive aspects about Medicare Plus Choice that people were looking for so that that sort of took the air out of the Medicare Plus Choice market.

And then you had a slide that I think said you were not going to put any more--you did not anticipate putting more money into the system and you didn't have a slide indicating that for prescription drugs people might actually be able to get a drug benefit without going to Medicare Plus Choice assuming we have some new drug program.

So I'm trying to understand what--.

**UNIDENTIFIED MAN:** (inaudible)

**MR. GROSSMAN:** No. I don't think that there was. But let's pause it that there is a prescription drug benefit as part of this. So I'm trying to understand why one should be at all optimistic about any aspect of Medicare Plus Choice plans?

**MR. SCULLY:** -- No. I'm just kidding. As most of you know, Ed writes most of the health care laws in this country. The Congressmen actually act like they do, but Ed writes them all most of the time. No, I think if you're a Medicare Plus Choice carrier, I don't see unless there's a--I don't even see a big move in Congress to make a priority with all due respect to Karen to put money back into the managed care base this year. And I don't think at HCFA that I have any discretion to do so in any way that I'm aware of so I wouldn't be hopeful there's more money.

There are ways, you know, I haven't explored them all yet and I'm not confirmed yet. But there are ways probably to make their lives easier and on the margins. I know very few members of Congress including Ben Cardin for instance who's already lost a lot Maryland carriers who don't want to keep the existing Medicare Plus Choice plans in. So my hope is to do everything I possibly can to at least keep the existing people in. And my point was to

show, you know, it's pretty much dollars and cents and pretty obvious what's happened as to why people have bailed out.

So in the future, what's the hope for them? I mean, I personally believe that a lot of people preferred those plans. I had two parents in them. They were Medicare Plus Choice plans. They've both had their plans pull out. So that was a perfect case study of what happened; one in Pennsylvania and one in Baltimore.

But I think that there's going to be a big push and not to get ahead of myself, I'm the only person here from the Bush administration, but President Bush is going to--there's going to be a very big push as Nancy Johnson alluded to, as soon as the Tax Bill's over, to do a Medicare drug benefit. Whether it happens or not, as Chris knows my first job in the first Bush administration was saving catastrophic in 1989. So I was realistic hopefully, but the prospects for a drug benefit. But I think President Bush is going to push one hard and I think it's probably going to be done hopefully in a reasonably bipartisan subtle way because my own view is when a president announces a big plan, does it in the Rose Garden with great fanfare, that it usually it's the last year of it because it becomes partisan.

And I hope that, I mean, I personally believe that if we had a big drug benefit and we structure it the right way and reform Medicare that there will be significant status restored to make, you know, look at private choices. And I personally think that a lot of people, especially low-income people, would frequently rather trade off more drug benefits and more benefits for a slightly tighter network and a slightly more limited group of hospitals. And I think that's the option they should have.

That doesn't mean that I don't like Medicare fee for service. It means that I think people should have the option to trade off tighter benefit packages and have the opportunity to swap things in Medicare. And I think it would be popular and I think it would get back to the 30 percent of the population if that's there. I think absent a big bill to put some more money back in the system like a Medicare drug bill and reform bill would, you may be looking at providers treading water for a couple of years because I don't see another big infusion of cash coming.

Was that the answer you're looking for? That's the last answer you'll really get straight from me. I can see that.

**DR. ALTMAN:** Cybill first and then you.

**UNIDENTIFIED WOMAN:** Hi. I had just a couple of thoughts on Karen's first chart. And it's the chart, of course, that we had passed all over the Kennedy office a couple of years. We got a kick out of Karen's first chart for the first few years of the Patients Bill of Rights debate.

And on one hand, I think, you know, you look at it and really it looks very similar to charts we saw during health reform and other kinds of things. And perhaps one of the simplest answers to that chart is single pairs. It's not likely to happen. Not that it's going to happen any time soon, but you know, it's just sort of part and parcel of operating in our fractured and bifurcated health care system.

And in terms of cost effectiveness, I think there's a lot of interest from a lot of members in looking at some of those issues. But you know, recall that Republicans when they took over Congress, (inaudible) they also—the (inaudible) took on ARC when they started to make some practice guidelines and other kinds of things. I haven't seen sort of a huge rush from providers and others for us to create a US version of KNIGHTS, the British cost effectiveness also.

