CITIZENS' HEALTH CARE WORKING GROUP
WORKING GROUP PUBLIC HEARING

State Capitol West Building
350 North Main Street, Room 125
Salt Lake City, Utah

Friday, July 22, 2005
8:30 a.m.

Present:
Randall L. Johnson (Chair)
Catherine G. McLaughlin, Ph.D. (Vice Chair)
Frank J. Baumeister, Jr., M.D.
Dorothy A. Bazos, R.N.
Montye S. Conlan
Richard G. Frank, Ph.D.
Joseph T. Hansen
Therese A. Hughes, M.A.
Brent C. James, M.D.
Patricia A. Maryland, Dr.P.H.
Michael J. O'Grady, Ph.D.
Rosario Perez, RN (Excused)
Aaron Shirley, M.D.
Deborah R. Stehr
Christine L. Wright, R.N., M.P.A.

Also Present:
Larry Patton, Designated Federal Representative
George Grob, Executive Director
Andy Rock, Senior Program Analyst
Caroline Taplin, Senior Program Analyst
Jill Bernstein, Research Director
Rebecca Price, Program Analyst
Rachel Tyree, Program Analyst
Paige Smyth, Program Analyst
Jessica Federer, Program Analyst
Mary Ella Payne, Staff to Pat Maryland
Members of the Public

Presenters:
David M. Walker, Comptroller General of the United States
John E. Wennberg, M.D. M.P.H., Dartmouth Medical School
Stanley M. Huff, M.D., Senior Medical Informaticist
Scott D. Williams, M.D., HealthInsight
Peter Lee, Pacific Business Group on Health
David Blitzstein, UFCW
Elizabeth Gilbertson, HERE
Senator Orrin Hatch, United States Senate

AGENDA

P-R-O-C-E-E-D-I-N-G-S

(8:30 a.m.)

CHAIRPERSON JOHNSON: Well, good morning, everybody. We'd like to welcome everybody to our hearing this morning. And we'll just begin by going through the agenda for the day.

Starting at 8:30 David Walker, who is Comptroller General of the United States, will be providing testimony to us.

At 9:30 a.m., Dr. John Wennberg will be here in person, and Dr. Don Berwick is going to join us by telephone.

At 11:15 we'll have a testimony by Stanley Huff and Scott Williams on health information technology.

And then at 1:15 and 2:45--or through we'll have an employer representative and two union representatives providing testimony in our behalf--or for us, I should say.

I'd like to welcome David Walker to join us this morning. David, first, thank you, in behalf of all of us, for appointing us to be part of the working group. I can assure you, after being with our group for now about five months, that everybody in the group is

energetic and dynamic--dynamically involved and committed to excellence in providing a great work in behalf of representing the American public to the Congress and providing input to the Congress and President as legislation requires.

David Walker is the Comptroller General of the United States and began his 15-year term in 1998. Prior to that he's been with a number of private firms as well as in the Department of Labor and acting director for the Pension Benefits Guaranty Corporation, all of which have been very significant roles.

Our working group has your bio, and instead of going through that in greater detail we'd just like to have you take the time to talk with us for about 15 minutes or so in a formal presentation and be willing to take dialogue from us.

When we get to five minutes, for our working group's interests and so forth, I'll put my time--my table tent up to give us all a warning that we're approaching the end of the session.

So without further ado we'll turn it over to you.

MR. WALKER: Thank you, Mr. Chairman. It's a pleasure to be here.

Is this working? There we go. It's working. Thank you.

First, I want to thank all of you for your willingness to serve. You have a very challenging and important assignment. Probably the largest domestic policy challenge facing the United States is our health care system.

And what I would like to do this morning is, based upon the very good work that our very capable staff at GAO has put together; I'd like to walk you through some material in the form of this presentation. My understanding is that all of you have a hard copy of the presentation before you. But before I go through this, there are a couple of things that are relevant for you to understand, as it relates to my background. In addition to being Comptroller General of the United States and, therefore, with the assistance of 3,200 very capable GAO professionals, basically having to get involved in everything the federal government is doing or thinking about doing anywhere in the world, including health care, I also was a trustee of Social Security and Medicare from 1990 to 1995. I was Assistant Secretary of Labor for pensions and health and, therefore, oversaw the private health system as well as the fuller

perspective and the pension system. I practiced in the private sector with Arthur Andersen as worldwide head of their Human Capital Strategy Practice, which included health care, as well. And so I'm fairly deep in this issue, although I'm not a physician and I'm not a Ph.D economist specializing in this particular field.

What I want to do this morning is I want to try to help put this issue in context, because one of the things that I find, at least in Washington, is that there's a tendency toward myopia—that is to look at this year and maybe five years, and that's about it. There's too much of that. Secondly, there's also a tendency to take a particular issue, whether it's Medicare, employer-sponsored health care, Social Security, or pensions, and just look at that one issue without understanding how that fits into the overall picture and how decisions in one area can potentially end up impacting other areas.

I want to touch on four issues. First, the long-term federal fiscal outlook for your government. Second, health care system challenges regarding cost, access and quality. Thirdly, I'd like to talk about some of the issues that we would respectfully suggest you may wish to consider, in examining cost, access, and

quality as part of your deliberations. And then, last, to sum it up, and hopefully I'll have plenty of time for Q&A.

It's important that you understand where we've been, where we are, and where we're headed, from the federal government's standpoint. In 1964, a little more than 40 years ago, the federal government spent almost half of its money on defense. Fast forward 40 years to 2004, it's down to 20 percent. It would have been 17 or 18 but for the wars in Iraq and Afghanistan.

Now, where did the money go? It went to Social Security, Medicare, and Medicaid. If you look at 1984, you'll see that Medicare and Medicaid represent nine percent of federal spending. By 2004 Medicare and Medicaid have grown to 19 percent. It's the fastest growing portion. However, if you look at 1964, you'll see Medicare and Medicaid were zero because they came into effect in 1965. The past cannot be prologue. This is an unsustainable trend.

Another way to look at it, which I don't have a chart on but I'll just mention: in '64 the Congress got to decide how two-thirds of the federal budget would be spent. Last year it was down to 39 percent and it's going down every year. The budget's on

autopilot. That cannot continue, as well.

The other thing is that last year we had an on-budget deficit of $567 billion, almost five percent of the economy, and yet we haven't had a recession since November of 2001. We had the strongest GDP growth rate of any industrialized nation last year, and only about $100 billion of that deficit had anything to do with Iraq, Afghanistan, or incremental Homeland Security costs. My point is the federal government is on an imprudent and unsustainable fiscal path. It has serious problems. Its financial condition is worse than advertised, and ultimately we're going to have to make some tough choices.

I'm going to show you two simulations of the future. The bars represent spending as a percentage of the economy. You'll see Medicare and Medicaid are the red. They are the fastest growing portion in this analysis. The white line represents revenues as a percentage of the economy. So inflation is taken out. To the extent that the white line is below the bar, that's a deficit. Now, interestingly, this is the score keeping that Congress is using to make decisions, but let me tell you there are four problems with this. Number one, it assumes no new laws will be passed.

Number two, it assumes that discretionary spending, which includes national security, homeland security, judicial system, education, transportation, etc., will grow by the rate of inflation. Number three, it assumes that all tax cuts will sunset. And, number four, it assumes that the alternative minimum tax will not be fixed. None of those assumptions are realistic. As a result, this simulation does not provide a very meaningful picture of where we're headed, but, yet, nonetheless, that's how decisions are being made right now.

