

**Center for Studying Health System Change -  
“Tracking Health Care Costs”  
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Washington, D.C.**

MALE SPEAKER: -- so I figured that this an important - I've got important people in the audience. And I was wondering if it's Jerry Graz [Misspelled?]. Is that your car, Jerry?

Okay, well to get serious, you know, I'm president of the center for studying health system change, HSC. And we're a nonpartisan policy research organization funded exclusively by the Robert Wood Johnson Foundation. And we conduct independent research to provide policymakers with objective and timely information about changes in the healthcare system.

I want to thank you all for coming here. This is our seventh annual analysis of healthcare spending and premium trends for employer sponsored health insurance. The study's being published today in the "Policy Journal Health Affairs" as a web exclusive article. I'd like to thank Kaisernetwork.org for making a webcast of this briefing available later today at [www.kaisernetwork.org](http://www.kaisernetwork.org).

Before we dive into the study findings, I want to thank John Gabel of the Health Research and Educational Trust, co-author of the study, and introduce Brad Strunk, an HSC analyst and the lead author of the study, who's going to provide more details about the findings.

Then we're going to hear reactions from

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Carmella Coil, who's senior vice president for policy at the American Hospital Association, and Larry Atkins, who is president of Health Policy Analysts, and an advisor to a number of Fortune 100 companies on health benefits issues.

The study we're releasing today analyzes per capita spending on healthcare services, in patient and outpatient hospital care, physician services and prescription drugs, commonly covered by private insurance.

These are the major underlying spending components that drive private health insurance premiums. The news is not good. Overall, health spending per person jumped 10 percent in 2002, the first double digit increase since 1990.

In other words, spending on healthcare grew more than seven times as fast as the overall economy in 2001. Consumers are going to feel the hangover from this spending spree in future years. They're going to have more taken out of their paychecks to cover the cost of health insurance. They're going to pay more when they go to the doctor or to fill a prescription. And they're going to forego larger pay increases.

As consumers are asked to shoulder increased costs, more people will decide they can't afford health insurance in some businesses, especially small firms, will drop coverage.

Later this week, the Census Bureau is scheduled to release its latest estimate of how many Americans lacked health insurance in 2001. The numbers are likely to be up from 2000 when 38.7 million people were uninsured.

Many people have lost their jobs. And the cost of health insurance has increased significantly since 2000.

I've become convinced that short of a major public investment, either through subsidies to purchase private health insurance, or public coverage expansions, we're going to see more and more uninsured Americans in the years ahead.

We also know that employers in 2002 began to shift more costs to workers. And in 2003, this trend will pick up, as employers move more aggressively to help keep healthcare costs from cutting into their bottom lines.

Several weeks ago, health affairs published a study by John Gabel and colleagues about 2002 premium increases for employer sponsored insurance, confirmed what a lot of us were expecting, a second straight year of double digit premium increases. The average premium increase for all firms in 2002, according to study, was 12.7 percent.

But the increase in the cost of health insurance was actually higher. To control rising

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premiums, many employers used the term "bought down" the price of health insurance in 2002 by reducing benefits and increasing cost - patient cost sharing requirements.

The most important benefit of buydowns was increased deductibles, and higher drug co-payments. Overall, the benefit buydown added two to three percent to the cost of insurance in 2002. So the real increase in the cost of insurance was about 15 percent, not the 12.7 percent in just the premium.

Many Americans will be spending more of their take home pay on healthcare. Giving consumers more of a financial stake can raise awareness about the costs of care, but too much cost sharing can become a barrier to need of care, especially for low income people and people with chronic diseases.

So why did healthcare spending increase so rapidly in 2001? Well, it's not the aging of the Baby Boomers, but Brad will tell you more about that when he speaks. What we have found is that increased spending on hospital care, particularly outpatient services, accounted for the largest portion of increased spending, more than half of the overall increase.

Spending on hospital care is increasing because people are getting more tests and treatments, and being hospitalized more often, as managed care plans abandon type restrictions on care.