So it's a difficult thing. I think there is a need for an unbiased look at some of these issues, especially in some of the new pharmaceutical therapies and devices and some of the new things that are coming out to figure out whether the sometimes marginal benefits are worth the additional cost.

But those are all valid and patient safety are separate arguments from the Patient Bill of Rights today because they're really apples and oranges. And I think there is room for some broad agreement, for example, on error reduction and patient safety initiatives.

And going back to the earlier set of discussions where a couple of us were sort of unable to comment, I would also echo Karen's comments frankly on external review. There is broad agreement in the Patient's Bill of Rights today that there should be external review. And in fact, all of the bills, the Democratic bills, the bipartisan bills, and ultimately even the Republican leadership bills had forms of external review. Now the details are very important there and there were dramatic differences in some of those, but everybody wanted external review first. And everybody I think believes that that will mitigate significantly the need for litigation. But the accountability issues, which is the euphemism everybody's used for liability, are still very important. And notwithstanding the vote in this room, last time I looked, a clear majority of both houses still support increased liability for health plans as part of this debate.

And the danger right now that we've seen is in the four to five years that we've been discussing this, as Karen mentioned, with the court decisions, people have begun to gain more rights. And now it's trickier to do liability without rolling back some of the rights that people are currently gaining. It's no longer a simple state versus federal. And that's brought a more complicated picture but that's what's happened is the courts moved out from under Congress' inability to reach agreement.

**MS. IGNAGNI:** I just want to make a couple points. I think (inaudible) make as usual very thoughtful comments. And the only thing I would say is that I think that there is a need to inextricably link the concept of patient protection and cost effectiveness and safety and quality. And I think precisely where we've gone wrong is that we haven't. And the IOM report really should hit all of us over the head because you can't get to that path, I would argue that through the way or through the prism that we're now looking at it on Capitol Hill. I think there is room for agreement. I think there is room for opportunities for consensus, I don't think, if we were having a policy discussion. But unfortunately, in many cases, we're not really having policy discussions, we're having political discussions. So I'm not going to add to that, but just to say that I think that it's time to begin to and what I try to do is begin to lay down some issues that have gotten lost in the shuffle. And for many of you in the academic community particularly, I think there needs to be more research, more analysis, and more thought about regulatory framework. It happened in other industries and frankly, it led to some real reforms and I think it's time now for this to happen in health, not to drive you to where you need to go in terms of the ultimate answer. But I think it's time now to do the research and analysis because you may be very disturbed if you look at what we have and where it's taking us and what ultimately it's going to crowd out. And I think that that's really an issue.

**MR. SCULLY:** Your comment about crowding out. I earlier made a comment that I thought we wasted six, seven years on patient protection. It's not that I don't care about patient protection. And Karen probably heard me say before I think from my point of view from the Oxford board, most of these patient protection bills, Democrat or Republican, it made very little difference, many of the tasks—

**MS. IGNAGNI:** You weren't talking about liability?

**MR. SCULLY:** No. I wasn't talking about liability. I mean, I'm just saying purely from the view of a board member, I wish the thing was over years ago because relatively--not that relative, my frustration is we spent a lot of emotional energy, political, capital on issues. And to me the bigger issues

are that whether you're a Stuart Butler fan or a single payer fan, what do you do with 40 million uninsured people? How do you ever get to a long term fix in the program when you've got a Medicaid system that's completely vulcanized and it's a joke in my opinion, from a payment point of view. Anybody that wants to rationalize the system where you get 9,600 bucks a person in one state and 1,200 in another, I mean, there's just much, much, much bigger issues. And the political capital that's been spent on the patient protection bill in the last five years has distracted from the other much more--not that this isn't a serious issue, but there are much bigger issues that I think this had dragged people away from and I think that's unfortunate.

**UNIDENTIFIED MAN:** (inaudible) talked about calling for a conversation. And I'm trying to figure out how to make that work. I know that a number of times you made reference to the need for more research. It seems to me that the way we come up with conversations is actually a reaction to a perceived threat and cannot really cope with any more threats against it. Okay? The reaction has not been good in terms of those perceived threats.

So how do you engage that conversation? How do you make it happen without doing potentially more damage to it?

**MS. IGNAGMI:** I think that the conversation needs to occur around whether or not we have the right structures to carry us through to the future and to begin to assess all of the new pressures. If we had a little dry run at this over the last several years where every specialty society brought a mandate proposal to Capitol Hill and you can accommodate some. You start accommodating everything and you're writing insurance contracts. And arguably we have, as Carl knows, we have a great deal of that problem now in the delivery system today.