This is an alternative scenario. Under this scenario there are only two differences from the first one. Number one, discretionary spending grows by the rate of the economy, and, number two; all tax cuts are made permanent. In this scenario the federal government is at risk of default in the 2040s. So we have a large and growing structural deficit.

Now, another way to look at it is if you can look at the total value of all the liabilities that we've already assumed and commitments that we've already made, unfunded commitments for Medicare, unfunded commitments for Social Security, unfunded commitments for military and civilian pensions, health, etc., you'll

find that as of three months ago that the total liabilities of unfunded obligations of the United States were almost $46 trillion, of which Medicare is about 30, and Social Security is only about four. This translates into a burden of about $150,000 per American, including the newest newborn, or about $370,000 per full-time worker. The average annual compensation in the United States is $50,000. So you can see that the numbers just don't work.

Now, what does this mean? It means that we are on an unsustainable fiscal path. Economic growth can help but it isn't going to solve our problem, and ultimately the federal government is going to have to do three things: number one, it's absolutely essential to reform entitlement programs—Social Security, Medicare, Medicaid. Number two, look at the base of discretionary spending and mandatory spending and re-engineer these for the 21st Century. And, number three, look at tax policy, that is, how much revenue do we need to have and how shall we derive those revenues. The government is going to have to do all three, and it needs to start sooner rather than later because right now we've gone from being the greatest creditor nation in the world to the greatest debtor nation in the world. We're adding

debt at or near record rates. Debt on debt is not good. And, in fact, in that second scenario I showed earlier, the fastest growing portion was interest on the federal debt.

And so we have a serious problem. Now, our biggest problem is our budget deficit and our balance savings deficit, those are much better threats--or bigger threats to the United States than any country or terrorist group. But underneath all that is health care, because one of the big drivers, not just for the federal government but for the state governments—-is health care. The fastest growing cost and the second largest expense for all state governments--is Medicaid. And employers, as we all know, are facing increasing health care costs which, among other things, has an adverse effect on our competitive position overseas.

The thing to keep in mind is that health care is a subset of a broader challenge, economic security both during the working years and retirement. You've got to have adequate retirement income, you've got to have adequate, affordable health care, we need to think about long-term care, and we need to think about what the division of responsibilities are between the different players: government, employers, individuals,

family, and community.

You're probably familiar with some of these numbers on health care. We're spending about 15 percent of our economy on health care. I think there's only two other nations in the world that spend over 10 percent—Germany and France. Everybody else spends less, and the U.S. is growing at the fastest rate. So it's not a matter of whether we're spending enough money, but whether we're getting the desired outcome for the money we're spending as it relates to access, as it relates to qualify, etc.

This next slide shows the spending trend and projected spending trend for Medicare and Medicaid as a percentage of the economy. And, by the way, this includes Medicare prescription drugs. And just to give you a sense of the magnitude of those costs, four months after the Medicare Prescription Drug Bill passed, the Trustees estimated that over a 75 year period, the federal share would be $8.1 trillion. The entire outstanding debt of the United States since the beginning of the republic is $7.4 trillion.

I think an important issue that needs to be focused on is the issue of tax expenditures or tax preferences. The largest tax preference in the Internal

Revenue Code today is for health care. This is the estimate of the cost of the forgone federal revenues due to the fact that individuals never pay income tax on the value of employer provided health care, irrespective of how lucrative the policy is and irrespective of how much money they make or how much money they have. If you added on top of that the fact that they never pay payroll taxes, meaning for Social Security and Medicare, on the value of these benefits, that $102 billion goes up to about $150 billion. And it's the fastest growing tax expenditure and it's off the radar screen.

When you get your W-2 from your employer there's nothing on there for health care. When you look at your tax return, unless you have really catastrophic health expenses there's nothing on your tax return for health care. And yet it's the fastest growing problem. Since 1964 a disproportionate share of rising health care costs have been borne by governments and by employers. Individuals are paying more of their own money on a relative basis but they're paying much less than employers and/or than government. And that's going to have to change. And it's starting to change now to where the costs are starting to get shifted to individuals. Individuals, obviously, don't like that,

nobody likes cost shifting but the status quo is not sustainable.

So what are some of the direct implications of these trends? Increased spending by federal, state, and local governments, increased competitive prices on American businesses, increased financial and family implications for individuals, and increased costs and practice implications for providers.

What are some of the indirect implications which people don't think about too much? Slower workforce growth, less employment opportunities, pressures for American business to move jobs offshore, additional part-time versus full-time workers, where you hire part-time people for less than 20 hours a week and you don't have to pay them health care benefits; reductions in retiree health coverage, pensions, and other benefits, because the number one preference of employees is health care, number two is health care, number three is health care, and if you have to dedicate more money to health care it squeezes out how much money you have to dedicate to other benefits. Only 50 percent of Americans have a pension or savings plan, and it's probably not going to change any time soon, and in large part because of the increased cost of health care.

And then something that a lot of people don't think about is slower growth in revenues from individual income taxes, both federal and state, as well as payroll taxes, because individuals never pay income or payroll taxes on the value of employer provided health care. And so, therefore, if that's the fastest growing cost, individuals' cash wages are going to go up slower than otherwise would be the case because more and more of their total compensation will come in the form of health care rather than in cash wages or in pensions or whatever.

Well, you are familiar with some of the access challenges. We've got 45 million people that still don't have health care coverage. Now, frankly, in fairness, some of those had the opportunity and they declined it. Some of those are young people who never think they're going to get sick. Maybe they won't when they don't have coverage. But some of those had an opportunity and they declined it.

A growing percentage of workers are losing their employer-based coverage. Millions of Americans are underinsured or they've lost their benefits or they're unaffordable, and the states have a serious budget problem.

On quality, we spend plenty of money and we have good outcomes in certain areas, but in other areas we lag. In measures of infant mortality, life expectancy, and premature and preventable deaths, we're in the middle of the pack for industrialized nations.

Quality is uneven across the nation. Practice patterns are very uneven across the nation for the same type of procedure. We don't have uniform standards and are not sharing best practices enough based on evidence-based medicine. And we also have some challenges with regards to inadequate use of information technology to be able to leverage this information. Although a tremendous amount of money could be saved through emerging information technology, we also have to be concerned with privacy.

In the long term, my personal view is — and GAO is on track with this, as well, that for any system to work, whether it be a corporate governance system, whether it be a health care system, whether it be a tax system, you fill in the blank, for any system to work you have to have three essential elements: You have to have incentives for people to do the right thing, you have to have transparency to provide reasonable assurance that people will do the right thing because

somebody is looking, and you have to have accountability mechanisms if people do the wrong thing. I would respectfully suggest that we don't have any one of these three in adequate measure in health care and that's one of the reasons that we have some of the problems that we have.

As far as going forward in the long-term, and then I'll come to the short term, we've never asked some very basic questions of the United States. We have millions of people that don't even have their needs met in health care. And one of the things that we never really ask as a nation is, what are the basic and essential services for which there is a broad-based societal need, and there's a broad-based national interest to make sure that every American, irrespective of your age, irrespective of your location, etc., has access to? Now, I don't know what those needs are but I'll give an example of some of the things that I would argue that should be in the base.

This list is illustrative: inoculations against infectious diseases, certain types of wellness procedures, protection against financial ruin due to unexpected catastrophic illness, and guaranteed access to health care coverage at group rates. But that

doesn't say who pays for it. We've never asked those questions, we've never answered these questions, and as all too frequently it happens in the government, you start out with something and you just add onto it without getting back to the basics and saying, "What makes sense?" Medicare is basically what Blue Cross/Blue Shield was in 1965. Guess what? A lot of things have changed since 1965. I mean, I could give you many more examples. We cannot sustain the status quo, and we need to start asking some of these basic questions.