In many ways, 2001 was the year where all of the stars were aligned in the worst possible way from a healthcare cost containment standpoint. Employers hadn't yet begun to increase cost sharing because they didn't know that the economic boom was over. So we had the rich benefit structure, we've all become accustomed to under managed care, the modest co-pays and the generous coverage of preventive services. At the same time, managed care began easing its restrictions on care, meaning there were fewer controls in place to constrain the use of services.

Now increased use of healthcare services isn't necessarily bad. No doubt much of this increased use has value, and has improved people's lives. But we also know that some of this care is probably unnecessary.

Insurers, for example, are reporting big increases in the use of MRIs and other imaging services. Now if those MRIs are being used to diagnose brain tumors, that's one thing. But if they're used to diagnose sprained ankles, that's another.

Higher prices played a role as well, as hospitals used bargaining clout to win higher payments from health plans to regain their financial footing. And I should mention that hospitals are facing intense financial pressures from rising labor costs, because of shortages of nurses and other skilled hospital workers.

Let me close with a bit of good news. We've

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examined spending data for the first half of 2002, and see some evidence that healthcare spending trends may have peaked in 2001.

Through June of 2002, compared with the same period in 2001, the increase in total spending per capita slowed from 10 percent to 8.8 percent. Part of this is likely due to higher cost sharing, which appears to be slowing the demand for care. Another reason might be the completion of the transition to a looser form of managed care.

Now I'd like to turn the briefing over to Brad Strunk, who's going to take you through the findings in more detail. And then we'll hear from Carmella and Larry, and then take your questions.

BRAD STRUNK: Good morning. As Paul said, I'm going to take you through a little bit more of the detail of the study we're releasing today.

I'd like to start by highlighting four general findings I'll touch on in more detail, as I proceed. First, healthcare spending increased rapidly in 2001. Second, increased spending on hospital care, particularly outpatient care, accounted for the largest portion of the total increase in healthcare spending.

Third, the aging of the Baby Boom generation is not, in fact, an important driver of rapid cost growth. And finally on a bit more positive note, 2001 could turn out to be a peak year for spending trends.

In 2001, healthcare spending per person increased 10 percent. That's the first double digit increase in more than a decade. The U.S. economy by comparison grew 1.4 percent per person last year.

Our study examines per capital spending on healthcare services commonly covered by private health insurance. These services include hospital care, physician care, and prescription drugs. Spending includes payments made by insurance companies to providers, as well as out of pocket spending by patients, such as deductibles and co-pays.

A large increase in spending on one type of service in particular, hospital care, accounted for the largest portion of the total increase in healthcare spending. Spending on hospital care increased 12 percent in 2001, and accounted for more than half or 51 percent of the total increase in healthcare spending.

And you could see that on the chart here to my immediate left, as a combination of both the dark blue and the red bars.

By comparison, spending on hospital care increased 7 percent in 2000 and accounted for 39 percent of the total increase in healthcare spending. You can see in the bar chart that if you look back even further, spending on hospital care has grown since 1999, while the role of prescription drugs has actually been declining since that time.

Spending on outpatient hospital care, things like same day surgeries where patients don't stay overnight, whether the care's delivered in a hospital or a freestanding surgery center, surpassed prescription drugs as the fastest growing component of total healthcare spending in 2001, growing 16.3 percent, compared with 11.5 percent in 2000.

Moreover, as you can see here in the dark blue portion of the bar chart, spending on outpatient hospital care is now the single largest contributor to total - to the total increase in healthcare spending.

Spending on inpatient hospital care increased 7.1 percent in 2001, compared to 2.5 percent in 2000. That's nearly a three fold increase in just one year.

The 2001 increase is even more startling, however, if you look back five years. In 1997, spending on inpatient hospital care actually declined by 5.3 percent. So spending on inpatient hospital care has staged quite a remarkable turnaround.

Increased use of care accounted for about two-thirds of the overall increase in hospital spending. While higher prices or payment rates to providers were responsible for about a third of the increase.

Hospitals are facing real financial pressures of their own. In 2001, hospitals payroll costs, which are usually their largest expense, increased 8.6 percent, which was more than double the rate in 2000.