Leaving that aside, as we look down the road at the new technology, as we look at the lesson of ABMT, where mandates proceed in the absence of any knowledge about the science and where now we know we've put people in jeopardy, I think we're at risk very highly of doing more of that, not less in the future because you, particularly for all of you who live and work on Capitol Hill, you have no breathing space. You have no place to go for objective analysis.

So you have to cope with the petitioners coming before you and making very real and impassioned arguments about government taking action. And I think that that is not going to lead us to an objective balanced system. I think it's only going to continue to use government to solve market

problems, market issues no matter what side you're on. I'm not sure that that's the right thing for the future.

So I think in terms of where we go from here, I think it's important to talk about the systemic flaws and where we go to begin to think about adding something on to the structures we have today to begin to look as other industries have at reform in a broader way than we're looking right now. We've had a five year conversation about nothing but managed care. Nothing about other entities in the delivery system reporting data. Nothing about how do we measure quality. Everybody gets up and gives speeches about performance standard versus micromanagement. How do we assess performance standards? How do we make decisions about them? Who's going to decide?

And so I think these are the kinds of questions that we need to begin teasing out and it's key for you folks who are going to be coming after us on this program, who are looking at innovative products responding to consumer interest to begin to have this discussion.

**MR. SCULLY:** Let me ask you something on that because this is one of my other pet projects which I'll probably get fired for before I actually get hired which everyone wants to do measurement. And I think the IOM study is great. I think measurement's great. But every time Cybill mentioned the--I don't know if she's back there--the back surgeons got creamed, you know, when ARC went after them, when HCPR went after them. Every time somebody's tried to do something significant in that area, they get the crap beat out of them which I think is frustrating.

So I mean, let's say hypothetically, we went out tomorrow and took the HEDIS data and started publishing the relative HEDIS values in the New York Times with a full page ad as the government. Would you guys like that? I mean, I personally think--.

**MS. IGNAGNI:** Well, Peggy actually--Peggy O'Kane publishes it and it's often in USA Today and a number of the other publications. But--.

**MR. SCULLY:** So the hospitals, the docs and to me, the biggest change in personal behavior is going to come when we start collecting reasonable data which is what some people--see I was involved in making whatever it used to be called before 1989, we figured for 10 million bucks to 150 in the '89 RBS told the idea that AHCPH was going to collect that kind of data, do practice guidelines, publish it. And my personal view is real behavior in health care is going to happen when hospitals start having comparative data published, get a lot tougher with docs, health plans. I think that makes a

much bigger change in behavior of everybody in the health care system than having, with all due respect to all the research grants that RWJ may give out, a lot more research grants and papers.

**MS. IGNAGNI:** And I agree with you. I think that what you're talking about is a uniformity, standard uniformity.

**DR. ALTMAN:** Mark has a question. Push the button.

**MARK:** Each one of you is the best in the world at something, you just have to figure out what it is.

And I guess my question is that a lot of the quality measurements seem to flow to the same objective being quality measurement systems, the idea is to find some in the system that has something good to say about almost everybody (inaudible). My question is whether there is a way to think of a process, measurement if you will, is there any more information (inaudible) or is it in the interest of all providers to say that (inaudible). If that doctor account is better than all the others, in ordinary commerce we have no problem or quality that's not (inaudible).

**MR. SCULLY:** Well, you had the (inaudible). I don't know that the data's right or wrong. If Wharton dropped to number seven, you have a new dean. Right? You probably would pretty quick.

**MARK:** (inaudible) We were number one, now we're number two and everybody's a lot more (inaudible).

**MR. SCULLY:** It's a bigger market, that's all.

**UNIDENTIFIED MAN:** But where do we get the information (inaudible).

**MR. SCULLY:** It's not even a process. (inaudible) my frustration I use the example again. The automobile manufacturers still scream and bitch and moan about crash tests and whether it's fair or not. But you know, you go probably bitch the most. You know, regardless of what the standards are, it's changed behavior in the automobile business and that's good.

And I'm sure you could have a hell of a debate with the automobile manufacturers on whether you're measuring them fairly or whether it's right or wrong or good. But the reality is people are much, much more focused on safety than they were before. And that's a good outcome.