And, secondly, what's the appropriate allocation of responsibility for financing health care between government, employers, and individuals? Well, arguably if there's a broad-based societal need then government has more of a role to make sure that that is there and maybe a role in the financing. But if it's beyond the broad-based need, and I mean, basic, and essential, then you have to look for other options. You'll have to look to employers, you have to look to individuals when it's getting more into the societal wants rather than the societal needs. And then, we need to ask what type of incentives are needed in the health care system to help providers make prudent medical

decisions and help consumers make more informative choices?

Now, as far as areas that you may wish to consider--this is your judgment, but here are some areas that I would suggest that you may wish to consider--and these are pretty broad, they go from the macro to the micro, and I'm going to add one at the end which I'm surprised wasn't on here.

One of the things we have to be thinking about from the budget standpoint is we have too much of the budget that's on autopilot, including health care, and one of the things that has to be thought about is, do we need some type of mechanism that when we spend more than "X" percent of the budget or "X" percent of the economy on health care that it will trigger some action by Congress? We need something to get us beyond autopilot. And I hope that your recommendations will trigger a reexamination in some areas in and of themselves. But irrespective of this hope, we need to reexamine areas periodically rather than necessarily relying upon commissions or working groups being created automatically over time.

In addition, what about the tax preferences? There's a lot of money that the federal government is

spending on tax preferences. It's off the radar screen. You know, it's not in the federal budget, it's not in the federal financial statements, and it's not on individual's W-2s or on their tax returns. What can or should be done in order to consider the $151 billion a year and, does it still make sense to advance this as a tax preference? Should that be scaled back? What do you do with the revenues that would be realized as a result of that? How can the insurance market provide adequate pools for risk sharing and at the same point in time offer alternative levels of coverage from which individuals can choose? In other words, if the government takes care of the basic and essential services then how should the market provide other options that people, along with their employers or others, could end up deciding to choose from? It could be similar to the federal health benefits plan model where people have a whole cafeteria of things that they can choose from. Depending upon what they choose then their cost is going to be different.

How can the information structure be developed in order to provide more reliable and timely data to monitor costs, quality, and system integrity? You know, one of the things that is amazing to me is

that we had more than 15 of our economy dedicated to health care, and when we try to get data on health care spending, typically it's at least two years old. And it's over 15 percent of the economy. And that's outrageous. Now, on a micro basis, you know, you might be able to find something--a particular facility might have some data--but on a macro basis we just don't have it.

What efforts should be made to help control health care spending focusing on a case management approach for people with chronic conditions? A vast majority of the cost of Medicare and Medicaid are concentrated in relatively modest or moderate portions of the population, but we don't have large case management. And that's not only from the standpoint of costs but also from the standpoint of quality to protect the consumer. For example, they could be basically taking way more prescription drugs or have way more procedures than necessary--it makes sense for them as well as us, collectively.

Is this your 15-minute warning mechanism?? (Laughter.) Thank you very much. Well, I'm getting near the end, by the way. (Laughter.)

And how can the federal government leverage

its purchasing power? V.A. leverages its purchasing power, but we don't leverage it across the government. And there are opposing viewpoints on that. I mean, let's face it. Okay?

What can be done to help better control the prescription drug bill costs, because it's going to cost a lot more than people thought. And what, if anything, could be done in addition to cost sharing options or leveraging the government's purchasing power—for example, what about selected reimportation of drugs from certain countries? I'm not saying it's good or bad, that's not my job. It's for you to be able to consider--there are pros and cons.

Should early retirees and possibly others be allowed to purchase basic and essential care? And, by the way, "basic essential care" is not today's Medicare or Medicaid. Basic and essential care, through Medicare or otherwise, as a bridge to the future and as a way to try and help deal with some of the insured right how.

What, if anything should be done with Medicare's eligibility age? You know, one of the real problems is we have very slow workforce growth. We've moved from an industrial age to a knowledge age, where this is what drives value (gesturing), not this

(gesturing). And a vast majority of people think the economy is going to grow. They're using this (gesturing) rather than this (gesturing).

And the largest untapped, underutilized resource of the United States is its senior citizens. We need to be encouraging senior citizens to work longer, not only for our economy but also to be able to help to provide revenues and expenditures. The retirement age that was set for Social Security might have made sense in 1935--by the way, Medicare was set in '65, as you know--but they sure don't make sense today. Believe it or not, a little aside, the first time an age was set for retirement was in the 1870's by Otto von Bismarck. It was age 65. The average life expectancy was age 55. He was a brilliant politician, who made a liberal policy which was fiscally conservative.

In 1935 we picked 65 for Social Security. The average life expectancy was about 65. And in 1965 we picked 65 for Medicare, so that's what it was for Social Security. Life expectancy was higher. It's even higher now. You need to rethink that.

Last, but certainly not least, and then I'll have my say, is what types of international agreements do we need to be thinking about for information sharing,

especially, for example, for R&D, because we're paying way more than our fair share of R&D. And that benefits the world. It doesn't just benefit our citizens. It benefits the world. You know, we've had burden sharing negotiations over national defense. Why can't we have burden sharing negotiations about some other things?

And the last thing that I'll mention is standards of practice. What, if anything, can or should be done to help promote standards of practice that could be uniform, that can help to hold down costs, improve quality and reduce litigation risk? And these are things that have to be done with the physicians, obviously. A related point is that we've got a lot of monies being spent on heroic measures, a lot of monies being spent near the end of life in circumstances where they will not necessarily improve or extend life. And somehow the government shouldn't be making those decisions; the physicians need to be making those decisions. But we need to recognize that we are not going to be able to continue to dedicate an increasing percentage of our economy to health care. So the question is how can we more rationally ration health care? How can we take the money that we have now and target it to make it much more effective?

I think there's tremendous opportunity here but you don't want the government making those decisions, you want those that are practicing medicine to be able to make those decisions. But to the extent that you can have some standards of practice I think that could help ensure consistency, reduce costs, and reduce litigation risks that are driving some of the costs.

So those are just a few thoughts, and the sum-up is that we have a large and growing challenge. It's getting bigger every day. There are no easy answers. Tough choices are going to have to be made. I would respectfully suggest that one of the things that ought to happen is that we ought to take a modern Hippocratic oath, "Do no harm." By that I mean don't dig the hole deeper. We need to figure out how we can use what we have now more wisely, because the answer is not spending more money, because ultimately we are going to have to come to grips with that $46 trillion gap.

Now, don't get me wrong. I think over time there's no question that in addition to reforming the program, and looking at spending there's going to be something done on the revenue side. It's going to have to get done. But there's a limit of how much Americans

will allow themselves to be taxed and there's a limit as to how much you should tax in order to maintain economic growth and in order to improve the standard of living. And in the current climate the tax side is probably going to be the last resort rather than the first resort, but ultimately they're going to have to get there. But what about these tax preferences? Those are just a few thoughts.

Lastly, I think the Clintons had one thing right and two things wrong, in my personal opinion. The one thing they had right was we clearly are going to need to reform the entire health care system. The one thing that they didn't really have wrong but people said they had wrong is it was going to be a government-run system. They weren't really totally proposing that. Some characterized it that way but it wasn't going to be that. And, secondly, it isn't going to be done all at once. It's going to be done in increments. So one of the valuable things that I think you can do is to think about the fact that, "Here's where we are today. Where do we need to be in 20 years? What makes sense?" And then we're going to have to figure out how can we figure out a transition plan from today to 20 years from now, where we make incremental changes over a period of time

in order to help us to get to where we need to be. We need to do this in a whole range of areas in the federal government, and it's probably going to take at least 20 years. But we need to start today because time is working against us.