One reason for the large increase in hospitals' payroll expenses is a large increase in wage rates for hospital personnel. In 2001, the average hourly hospital wage increased 6.1 percent. That's about double the 2000 increase in the wage rate.

This likely reflects the severe labor shortage, particularly for nurses, that has plagued the hospital industry for several years now.

Hospital personnel are also working more hours, probably because of the large increase in hospital use I discussed earlier.

For the second year in a row, growth and spending on prescription drugs slowed. In 2001, spending on prescription drugs increased 13.8 percent as compared to 14.5 percent in 2000, and 18.4 percent in 1999, when growth in drug spending reached its peak.

Moreover, as you can see here in the bar chart, the 2001 increase in drug spending accounting for only about a fifth of the total increase in healthcare spending. This slowdown likely reflects the increased use of three tier prescription drug co-pays by employers, fewer blockbuster drugs being brought to market in recent years, as well as a number of recent and important drug patent expirations.

Spending on physician care, which is the final type of healthcare service, usually covered by private health insurance, increased 6.7 percent in 2001,

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accounting for 28 percent of the total increase in healthcare spending.

Contrary to popular belief, the aging of the Baby Boom generation is not an important driver of the health spending trends I've been describing to you. We've estimated that aging of the population under 65 contributed about .7 of a percentage point to the total increase in health spending in 2001.

As you can see in the chart to my far left, viewed in relation to the total health spending increase, which is the blue portion of the chart, the effect of aging, which is the red portion of the chart, is quite small. Please note that the blue portion of the graph is based on a different source of data on health spending, but one that's a little more analogous to our measure of the impact of aging on costs.

Aging will continue to play a limited role through the end of this decade. That's because the difference in spending by age - differences in by age are not large enough. And the U.S. population is not aging quickly enough to make aging a major cost driver.

Between the ages of 18 and 64, health spending rises an average of \$74 for every year we grow older. The average - also, the average age of Americans younger than 65 is increasing a little more than a tenth of a year annually.

We've estimated - the estimated 76 million

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Baby Boomers will start to age into Medicare starting in 2011, which will surely drive up Medicare spending as the financing of their care shifts from the private to the public sector.

However, the large number of people joining the Medicare program, rather than more spending per person will drive the sharp increases in Medicare spending.

Aging does contribute more today to increased spending, and will continue to contribute more in the future than it did in the early to mid 1990s. For example, in 1991, aging contributed only a tenth of a percentage point to the cost trend.

This is because the Baby Boom generation had not yet begun to reach the age of 50, when health spending begins to rise at a faster rate for every year we grow older.

Finally, despite the negative picture I've painted for 2001, cost trends may have reached a peak last year, and may not be slowing. For the first six months of 2002, compared to the same months in 2001, health spending increased 8.8 percent, reflecting a slowdown in spending growth for each of the four components of healthcare spending.

While still large, this increase could signal that annual increases in health spending could continue to fall through the rest of the year and into 2003.

Two factors could be driving this slowdown. The slowdown of the U.S. economy will inevitably lead to changes that will slow costs. The most prominent one being increased cost sharing, which we're already seeing.

Increased cost sharing will reduce the use of healthcare services. Also, the cost of the retreat from tightly managed care may be a one time phenomenon. And we may have absorbed most of it by now.

A slowdown in health spending growth will eventually help to slow health insurance premium increases. Also, insurers are likely to start asking for smaller premium increases soon because they are very profitable now.

These forces could slow premium growth by 2004, but won't offer consumers much relief in 2003. Thank you.

PAUL GINSBERG: Now we're hear reaction from Carmella Coil.

CARMELLA COIL: Thank you very much. And my thanks to the Center for the Opportunity to contribute to this discussion this morning. My thanks also to Paul Ginsberg and John Gabel and Brad Strunk for yet another important contribution to the research that I think helps us all better understand the complexities of our healthcare system in the United States.

I'd like to make three observations, given

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everything you've heard this morning, most certainly from the perspective of the hospital field.