**MS. IGNAGNI:** But let me just mention one problem which you know well, Mark, which is that we have the federal government by program publishing standards. We have states, 50 states publishing 50 different requirements for standards both capturing data as well as publishing data. And then we have--we're now moving into broader federal activity in this area and then over to the private sector plans, so we have all these different requirements. No uniformity, no cohesion, no strategy. We would be hard pressed as a group to describe what our health care is in this country because we don't have one. It's about people coming to Capitol Hill to require and request government action to solve market problems. And I'm not sure that's going to take us into the future.

**DR. ALTMAN:** Gary. Push the button though.

**UNIDENTIFIED MAN:** (inaudible)

**DR. ALTMAN:** Three or four (inaudible) and then you guys can get at it and then we'll (inaudible). Around the same issue, Hal.

**UNIDENTIFIED MAN:** At least I'm pushing the button.

I think I make an important distinction between differential assessments of various aspects of quality versus different measures. And I think having umpteen different regulatory and private agencies each asking for different data is very different than having each of those people differentially wait for the information.

So for example, the American Diabetic Association may care a lot about control of diabetes and not care a lot about management of cystic fibrosis. The underlying information might be collected in a relatively uniform way, in fact, in an absolutely uniform way. And you could put some of those resources that we spend collecting lots of inconsistent data into appropriate risk adjustments for appropriate (inaudible).

Then the question is who calls it? And you know, if you go back to the crash test and the evaluations of cars, you know, Consumer Reports and Motor Trend rate cars differently, but they all work off of some of the same basic data. And one of the nice things about the Internet, you're talking about how it really won't solve all those problems tomorrow, but it is very good at aggregating an underlying database in different ways. And that's one of the things where the technology affair we just need to get consistent collection of the underlying data.

**UNIDENTIFIED MAN:** I'd like to have Karen comment on the relationships (inaudible) that basically said (inaudible). It's hard for me to see (inaudible) in that development coupled with a longer (inaudible). That seems to me to be more central than some of the things about federal and state regulation (inaudible), but it strikes me that you don't have (inaudible).

**MS. IGNAGNI:** You can go first if you like.

**MR. SCULLY:** David Bradley is an old friend. So I remember his real big, big briefing books that they were going to sweep in the--although, you know, it must have worked because I saw a huge picture of Leonard in Business Week last week in giant size, so something must have worked.

But I think some of it is true. When you look at the California model HMO sweeping from west to east, to a large degree people along the way arm themselves and fought back and said it wouldn't happen. But I think you've got some of the natural balance where, I mean, I can tell you from the hospital point of view, there were a lot of hospital mergers, a lot of non-profit mergers, frequently in name only, just for the purpose of negotiating a managed care plan.

Certainly on the hospital side, because I saw it happen, the world did arm itself to push back against managed care as it moved from west to east. And I think a lot of the stiffer model managed care plans weren't particularly popular and I think you got to more of a market equilibrium where you had looser managed care plans, more options. There not as powerful as they were supposed to be five or six years ago. And I think to a large degree, the army started marching east and it met strict resistance along the way and it came up with some of the compromise.

So I don't think that there's not benefit structure there. I think it is there and I think the last four or five years have been an ugly process of working out a balance between different providers. And probably the ones coming out on the short end of the stick is largely the docs for one reason that their integration which was basically, you know, physician practice groups imploded. Let's see, you almost got a fragmentation back to docs and a lot of places, there's too many of them. So the hospitals are getting stronger and tougher and have much more ways leverage. And the managed care plans have been weakened a little bit along the way by public beatings and stronger hospitals. And probably the guys that have lost out the most and they're probably one of the most unhappy are the docs and that's due to a lot of different things that happened along the way including a ridiculous bidding war between non-profit hospitals and the med partners of the world, that you know, imploded.

So I don't think---I think a lot of what's happened is not that hard to track and I think the system is there.

**MS. IGNAGNI:** I have a slightly different view about what happened. I think that what we have had is very much like the PSO discussion. The promise of physician practice management companies, a number of companies convincing physicians to join up. No regulation, no requirements, no infrastructure capacity. And they went belly up. And it wasn't surprising if you thought about sort of what glide path they were on.

Now the question is sort of what is the strategy and what should it be? I suspect what you're going to be hearing from Leonard tonight and from the folks tomorrow is that government shouldn't be deciding strategies. And what we should be doing in government is creating a regulatory structure that allows a number of strategies to compete with another but assures consumers that there are rules that are adhered to, that there is transparency so consumers can see what's being done, and there's protection and accountability.