Thank you.

CHAIRPERSON JOHNSON: Thank you very much. I'm changing our screen here, I think, so that we can get everybody on the mike. There we go.

If I might, I'd like to start with a question. In 1995, when Motorola implemented its Health Advocate Plan--Health Advantage Plan we installed wellness screenings at that time, and a series of two or three major screenings, but in addition to that a health risk assessment. And one of the questions we asked was "Are you ready to make a change" we asked employees, "Are you ready to make a change in the issues you're dealing with?" How--to what extent do you think the American public is ready to make changes, based on the comments that you've had, through understanding the issues and need to make changes, and then to what extent do you think our policy makers are ready to make changes to deal with the issues that you've been articulating?

MR. WALKER: The fact of the matter is that

they don't understand well enough, and part of the reason they don't understand well enough is because they haven't been told the facts. And one of the things that has to happen, both with regard to our overall fiscal situation as well as our health care system is that we need to engage in a public dialogue, a public discourse. You're helping in that regard with this group, but it's got to go retail and it's got to be much more massive.

I believe that the if the American people understood where we are and where we're headed that they would be willing to make a change, but people are not going to make a tough choice, deal with the tough issues until they're convinced that they have to or need to or it's in their interest to do that. We're not there yet. And that's got to be part of the effort to help people understand that we're on an imprudent and unsustainable path and that collectively we need to do things different and individually we need to do things different.

CHAIRPERSON JOHNSON: A follow-up to that. Do you know of any plan to make that happen, to provide more and more information to the public and to provide discourse, other than the working group?

MR. WALKER: Well, first macro and micro.

Macro has to do with our overall fiscal situation for the country, and then micro for this, which is big enough, it's health care, all right? And my view is the big part of the macro issue is health care, as you saw with the numbers.

Yes, there are a number of groups that are forming a coalition, a consortium that will start this fall to conduct townhall meetings in cities around the country to try to help start getting the message out as to where we are and where we're headed. It's a very broad coalition. People are coming to it every day. And I expect that this effort will go on for a year or two. Now, that'll be a beginning, but it won't be an end. There will be an effort to try to jump start the process.

It's similar to what happened back in 1998. I participated in an effort that was engaged by a coalition on Social Security. There were townhall meetings held in Providence, Rhode Island and in Kansas City, Missouri and in Tucson, Arizona as a precursor to broad-based legislative efforts. Unfortunately the last president had some personal indiscretions and he kind of derailed that effort, but it was a very successful initiative, and that's kind of what we're trying to

pattern it after, but on the bigger picture issue.

CHAIRPERSON JOHNSON: Thank you.

Additional questions or comments by our working group?

MS. MARYLAND: Comptroller General, this is Patricia Maryland. I'm intrigued by the idea of--and you've mentioned a little bit about this, how we move forward to promote standards of care, and using an employee, some of these evidence-based protocols which are now in the hospitals and care process. Has there been any discussion or thought from Medicare's perspective or even regarding how to link that maybe with reimbursement, associate it with the clinical outcome?

MR. WALKER: There has been some discussion but there really hasn't been any meaningful progress. And I think it would be very helpful if your working group, focused on whether or not you think there's merit to this concept, and, if so, whether or not that should be part of your recommendation.

And then the key is who's going to make it happen? It's going to have to be a collaborative effort between government and the providers and other interested parties, there's no question about that. But

I think there's great conceptual merit to it.

MS. MARYLAND: Thank you.

CHAIRPERSON JOHNSON: Aaron.

DR. SHIRLEY: Aaron Shirley.

MR. WALKER: I'm still here. (Laughter.)

DR. SHIRLEY: You made reference--

MR. WALKER: I think this is the board up here. (Laughter.)

DR. SHIRLEY: You made reference to the 45 million uninsured. Are there some numbers to what degree those uninsured individuals are contributing to the escalating costs overall?

MR. WALKER: I can go back to our team and see if I can find out something on that. I don't know anything off the top of my head on that. But maybe we can talk and you can tell me specifically what you're looking for and I can see what I can do for you.

DR. SHIRLEY: Well, one of the things is individuals' premiums increased--

MR. WALKER: Right.

DR. SHIRLEY: --the fact that the uninsured individuals are receiving here--

MR. WALKER: Right.

DR. SHIRLEY: --and the providers are eating

their cost.

MR. WALKER: Well, yes, in some circumstances that's true, and the result of that is cost shifting, all right? And one of the other issues that I didn't mention, but it's a growing issue, is you're finding--at least I'm finding--with increasing frequency that individuals who are uninsured, and they may not be uninsured in total, they may be uninsured for certain types of services, dental let's take, for an example, okay, actually are asked to pay super retail prices because they're not insured. And, obviously, when you're insured typically there is some type of arrangement to try to get group rates and hold down the cost.

If you're not insured then you don't benefit from that. If you're indigent, you know, then they're going to get covered by Medicaid or whatever else, it's not a big issue. But if you're not indigent then you could end up having to pay way above average prices. That's another type of cost shift that's going on and starting to increase in frequency.

MR. FRANK: I'm intrigued by the tax deductibility issue, and I'm sympathetic to your argument about the alignment or the incentive. My

question is really the devil's in the details in how you do that, because potentially is that if you don't do it right then you'll increase the uninsured problem by making insurance affordable. Do you have any thoughts on sort of how you take that on?

MR. WALKER: Well, first, I think there are a number of tax preferences provided to health care. The two biggest ones are the exclusion and the deduction, the deduction to the employer, the exclusion to the individual, and with regard to the payroll taxes; obviously, the preference goes to both the individual and the employer, okay? My personal opinion is that you don't want to play with a deduction because if you tell some employer that you're not going to get a deduction for health care costs but you could get it if you paid it in cash wages, then that is a very powerful disincentive for employers to offer health care coverage or to enhance health care coverage. I think that it might be easier politically to do but I think from a policy standpoint it would be very counterproductive.

The other thing that I would respectively suggest is that governments and employers are very sensitive to the increasing costs of health care, while individuals are not as sensitive, and, therefore, to the

extent that we need to sensitize individuals to make more prudent choices, then the exclusion is what should be looked at. In other words, whether and to what extent all or part of the value of employer provided and paid health care--and I'm talking about the insurance value of it, I'm not talking about the cost associated with when you go to the hospital and you have open-heart surgery, but whether all or part of the insurance value should be included in taxable income and whether all or part of that should be included in taxable wage base for Social Security and Medicare, as a way to sensitize people more to this cost and as a way to get them to think more. And I think they'll have to be combined with other things. They might have to be combined with giving people more choices, you know, so they then can decide, "All right, how much of my, you know, direct or indirect income do I want to be able to dedicate to health care?"

MR. FRANK: Can I ask you a little bit on that?

MR. WALKER: Sure.

MR. FRANK: I think that I--certainly I agree. I think that's a very thoughtful response. But the question is, would you sort of set thresholds on income or value of insurance and then change the

originality above that? How would you--

MR. WALKER: There's a lot of different ways you could do it. I think one of the powerful concepts that needs to be explored, at least in my opinion, is how would one define basic and essential services that it's in our broad-based societal interests to make sure that over time everybody has, okay?

One interesting way might be is you define that--and, again, I pick those words carefully--"basic" and "essential," and broad-based societal interests.

One interesting way to do it is to define that and come up with an estimated value of what that would cost, okay? And then, say, if you have a value of a policy that's in excess of that you've got to include that in taxable income, which kind of helps us move along the path towards the point where we can provide basic and essential services to everybody and also would generate revenues that could be used for other laudable purposes.