First of all, the study that is being released today really set out to answer a question that's important to all of us. And that is why are private insurance premiums, the rates that you and pay for health for insurance, on the rise? And here's what they found.

One of the most important reasons for increases in private health insurance premiums is the facts that Americans are using more hospital care.

Of course, the question then becomes, why? Now we couldn't agree more with the findings. Americans are using more hospital care. And it's something that we've known that hospitals have been experiencing and trying to address certainly over the last year.

It's something you've seen. It's something you may have written about. We see inpatient admissions up, outpatient patient visits up, emergency department visits up. And we see the capacity of hospitals being stretched to its limits.

We released a study earlier this year, just taking a look at capacity in the nation's emergency departments. And there, what we found is 62 percent of all hospitals reported that their emergency departments were either at or over capacity. If we look at just

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urban hospitals in the United States, some 79 percent of all urban hospitals reported that their emergency departments were either at or over capacity.

So why is it happening? Why are Americans using more hospital care? A number of potential reasons, let me cite three.

First of all, the demographic issue and the aging issue. I think Brad has just walked through what is a smaller impact of aging, as we take a look at healthcare spending overall in the United States.

It's likely, however, that aging may have a more important contribution as we look just at hospital spending, and the use of hospital services. The Baby Boomers, as we've just been talking about, certainly turning 65 in the year 2010, they're 55 now. And whether it's cardiac care, prostate cancer, breast cancer and the like, the potential for more hospital services being used.

Second, the issue of technology. We simply are able to do more for more people than we've been able to do in the past. There was a recent study just released that talked about what we can now do as a society within that golden hour.

People who used to suffer traumas, now their lives can be saved either through EMS transport systems, what we can do on site, and the miracles that can now be performed within emergency departments.

And third, and it is the most important factor, and that is the lifting of restrictions in terms of managed care plans. Most states, as you probably know, have now enacted laws that make it easier for you and I to access care, whether that's emergency department care, the so called prudent lay person laws that have put into place, that make it easier for us to access that care. And in fact, we do.

Second point, and a point where I may disagree a bit with the authors, they talk a bit about the remaining increase in terms of hospital spending, resulting from hospitals driving a harder bargains with insurance companies in terms of the rates that are paid by those insurance companies to the hospitals.

It may be a bit of an overgeneralization, at least as we take a look at the hospital field overall. You may know, there are about 5,000 hospital in the United States. About half of those, about 2,500, are located in the small and rural communities across the United States, where managed care is virtually non-existent.

We've got markets like Philadelphia, where in fact, the insurance companies are the dominant forces. And certainly, it's not the case of the hospitals being in the driver's seat. And I think the third point, just the statistics, you've got a third of hospitals in the United States losing money every day on the care

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that they provide, another third barely breaking even, certainly not the kind of statistics that suggest that those organizations, if you look at the field as a whole, are in the driver's seat when it comes to those negotiations.

And my third point, and I think something that the authors mentioned, and it's very important, that many have left out in this analysis of what's going on with private health insurance premiums. And that is, as we look to better understand what's going on, few people are talking about the contribution of insurance company profits in that mix.

Most certainly it's a factor, as insurers historically really cycle between absorbing losses to gain marketshare, and then going back and capturing those, or taking profits.

It was evidenced, I think most recently. Many of you may have seen a Wall Street Journal article about Weiss ratings, talking about 25 percent increase in insurance company profits. And I think while it could definitely be said that profits are a factor for all of the healthcare stakeholders that are involved in this, if we take a look at hospital profitability that has been on the decline for the last few years, and seems to have leveled off, well, we seem to be seeing increases on the insurance company side.

Bottom line to all of this, I think the

concern for everyone of us is the potential for greater spending, higher premiums to result in more underinsured and more uninsured in the United States.

And bottom line is that that means more people who will not have access to primary care and preventive services in the United States. More people who will not have a usual source of care, potentially more people relying on hospital emergency departments as their only option for receiving care. Thank you.

MALE SPEAKER: I also want to thank the Center for a really good piece of work. And these studies have come out of a really fascinating - I think we do a great job of [unintelligible] the depths of the information and getting a lot of nuggets of value out of this.