That doesn't mean the chart we have now, it means that you could do--you could achieve those goals with a very different regulatory structure that would allow far more money to be available for care giving, just what Hal talked about, the sheer process of meeting all the different conflicting regulations now is beginning to add up considerably.

And so when I talk about research, I hope that all of you who are in the research community not only will begin to give more attention to the research question of how we achieve uniformity in terms of data, but how do we assess where no where are we assessing the regulatory burden. And what are the upsides, downsides, what are we crowding out? And I think it's time to do that as well.

So I think that where people go wrong is to say this is the strategy. And this is what's going to happen. We have a market where we should be looking and encouraging innovation and a lot of competition that's real competition, not one size fits all.

**DAVID IVAN:** David Ivan of the (inaudible) Health Plan. You know Stuart, I think the health services researchers should do research on the cycling of topics at conferences because when I was young in this field, David Helms and I would sit around with Bob Crane and talk about excess hospital capacity and outrageous rising health care costs. And somehow or another,

premiums moderated and the rate of growth stopped. And we stopped talking about health care costs. It's no longer interesting.

And so we talk about all these other things today as if these actions have no consequence. You know, it's okay to have all the regulations in the world on health plans, but it's not without a cost. And we have been looking at some data within our own plan relative to emergency rooms since the passage of prudent lay person.

And prior to the passage of prudent lay person, less than 30 percent of our members who went to an emergency room were admitted to the hospital. Since the passage of it, in New York which is a particularly robust form of this legislation, 60 percent of our members who go to an emergency room end up being admitted to the hospital and of those, 23 percent are discharged the next day, so less than a 24 hours stay. You know, I think this is kind of like the 48 hour stay. It's okay. I mean, I argued at the time the 48 hour stay thing came along, we should be for it because we ain't going to pay for it. Just going to pass it on through in the premium. It's the same thing with that prudent lay person. And I am very strongly supportive of a prudent lay person.

And what I find amazing about this discussion is here is an industry that is basically saying we're going to lay out our most important business decision to second guessing by an external party that we absolutely are willing to abide by, our most basic decision, you know, coverage, not coverage, pay, don't pay. There's not another industry in America that would make that statement, certainly not the providers. They've never been willing to accept that kind of oversight.

And when we say that we're willing to have that most basic business decision, in essence, second guess and judge by an external set of experts that by the way, you society will choose, not us, the answer is well, that's not good enough. What we'd really like is uneducated juries and judges making those same decisions.

Well, you know, really I think, I mean, Karen has done a brilliant job of maneuvering in the political thickets and keeping this from happening over the years with a lot of other people. But I'm kind of at the point now of just saying okay, fine. I mean, let's go there. But at least don't make fun of us when we suggest that rationalizing this system, that not having conflicting federal and state, you know, I've been at HIP for five years. There has never been a day in those five years that a regulator was not sitting in the building. I mean, we have a permanent suite of offices dedicated to regulators reviewing the actions of the company. I'm sure Leonard is no

different. I know Oxford is no different. I mean, that's the reality of the system that we have created.

So I think you know, Karen's plea which is really just saying look, keep in mind it does have consequences. There are monetary implications of these policy decisions that we have made and they are costing us significantly with respect to health care costs. That's fine. I mean, you know, we as a nation have it within our grasp and within our discretion to decide whatever kind of system we're going to have. But they do have implications, it does cost money and we as health policy people, it seems to me at a minimum, ought to be trying to figure out what's the best way to do it.

And if we, in our ultimate wisdom, have decided which is by the way totally contrary to health policy thought for the first 20 years of my career and now I'm going to tell you how long it is by implication, that we think, you know, judges and juries are the best way to make decisions about health care, something that we were all totally against throughout the entire period of the 70's and 80's when I was being educated and getting started in this field. But if that's the decision we're going to make, I agree with Tom. Let's get it over with, let's do it in the next month and shut up about Patient's Bill of Rights.

**DR. ALTMAN:** We're going to have to--on that shut up, that's about the--now let's just go through the--we're running--we let it go on a little longer, so we're going to push everything back a half hour, except for the drinks. So I've been told, I mean, people who come in there. You're the boss, you decide. I was told that we're going to move dinner back a little later because we'll never get--and so people can--if you come over at 5:30, we'll have the cocktails there, but if you take a little longer—

END

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