MR. FRANK: Thanks.

MR. WALKER: Okay.

DR. BAUMEISTER: I'm Frank Baumeister. I would just like to hear or see a visual of what it's going to be like if nothing changes.

MR. WALKER: You mean with regard to the economic picture?

DR. BAUMEISTER: The overall picture in the country if nothing changes, because there seems to be a sort of a forensic dance going on that you see between world wars and where there's a denial. You know, it was like there was a cartoon in a magazine years ago that showed two golfers on a green and--and behind them was a big mushroom cloud of an atomic bomb, and one of them says, "Go ahead and putt, you know, it takes two minutes before the shock wave hits." And it seems like that's the way people are living. And it's like they can't see what's going to happen. And I can't either, I mean, you know?

MR. WALKER: Well, if we don't start getting realistic soon then, obviously, what ends up happening is you have several choices. You end up increasing tax rates to levels up to two and a half times what today's tax rates are, which obviously would have a significant adverse effect on economic growth. It obviously would have a significant adverse effect on disposable income, it would obviously have a significant adverse effect on quality of life for, you know, our children, our grandchildren, and future generations of Americans. Or

you end up cutting back, government in draconian and dramatic ways, or you end up risking default and/or hyperinflation or some combination thereof.

You know, my view is we can, we must, and we will take steps to avoid the economic equivalent of your outcome. However, my concern is that we need to get started sooner rather than later and that there are too many people focused on today, not enough focused on tomorrow.

Let me give you an example of that. Last week it was announced by the Office of Management and Budget that the estimated deficit for this year will only be $333 billion rather than the last year's $412 billion. Now, don't get me wrong. Lower deficits are better than higher deficits. But, when you really delve underneath the surface you find out that 333 is really over 500 because we're spending every dime of the Social Security surplus on operating expenses. You also find that this is a near record deficit. You also find that every day our long-term imbalance is getting worse. Every day our long-term imbalance is getting worse, okay?

And so my view is you can't solve a problem until, A, people admit that there is a problem that

needs to be solved, and, B, you can't make progress until a majority of the decision makers agree that not only is there a problem that needs to get solved but it's prudent to do it sooner rather than later.

And I'm working on number one, then we'll start working on number two. But I think it's important that all groups, your group and other groups that are trying to deal with the very important issues facing the nation keep this bigger picture in mind, because in the end the first thing you have to do when you're in a hole is stop digging. We're not there yet. And the second thing you need to do is figure out how we're going to end up reconciling the gap over time. That's why I come back to what I said before; you're going to have to do three things: entitlement, spending, and tax policy, all three. The math doesn't work. It would be too draconian to just focus on one you're going to have to take a portfolio approach.

VICE CHAIR McLAUGHLIN: Yes. I am interesting your thoughts about the basic and essential package. I mean, this idea came up in the IOM report as well. That was one of their conclusions after studying coverage issues. At--I'm having a hard time. I forgot, for the record. Economists think about risk

differently--

MR. WALKER: Uh-huh.

VICE CHAIR McLAUGHLIN: --than most other people, and, you know, I see a lot of things with them.

When we think about insurance and insuring against risk, things such as preventive care doesn't fit into that definition, and yet when you use the words "basic and essential" it implies including prevention. Now, there are a lot of reasons to include financial incentives for people to seek preventive care but it makes me wonder how are you thinking about this health insurance plan? Is it a combination of insurance, in which case we would just talk about high risk, high cost, unpredictable things, or is it a combination, really, of prepaid care for preventive services? Are you melding those two together? And I'm just interested in how you're thinking about that.

MR. WALKER: I'm trying to think outside of the box, because, quite frankly, I think the only way we're going to solve these problems and the only way we're going to solve a lot of the other problems is if we do that. It really is a combination. It's a combination of the things that we would normally think of as being insurance; for example, you know, financial

ruin due to an unexpected catastrophic illness. Now, that's different for me than it is for Bill Gates, than it is for somebody who's in poverty, okay? It's different. I do think that when I say "basic and essential" I'm not just talking about it from the individual standpoint. There's another dimension, society's standpoint, okay? I would argue that the catastrophic might be both from an individual standpoint as well as to reduce cost shifting with regards to care. On the other hand, from society's standpoint it is in society's interests for certain things to happen for individuals. I would respectfully suggest it's in society's interest to make sure people get inoculations. It's in society's interests to make sure that people get certain types of wellness care in order to, not only help them but to help us collectively reduce what would otherwise be the long-term effects of that not being done. And so it is a hybrid, I believe.

VICE CHAIR McLAUGHLIN: Well, I think that when that--when it gets, then, to--I don't want to use the word "patronizing," but it is more of a thinking of what we call "externalities" to the society as a form of welfare, in that if we put in tax incentives, as you said, well, of the basic and essential, then the income

going to that is not taxed, but if you choose something beyond it it is. You are, in fact, establishing for everyone, at the federal level, what you consider appropriate to be put into a plan and then other people make choice. And, you know, there's a lot of appeal to that, but it does mean that I think it means that we have to start rethinking what health insurance is and maybe not even use the words "health insurance" anymore because some of this is no longer insurance, it's really what's beneficial for society according to some power set of experts saying, Well, this is what the data suggests are good for all of us, and we want everyone inoculated for certain diseases because we find that that prevents the spread, and so, you know, you're aware, as I am, there are a lot of people who don't want their children inoculated because of concerns.

MR. WALKER: Right.

VICE CHAIR McLAUGHLIN: And so you get into this issue of what we think should be included. And I'm not saying it's a bad idea, I'm--

MR. WALKER: Sure.

VICE CHAIR McLAUGHLIN: --just asking you to address that.

MR. WALKER: And let me help you here,

because, again, I think it's important to keep in mind where are at, where do we ultimately need to be--where we need to be many, many years from now--and what can be done to get us to move us along that path?

Let me give you several examples. I'm not talking about forcing people to do something they don't want to do, okay? But, on the other hand, if in the future everybody had the opportunity to get inoculations, they had the opportunity to have certain wellness services--and it may be that this is the role of government 20 years from now. It may be that the financing of these basic and essential services is the role of government in the future, including maybe the catastrophic coverage. That's very different than what we have right now, okay?

When I talked about the tax preference what I'm saying is on the way if you want to think about whether or not the existing tax preference should be scaled back or should be better targeted, then one option you could possibly consider is if in the long term you think that basic and essential makes sense then you might use that as a basis to say, okay, you know, if in the absence of having some mechanism to make sure that everybody gets basic and essential, anybody who's

getting more than basic and essential ought to pay income tax on some or all of that, all right, and possibly payroll taxes, as a way to move you along the path. But I do agree maybe you need a different word, you know? Maybe it's "coverage," maybe it's "services" or I don't know what it is. But I do think it's different than what it is today because I know that what we have today is not going to get the job done.

CHAIRPERSON JOHNSON: Thank you very much for your comments and your being with us this morning. It's stimulated our thinking to start the day in a very good way, and we appreciate your coming.

We'll be taking your comments and integrating them in our report. Actually, when you talked about starting and building on the dialogue, our report committee has already begun to put together a substantive movement forward in our report. Our public relations organization, our public relations committee will do the same, and our community meetings committee will also be building on what we'll do in our committee meetings to do just exactly what you suggest. And so thanks very much.

We'll take a three-minute break while we change computers and take a stretch, and then we'll

begin our next panel in just a second. (There was a short break taken.)