From an employer, I'm going to look at this now from an employers standpoint and how employers are responding to this, and where we think the - this is all headed and what the future holds.

This has been a couple of years of double digit increases and premium or healthcare costs for employers. And it's commanding a lot of attention in a business environment where we have declining revenues, and we have declining earnings, and a lot of pressure on corporations to cut costs.

And this is one of the major costs that continues to increase. And this year, will have - has

accelerated at a rate of increase.

The drug expenditures have been the major focus in the business community in the last couple of years, partly because, you know, I think they're reacting somewhat to the data two years ago, and the fact that was a major driver, and it still is a major driver.

And also for employers response of retiree health plans, which are primarily drug benefits. The drug costs are having a substantial effect on the costs of retiree health.

There is a fairly substantial fallout, I think that they've been experiencing over the last two to three years from the weakening of managed care pools. And that's the combination of the increased pressure in the courts on managed care plans, and the backing away from a lot of managed care plans from really exercising strong controls on utilization review. It's the weakening of the bargaining position of managed care plans, and with the providers. It's not just the hospitals. Probably more significantly, physicians, but I think there's been a lot of people dropping a lot of hospitals and physicians dropping out of networks, rather than take continued cuts for managed care plans.

And so, the - and of course, the patient rights movement around the country and the states has been a factor. And so, utilization review has really

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fallen off in the managed care plans. A lot of managed care plans are promoting themselves on the basis that they are kinder and friendlier, and are you know, managing costs more with working with physicians on profiling and thinks like that, but not exercising strong utilization review.

And that -- the consequence of that is that we have more people being admitted to hospitals, and we have more people using specialty care at the physician level, because those are the things that were controlled before by fairly strong utilization review.

Because of the weakening of managed care plans, I think that's led employers to explore other options for trying to control costs. Most of you are aware that there's been kind of a mantra in the employer community about what some people call defined contribution, what employers call consumer direction.

A lot of employers have looked at changes in the health plan that will help to increase the employee sensitivity to healthcare costs. What employers have been concerned about is that there's been a growing, there had been a growing sense among employees of healthcare entitlement, and a lot of resistance to any changes in the plan. And as evidence of that, you can see in the latest Hershey strike, for example, one of the issues was an attempt to slightly increase the premium payment by the workers. And the - that was a

major factor in the strike and in the settlement.

Hershey backed off. And the union gave up some salary and increase instead.

So we still have that sense out there that people would rather take smaller salaries and get more health benefits.

But employers were worried about that because it - what they're interested in is trying to get employees to have more skin in the game, essentially. The idea is that if we're going to have to go into a period of fairly strong measures to control healthcare costs, we need to have the employees on our side. They need to agree with us that healthcare costs are a problem. We can't continue to have this situation where they see our attempts to manage costs as something as working against their interests.

And so, the redesign of benefits is going forward in some places, to try to give the employees more involvement in the decision making about healthcare, including paying more out of pocket.

And so, the trend, I think, that the Center has picked up is quite accurate, that there has been an increase in cost sharing by employees, largely in the co-payment area, trying to restructure the co-payments and co-insurance, so that people, when they're spending - when they're paying for healthcare, particularly in the drug area, that they're seeing more of the cost

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difference between various options that they have, whether it's a different drugs or whether it's different providers, that they're sensing - that they're getting - and they're paying out of their pocket, more of that actual cost difference, so that they're becoming more cost sensitive in their purchasing decisions.

So they - the big shift that's gone on, really, in the prescription drug area, but there's also been a restructure in co-payments and other areas.

I will say that the movement to consumer direction, obviously, involves a lot of different aspects, not only the cost sharing increases, but - and restructuring of the plans and the way plans work, but also trying to get the information to employees, to be able to make knowledgeable decisions about providers or plans as they have to make their choices.

And one of the things that's been holding this movement back is that there really are no good sources of information out there now, to be able to evaluate differences between hospitals and physicians. And employers are putting a lot of effort into trying to develop those tools, and present them to employees in a way that can help employees make decisions.