CHAIRPERSON JOHNSON: Well, good morning, again. We'd like to welcome you all back to our hearing. And in our next panel we are delighted to continue in hearing about opportunities that are available to us in our improvement of the quality that Dave Walker just talked about us needing to do.

And with us on the phone is Don Berwick and in our audience is John Wennberg. And, Dr. Wennberg, if you'd come to our microphone we'd appreciate that.

Both John Wennberg and Don Berwick you all have files on, but suffice it to say that both of you gentlemen are people that are well respected on a nation-wide basis. We have read and used your information. We commend you for the work you've done, your dedication of your lives to health care quality improvement and the health care system nation-wide. So we're delighted to have you with us this morning.

On the phone Don Berwick will be speaking to us, and Dr. Wennberg, as well, in front of us. We do not have a presentation to share regarding this. We will have copies of the presentation for you as a work group.

But I think we'll begin with you. Okay.

Very good. Thank you. We'll begin with Dr. Berwick. And let me just test with you, Don, the voice that comes through and with our working group, as well. Would you like to say "Good morning?"

DR. BERWICK: Sure. Thank you very much. It's a pleasure to join you, and good morning to you all. I wish I could be there in person with you.

Am I coming through okay on the speakerphone?

CHAIRPERSON JOHNSON: You are.

DR. BERWICK: Great. So I'll rely on you, Brent and Randy to interrupt me any time that people want to proffer something, and my plan is just to talk for a few minutes on a couple of matters that I think are of concern to you and then perhaps engage in some dialogue at a distance; is that okay?

CHAIRPERSON JOHNSON: That'll be fine.

DR. BERWICK: Great. I think what I'd like to do, very briefly, is summarize something that many of the members of the working group may already may have mastered, and that has to do with the framework that the Institute of Medicine has sent out for the changes needed in health care. The framework comes from a committee that Brent and I served on and that work from

Jack was certainly fundamental in back then.

I'll do a little bit of a few comments on the national policy issue that I think devolved from that framework and then talk a bit about the business issues and the cost issues that I think are not quite so clearly laid out in the Highland document that we're all very familiar with. Jack's research and entire career is as much responsible for what we now understand has happened and needs to be done as the work of anyone in the world, and I'm always honored to be on the same panel as Jack. And I defer to him for a lot of the science basis that he's been the primary motivator of. It's a privilege always to teach and work with him.

And Brent I want you to know is very much behind the vast majority of the understandings that we have in this country about where we're going to move, and I will also both acknowledge and thank Brent for everything I continue to learn from him. So I'm in the presence of colleagues here who know as much or more than I do about most everything I'm talking about.

We he have in the report the Institute of Medicine's Committee a Quality Care in America 2001, the report called "Crossing the Quality Chasm," what I would regard as invaluable charter document for guiding the

reform of American health care, which is what we need. The document's a complicated one. It's pretty wonky, actually. And for lay people, especially, but I think also even for professionals understanding it's not easy. I'll mention that I wrote an article in "Health Affairs" called "The Primer on the Quality Cost Report," a couple years ago because I sensed the need for a digest of what it says. And if you want a written record of what I'm telling you now that primer article's probably a pretty good place to go and a resource for you to draw on.

The "Quality Cost Report" is the work of a committee of the Institute of Medicine that was formed under the new program on quality of care in America. The Institute of Medicine, as most of you know, is the medical branch of the National Academies of Science. The National Academies were established in 1863 by Abraham Lincoln to advise Congress and the President on technical issues in science and its relationship to policy. There was no medical version of that until the early 1970's when the Institute of Medicine was founded, and the Institute of Medicine essentially is your national academy of science for medicine, the advisor to the nation on issues related to medicine. It usually

works on commission or request from Congress, as your work group is. But on rare occasions the Institute of Medicine itself launches an area of inquiry, and that's where the quality area came from. Congress did not request it, it was not asked for by the executive branch, it was by itself largely due to the work in the mid-1990's of a roundtable in quality that Mark Chat was in and Bob Galvin, who was the chairman of Motorola at the time.

What that roundtable found was that there are enormous problems in quality of care in America, that they're not confined to particular forms of payment or regions or types of organization, they are absolutely pervasive. And the roundtable, which was a very wide ranging group of many political views on that group, was unanimous in its finding. That led the IOM to decide to launch a program of quality care in America. That led to the formation of the committee on which Brent and I served, and the most famous of the reports was the very first one, "To Err Is Human," which was the IOM report on medical safety, but I actually think the Chasm report, which is the one I'm talking about, is more broad reaching than the "Err Is" report and so the "Chasm" report's what I'm going to talk about quickly.

The "Chasm" report, the title embeds the major finding. It says, "Between the health care we have and the health care we could have lies not just a gap but a chasm." It's a pervasive reiteration of a finding of the roundtable that American patients are not as well served by health care as they could and should be.

What the "Chasm" report did was outline divisions of improvement which are possible and needed, and it gave us this framework of six, quote, aims for improvement or conventions in which the care system ought to improve. And those dimensions are now pretty well recited and probably very familiar to you. There are six of them: "safety, effectiveness, patient centeredness, timeliness, efficiency, and equity."

"Safety" means avoiding harm to patients. Tens of thousands of people are killed actually by health care each year, and not due to any ill of--you know, of problems in the workforce, the work force is terrific. It's just that the systems are too complex, they let us down. And just like an airplane that isn't built right and crashes, despite a great pilot, health care can harm people despite great doctors and nurses, technicians, and most of whom we have.

So safety--the agenda of improving patient safety is a crucial one. The second is "effectiveness." This has a lot to do with Jack Wennberg's work, but we know there's a big, big difference between what happens to patients and what science says should happen to them. The work by Cap McLanta hopefully you've now heard or read about is probably the most recent important work, which tracks 7,000 or 6,700 patients for two years in America in 12 market areas, found that those patients only got 54 percent of the care they should have gotten--or 46 percent of the care they should have gotten and never got. And that's everywhere. We're not talking about just a few defective hospitals or clinics or whatever, it's everywhere. And that goes from Boston to Little Rock. It's--there's defects and gaps.

"Effectiveness," that's another edge which Jack Wennberg's the major scientist of, and that's overuse. Another form of lack of effectiveness is to do things for people that don't help them. That's where it studies things that people don't get, but we know a lot of things happen to people that can't help them at all. When Jack testifies in a little while I'm sure he'll be talking to you about that issue. It's a big, big gap. So the IOM says, "Let's take care of that. Let's make

the care address the signs."

That leads to the third agenda, which is "patient centeredness." And this is a big, big area, probably the most subversive in some sense, or the most radical of the changes we need, and that is basically put the patient in the driver's seat. This does not mean make the patient bear the cost of care. I'll editorialize to say there's nothing I know of in science that says anything like if patients pay more out of their pocket the care gets better. There's no evidence of that whatsoever. And we're the only western country that has any interests in that idea at all, and it isn't going to work. But what will work is giving patients power, control, decision making and for--technically, to help patients value control decisions. We've learned more that the better patients are informed about their care, the more choices they're given, the more we do what they value, the better the outcomes are, the cheaper the care gets, by the way.

Another form of "patient centeredness" is to enable patients to take care of themselves. There seems to be no limit to the ability of people, especially with chronic illness, to acquire more and more knowledge and capacity to take care of themselves. This is not

passing the buck, it's making care better by giving them the knowledge and the permission and the permission and the authority to do things for themselves and training and so forth. We're not invested in that in our care. We don't spend time or money to help patients learn how to take care of themselves. We regard--we treat productivity as doctors seeing patients or procedures being done not as skill being built in the patient.

A third form of "patient centeredness" is "transparency," which means patients ought to have all the knowledge they want and there should be no barrier to patients getting what they want. My own version of that that I think is crucial is what we need in this country is to begin to regard the patient's record as the patient's. But not all of us agree about this. Brent, in fact, and I have a little bit of a different view of this, but we're more or less on the same page in saying the knowledge that's in a patient record ought to be accessible to the patient without restriction, cost, or delay at all points in care. And the concept that somehow your laboratory tests or the notes I wrote about you or anything about you isn't yours also is outvoided and unnecessary and it impedes care.

The fourth variable is "timeliness." All of

the industries on--in the planet have begun to regard delay as waste, to regard delay as excess cost. And so it is in health care. Some delays are instrumental. Sometimes we wait to see what happens because it's informative to the patient. There are many other kinds of delays: waiting for your surgery to start, waiting to see the doctor, waiting to get your lab tests back, waiting in the corridor on a stretcher in the emergency room. These are all defects. And some timeliness is a key quality characteristic of health care, not timeliness just so that outcomes are better, that's not the point. The timeliness goal says delay itself is bad, in spite of the outcome. And that's a Chasm Report call.

The fifth article is efficiency. This has to do with waste. You track Jack Wennberg's work and there's no better work done in this part of the century, I would say. We have--hold the view of the level of waste in American health care, and I will tell you we're wasting approximately 40 percent of our expenditures. I know that's a bold idea but it is true, that we could have exactly the same outcomes we get today for 40 percent less cost than we have today, if we take fundamental radical critical changes in the way we do

care. That money is just plain being wasted, and we are failing ourselves in the opportunity to invest those resources in better health care, more equitable health care, or maybe even education or roads or arts, whatever you care about. This is a vast area of overstepping--overspending because of the way we built the system.

We know that, in part, because of international comparisons. We can visit other countries. Jack and I both do that. We can see in Scandinavia and England and in countries with health care systems that perform better than ours, and I'll come to that in a minute, expenditures of--at 60 or 50 percent of ours with just as good outcomes with their populations and better service in many respects.

And then, finally, there's the equity issue. And I actually think if I were going to rewrite the Chasm Report I'd probably put equity at the top. I would say it's the most embarrassing and unacceptable defect in our health care is the following fact. Here's the fact. If I were to pick an American at random and were allowed to do one test on that American to predict how long they will live and what their health status will be, there is a test I could do that overwhelms all

of the tests in its informative content, and that is just find out the risks. If you're black in America and you're born in inner-city Baltimore or Los Angeles you will live eight years shorter than a white, if you're a male, and six years shorter than a white if you're female. But no American health status variable is more predictable of outcomes than race, and I think as a nation somehow we've got to understand that that is probably, in some sense, an essential health care quality problem. It isn't just management's problem it's a quality problem, and I think as a nation we probably ought to just regard that as Problem Number 1.

Now, that leads to a set of ideas in the Chasm Report which are called "How ideas." The "what" is safe, effective, patient centered, timely, efficient and equitable care. And we can go there but we have to know how. Now, the Chasm Report rejects one option, and that is the option to be rewarding the workforce to do better. It says it will happen that we will try harder and succeed. It can't be done. That is, I think there's a sense in that Chasm Report that we're trying as hard as we can. The average doctor and nurse in America is working really, really hard to do a good job most days. They're not things but they're normal, good human

beings, and exhortation isn't going to work.

That, by the way, implies that incentives aren't going to work either because tests are just a way to get people to work harder. And so the whole idea of public policy as an incentive to lead us out of the chasm is I think an empty promise. It--we can certainly align payment better. It's not an incentive issue it's a structure issue.

So the Chasm Report asks the question, "Well, what's a health care system look like that is safer and more equitable, more person centered, more timely, more effective," and it outlines principals for the redesign of the system. And those are pretty important principles that come out as ten simple rules for redesign. That's where the wonkyness starts because they're not easy ones, but I think they cluster into three basic ideas, if you wanted to think about it efficiently. One idea is use knowledge. That is, we have science, we have data, we have patient voices, we have measurement tools, but we don't use them. We don't aggregate information and make sure that every doctor, every nurse at every point in the counter has access to the best medical knowledge. We don't have records on patients that are usable. We haven't made the

fundamental commitment to the patient to have an electronic medical record that works at the point of care. We continue to have essentially 19th century records systems. We're not using knowledge because we don't store it properly. We don't use knowledge for the patient. We don't ask them what they want, we don't work with them hand and glove.

And so knowledge-based care is the first general idea. The second is "patient-centered care," which means that the patient's in the driver's seat, like I commented earlier.

The third basic idea is "cooperation." Most of the defects that we can spot I think in health care can be traced in some fundamental way to lack of cooperation, lack of interfacing properly; patient's care, for instance, when the care is in transition. My best friend had cardiac surgery two or three weeks ago, and I could watch all of the hazards, and that some of the damage accumulated always was at a point when he was moving from one place to another or from one clinician to another.

We don't--we have to build team-based care, and that goes both at the personal level and at the institutional level, because when what you pay for care

has enforced barriers between hospitals and outpatient settings, between hospitals and nursing homes, between home health care and institutional settings, we don't move knowledge or information around because we pay for fragments instead of for the whole.

We had part of the answer back in the old days of managed care. Managed care is a "good guy and bad guy" thing. And certainly we rejected it as a nation because of the defects of the sorts of managed care we adopted. But the basic underlying idea of managed care, viewing care from the patient's point of view, managing the journey through one's illness, isn't an escapable idea. It's the only way out of the mess in some ways. If somewhere in this country we could rediscover the importance of integrating care in the process and experience of patients as a fundamental product of care, not the encounter but the journey, we could be back on the road to success.

Politically there are voices for single payer and other forms of aggravated payment. There are--that's one way to do it. There are other ways to do it. But whatever you do as a working party and whatever we end up recommending, this nation has got to understand that integration and care journeys are the

product and events and encounters.

So that's the Chasm Report, briefly. The Chasm Report then speaks to the question of policy environment, and it didn't really tackle it at the level that you're going to need to in this working party and that we'll need to as a nation. There are certain policy issues that are going to arise. I'll just flag one, and that is AIDS. I don't think as a nation we're going to improve care until we decide to do so, and I don't yet see that leadership. I don't see it from either political party or from any agency in government yet, the fundamental decision that care will improve. We certainly have a fundamental tendency now to be moving as a nation to try to avoid the overwhelming costs of care, but that's not what I'm talking about. I'm talking about improving care so that people are safer and treated better in more dignified settings and that care is more integrated. And I still would call for Presidential and Congressional leadership on that account, that we need a public policy that says "We're going to make care better," just as we have a public policy now to make our country's homeland safer. It's the same kind of thing. We have public policy on the environment, we're going to have our air be cleaner. We

have public policies on education, we're going to have our children be literate. Well, we need to say that the health care system will be better, and we've got to do that as a country. It's too fragmented for the individual stakeholders to do that alone.

Finally, as the chronic implications of all the above, I guess the fundamental question is, "Will a better American health care system be a more expensive one?" Absolutely not. Absolutely not. We have one gap, of course, which involves more expenditure, and that's the uninsured. We have 47 million people who don't have enough insurance--or don't have any insurance and another 40 million who don't have enough. But that's not the question. You have to zoom the lens out for a minute and look at the whole country. You have to face the following fact. We are spending 40 percent more on our care than any other western democracy say, and our care system does not out perform any western democracy. In fact, it's third or fourth or fifth, by some measures, 20th by others. In other words, it is possible to have care far less expensive than our care. It's fundamentally there. There's the money. There's the money to cover the uninsured and the gap in insurance. We have investment easily enough to cover

the needs, we just don't configure the resource well. We haven't centralized health care at the level that could do it, although as a nation we may not be able to. But we can't ignore the raw scientific fact that we're spending more than we need to to get care better than we have.