So you see a lot of large companies have just started to create websites and other ways of developing - distributing information to employees, to try to get

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some information out there, and then are working very hard to get better information.

But that lack of information is really holding back any major movement toward serious consumer correction.

MALE SPEAKER: [Unintelligible].

MALE SPEAKER: Yeah. And so, and the other trend that I wanted to talk a little bit about is I think that some employers are starting to look at the possibility of narrowing networks, and beginning to work with provider - trying to shrink the providers - number of providers that they're working with, the number of plans they're working with, and to try to eliminate from the networks the lower quality, lower - higher cost providers.

The bottom line is that healthcare spending has been driven by a lot factors that are beyond anybody's capacity to control a health plan. There's a lot of technology push that's been talked about, a lot of growing capacity to treat a growing interest in being treated, higher prevalence of chronic disease, partly because of population aging.

And this is the long term trend. It may slow slightly, but it's going to - there's going to continue to be fairly substantial cost increases into the distant future. And I think employers are recognizing that this is going to be a long term effort to try to

control costs.

MALE SPEAKER: Thank you very much. Love to have your questions. Yes?

MALE SPEAKER: With the exception of an aside that you made, Paul and Carmella, you treat this as a problem. I assume employers look at it as a problem, but as the Hershey strike indicates, maybe employees and consumers don't view it as a problem.

They seem to have a disposition to spend their increased income for healthcare services. And they valued them and they liked them. So why is this a problem?

MALE SPEAKER: Well, if consumers were using their own money to spend more of their income in healthcare services, I would have no quarrel with it. And I would say that this is the success of healthcare like other growing industries.

But the concern is that they're usually not spending their own money, that a third party's paying, you know, virtually the entire cost of treatment today. So these signals from consumers are not something that we just have to accept as we did in -

MALE SPEAKER: [Unintelligible] willing to spend their own money. They forego wage increases so that they don't have to pay any more for healthcare. That was a direct -

MALE SPEAKER: I think the issue - yeah, I

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mean, there's no question that you know, employees are very adverse to, first, you know, first dollar payment in the healthcare system. They want coverage as low as possible.

But there's a fairly significant issue of value in this, which is that it's not a question of how much we're spending. I mean, there's no question we're going to have fairly substantial increases in healthcare expenditures under the most optimistic scenarios going forward. Just simply because of the capacity to treat more growing population, growing older population, and the growing technology.

The question is, really, are we getting value for this? Or are we just wasting a lot of money on buying very expensive kinds of things? And I think what employers would like to do is have employees educated to be able to make value distinctions between alternatives, not just go buy the most expensive drug, because obviously, the most expensive must be the best. But have the information to be able to evaluate whether the most expensive is really substantially better than the drug that you could get for a lot less.

And so, I think there's an efficiency loss in the economy. If the spending on healthcare is, you know, for very low value, but allow us spending -

MALE SPEAKER: Actually - I'm sorry - you need to answer that question. Yes, one here.

MALE SPEAKER: We see rising spending. We see rising premiums. Dr. Ginsberg offers the opinion that the numbers out at the end of the week of uninsured are likely to rise. Are we approaching the situation where we were a decade ago, when all those things came together, to produce a call for a major overhaul in the healthcare system? For the panel.

MALE SPEAKER: Yes, certainly the - as certainly the - we look like we're moving in that direction. If I would characterize the early 1990s, that was a period when many people who had health insurance were worried about losing it.

And I think that's when you get to that period, that when a lot of people - in a sense it's - it doesn't seem to be enough now for the people who don't have health insurance to be upset about it, to get a lot of public policy movement. But when a lot of people that have health insurance are worried about losing it, and worried about they're being unable to afford medical care, I think that is the spark that creates - that pushes this issue up to the top of the policy agenda.

FEMALE SPEAKER: And just a quick - from the hospital's perspective, I think this confluence of forces that you're seeing, that I think John and Paul and Brad have articulated, really is a red flag for us. And I think it is time to renew the conversation about

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how do we create a system out of what is basically a systemless organization of healthcare in the United States.

MALE SPEAKER: Well, I do think we're in an analogous situation, except in the early '90s, we could turn to managed care, which had a history of demonstrating that they could deliver comparable care at a lower cost.

We don't have consumer driven care is just beginning. And we don't have -- no evidence so far, we don't have no evidence either way, whether it works or it doesn't work.

MALE SPEAKER: Next question? Gary?

MALE SPEAKER: [Unintelligible]. You didn't mention the matter of malpractice insurance costs and inflationary jury awards and so forth. Did you study that as a contributing factor to medical care inflation? In fact, I'll even ask a corollary question.

You talked about the increasing costs of testing, like MRIs. As you know and I know, there are lot of institutions and doctors are testing everything they can think of as a protection against malpractice.

MALE SPEAKER: You know, if - when you think about there are two things with costs. There are the reasons why costs are high, and the reasons why costs are rising.

I think our malpractice system is very high up on the reason why costs are high. But at least until recently, I don't think it's a major contributor to why costs are rising. But as you say, it interacts with other things in the system.

When MRIs had to be approved by insurers, then even if physicians wanted to do more MRIs to protect themselves, they couldn't. So in a sense, MRI spending was kept under control.

With the removal of these restraints, then probably malpractice concerns are part of the story of why MRIs are increasing. But they're not the whole story. We probably need to look to ourselves for part of the story. How many patients are not willing to take that two weeks and take aspirin and see if it's get better, and really are pushing the doctor for a definitive diagnosis right now.

You have a question? Do we have any questions on the phone? No. Okay. Yes?

FEMALE SPEAKER: Hi, I see physician services look like they're the second largest driver, this year, of the increase in costs. And Ms. Coil mentioned that the bargaining clout of hospitals have been reported to the increase. And I'm wondering if you can talk about bargaining cloud of physicians as well.

MALE SPEAKER: Yes. I would say that with the exception of some specialties in some communities,

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often when there's a large single specialty group, our work and site visits suggest to us that physicians' clout has not increased. And this is a source of great frustration to physicians that certainly politically have been raising issues about insurance company clout and concentration.

So in our site visits, we saw a real contrast between a changing clout on the part of hospitals and the lack of it on the part of physicians.

Now I should respond to something Carmella said before. It's one thing to say that hospitals have more clout. And that's what we are saying, backed up by the numbers. But we're not saying that hospitals have unlimited clout, and consent rates wherever they want.

It's just that they're better off than before. And in fact, a lot of people could argue that hospitals really were beaten down a few years ago, and perhaps were signing contracts with managed care plans that they shouldn't have signed.

And so in a sense, many hospitals see themselves as just restoring their rates to a reasonable amount, as opposed to they're just asking for the [unintelligible.]

FEMALE SPEAKER: To add onto that, if I could. Taking a look at the history here, I think, is really important. Hospitals actually, for several years, were

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cutting their costs.

And of course, you can't be in a world where you continuously cut costs over time. Part of what's driving, I think, some of these payment negotiations is costs again on the rise.

We were talking about malpractice insurance premiums as an example. We've got some recent data that shows that contribution, but it's that. It's the new technology. It's no longer x-ray machines and MRIs. It's pet scanners.

Whether it's leukocyte [Misspelled?] reduced blood, whether it's the labor issue that I think the authors have talked about, all of these add to increase the costs of care, and therefore, again, beginning to cycle the payments that are negotiated on an upward basis.

MALE SPEAKER: I think there's little doubt that since 1996, which we can think of as the glory days of managed care, that there's been a shift in the balance of power between the purchasers and the providers. I think of our health benefits survey in 2002, we found that 50 percent of all workers with health insurance are in plans that indicated they had broadened their network in the last two years.

And about 35 percent were in plans, which had broadened their network with regard to hospitals. And I believe once insurers' goal was rather than to sign

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up one-fourth of the providers in the community, but instead to make networks as broad as possible. I believe the purchasing, the balance of power made it a very dramatic shift.

MALE SPEAKER: Marilyn?

MARILYN: I have a question. Larry had talked a little bit [unintelligible]. Or your company's website, and actually look up physicians [unintelligible]. Do you ever get that point, and is that possible that that's what our goal should be?

Oh, it's not working?

MALE SPEAKER: No. Well, I understand - I heard the question.

MARILYN: Oh.

MALE SPEAKER: Can we get to the point at, you know, can we get to the point? I mean, I think, you know objectively, you should be able to get to the point, where you have some degree of price transparency.

Right now, there is not price transparency. There's no price availability at all. And I think with a lot of the information out there now is trying to get quality information out. Some of the health plans have been able to get quality information available on the group practice level, down to the provider group level, but not down to individual provider level.

And it may never - you may never be able to

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get validated down to the individual provider level.

But I think the answer is yes, you should be able to get it. I think there's going to be a tremendous amount of resistance in the medical field, and among the physicians in trying to find a way to get that information.

MALE SPEAKER: Yeah, I actually would add that when you think of tiered co-payments having, say, two tiers of hospitals or in this [unintelligible] physicians, this in a sense is a fairly crude way, but probably effective way, of communicating price information to consumers. It's certainly a lot simpler to know whether something or whether a drug you're taking is in the first, second or third tier, than to get this detail information and try to do something with it.

FEMALE SPEAKER: And if I could, one footnote. I think, Marilyn, your question is made more complex by the fact I think it's easier when we think of pharmaceuticals. More different when we realize in the case of hospitals, for example, more than half of their revenues actually come from the public sector, Medicare and Medicaid, where payments are less than cost.

In the private sector, it's negotiated on a insurance company by insurance company basis. So the price, I think, is often very difficult to ascertain. Ultimately, it's how much is that provider ultimately

paid by that particular company.

MALE SPEAKER: Well, I'll just add - I mean, I don't think prescription drug prices are all that easy either. We have a very highly segmented markets in healthcare generally, but particularly in prescription drugs. And nobody in the - who's buying prescription drugs really know what the prices is that other people paying. And there's no transparency.

But I think that's just generally true across all of the spectrum in healthcare.

MALE SPEAKER: If there aren't more questions, let me close with a thought. Excuse me? Oh, we've got one on the phone. Fine.

OPERATOR: Joyce Briden with "Oncology Times," please go ahead.

JOYCE FREEDEN: Yeah ,this is Joyce Freeden calling. And if the speakers could please identify themselves, I'd appreciate it.

I'm trying to reconcile what Mr. Akins said about more doctors dropping out of networks with what the center has found in terms of physicians having less clout in the marketplace. Because I would think that the insurers would still need the physicians to create a network.

So I wondered if anyone had any comments on that?

PAUL GINSBERG: Yes, well, this is Paul,

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Joyce. I think the - you know, the situation with a hospital is let's say the community has four and five hospitals. You know, if the - often if the plan doesn't have all or all but one of those hospitals, it doesn't seem like a good plan.

You have hundreds of physicians. So in a sense the percent that the plan has to have for the network to look attractive isn't as compelling. And I think this is one of the reasons why the markets are different.

Okay, actually, a thought I wanted to put forth is, you know, Carmella at the beginning of her remarks talked about the growing use of hospital care, and the problems that hospitals were experiencing with their capacity.

I mean, being able to provide all the care that they're being approached to provide. And my thought is that we're at a very challenging time for the leaders of individual hospitals that now have to decide how much of the increase in use or demand that they're experiencing now is a transitory factor, reflecting, you know, the transition from tightly controlled form of managed care, to a loosely formed - controlled form of managed care, and how much of it is more long term?

I'm convinced that the - I think many of the people in the hospital industry feel the demographics

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are important. I hope they pay close attention to these numbers and see that that's not the case, I think even for hospital care.

It's not to say that there might be a specific hospital service. It's used a lot by people in their 50s, that is experiencing demographically driven increases in use.

But I suspect that for all of hospital care, demographics are not the factor that many in the hospital industry feel they are.

So you know, the real challenge for hospitals is, you know, do they wind up overbuilding by interpreting current trends as indicators of long term? Or do they see it in a different light, and scale back their plans to expand?

Thank you very much for coming here.