Jack will I'm sure speak to some of the underlying dynamics of that. The difficulty dynamic that jack is forcing us to face is over supply. We have too much of some things, and that leads to over use without effect on health. I'm focussed just on that and also on defects. We waste time and money all the time by having defective processes. And I don't know how far the Citizens' Health Care Working Groups get into the range of changes we'll need in health care in order to recover that money and spend it more wisely, but I will tell you that if you want to be a scientist and you want to ask the question, "Do we need to spend more on health care in order to get better care," the answer has got to be, on scientific grounds, no. Whether that's a politically feasible statement I don't know. That's for you to decide. But if we had the public will to get a better care system at lower cost we can have it.

I think I'll stop there and (inaudible)

conversation or (inaudible).

CHAIRPERSON JOHNSON: Hi, Don. This is Randy Johnson again. And we'll ask each of our members, when we do ask questions of you, to identify ourselves. But would you like to stay on the phone and participate in the process with Dr. Wennberg, or do you need to take just a few questions and then leave right now?

DR. BERWICK: I have a heart close in about 20 to 25 minutes. If Jack gets started by then I'd love to sit in as he starts, but I will not, unfortunately, be able to stay through all the way.

CHAIRPERSON JOHNSON: So in that light, then, maybe we have a question or two for Dr. Berwick from our working group, and then we'll get into Dr. Wennberg's presentation right after that.

Do we have questions that anybody would like to ask?

Go ahead, Montye.

MS. CONLAN: This is Montye Conlan. Dr. Berwick, I thank you for in your remarks about empowering the patient. I love when our experts get into this area. As a chronically ill person myself I've really learned a lot about my disease and feel that I have empowered myself, but sometimes I feel, depending

on the personality of my physician, that they feel little defensive or maybe even threatened about that. So it seems like it's a two-pronged process, not only empowering the patients but somehow getting doctors to accept that, that we empower patients. Do you agree or do you think this is just a unique situation to myself?

DR. BERWICK: I could not agree with you more. First, as a person with a chronic illness you probably know far more than I do about the hypothesis that you're the expert, that, indeed, you probably know--you certainly know more about yourself and your history and your trajectory and your needs, what works and doesn't work for yourself than almost any provider that would deal with you. You're also--by now you've accumulated a ton of scientific knowledge about your own condition, and the more the better. So it isn't--shouldn't be a surprise that the more power and self-esteem and control and "participation" I guess is the word, but I think the more control you have the more likely things are to work out properly for you, especially if that includes your own values, because if I had the same chronic illness as you the right treatment might actually be different for me than for you, because my daughter's getting married in three

weeks and it matters a lot to me to be able to walk to her wedding, when that might not be the salient to someone else.

But you're right, it's a two-sided issue. The payer system has to honor that idea just as much as you do. We really haven't trained our doctors or our nurses, I think, although it's a little more deeply embedded in nursing, or technicians, for that idea. We've, rather, trained them, instead, to kind of kind of tell you what the answers are. If we had meters on health care encounters. I remember the paper I read that during an average encounter the doctor says to the patient, "How can I help you," the patient starts talking, and the physician interrupts within, on an average 17 seconds. So there's not even a space for dialogue in the encounter.

We have to reskill the professions. This involves medical education and nursing education, education of the many therapists that are involved in youth care and managing elementary education. And we've got to start that. There's--a lot of the work that you're doing doesn't have to deal with the pipeline of young people and what we're really telling them to draw up a profession is. I'll tell you this. I think it's a

routine finding that when get over that hurdle and the professions you deal with are now on a more equitable basis with you and you're more in control it's better for everyone. It's easier to give care, it's more pleasant, the outcomes are better. It's a much better experience in the long run.

But you're absolutely right, we've got to learn control matters first.

MS. MARYLAND: Dr. Berwick, this is Patricia Maryland. I have a question regarding where does technology and the new technology and advances in technology fit into impacting the escalating costs of health care? We talked about patients--a second part of my question is you talked about patients who are getting much more involved in understanding what their needs are. When you have patients that come to you and say, "I want to surround this hip," versus "I pay this and the cost associated with may be double the cost," how do you manage that process and how do you control, if you will, exploding costs of technology?

DR. BERWICK: Okay. Well, let's take one a time. Control of technology in the--perceiving the vision we're talking about, it is--potentially it's crucial. It's crucial and it could be far better. If

you take those three basic design ideas to use the knowledge, put the patient in the driver's seat, and cooperate, and you how could technology help us, I mean, it can break through in all three areas. That's using the knowledge, the pipeline of scientific knowledge that comes out of our medical journals worldwide is just much too big for anybody to drink from alone anymore. I mean, I once read a paper that said a doctor that begins reading a randomized trial every day today will be something like 10,000 years behind in their reading at the end of the year. That's how much we're producing. What we need in a mediary way is to take all that knowledge, package it up, and offer it for me in seeing my patient up at the care center. I mean, it's not that this is a drug that will work. This is the procedure you need to follow. Don't expect me to read and remember. I need the help at the sharp end to use that knowledge. You'll never find that knowledge in the medical record. Medical records are just a mess. They're a dinosaur. I sometimes think we'd be better off just throwing them all out right now and starting again, but this time do it the right way, with the vision of the medical record as a really usable device or tool for care.

On patient centeredness, technology matters a lot because the same knowledge issues arise for the patients, how do you get access to information about yourself? How do you learn? How can you get coaching if you're taking care of yourself? Communication issues matter. And then cooperation depends on information transfer. I mean, cooperation is the sharing of knowledge in some ways. We don't do that right now.

And I told you my best friend had cardiac surgery a few weeks ago. When he went home from the hospital they changed his drugs at the point of discharge. He became confused, he had a complication, and there was--nobody knew it, anything. His primary doctor had no knowledge of the change that had occurred. The doctor that had done it was on vacation. The medical records from the hospital didn't match his clinical records in the office. And he was at home, in either place. But he went to the hospital for help for that. So--technology is great and essential. The problem right now is we're investing billions, probably ten, hundreds of billions of dollars in new technologies, health care information technologies, but I don't think we've grappled with the issue most directly, how will this help us, how can we use this

stuff, not that the machines and the software but the processes, on the basis of which care will improve? But James is our national peer in answering that question. He's done more than on that topic than anyone in the world, probably. But that doesn't mean it's percolated nationally. And I think we're spending in some ways too much money on information technology without not enough thought on "How am I actually going to help that patient suffer less tomorrow?"

With respect to your second question, does patient power mean more expenditure, more profit, we all have this image I might say hoisted upon us that the patient then comes in and demands a test. Of course they don't. Who wants the more expensive drug instead of the least expensive drug? Dr. W.H. Standing, my great teacher, used to say, "The customer has no expectations that we have not created for him or her." And that's true in this case. The patients are only doing what they've been taught to do. We could teach differently. We each have a different set of dialogues with the community at large. We can teach America that often more is worse, not better. We just need to engage that actively and begin to have respect for oral exchanges with patients and then the families and people

who aren't patients yet but just preparing to be patients. But we don't treat that as an undertaking in our country that we have to become more sophisticated together.

Empirically there is not much evidence that patient centered care is more expensive. In fact, the evidence goes exactly the other way. Annette O'Connor, someone Jack knows well, has been a leader in analyzing information on what happens when patients are given their power, and what happens is costs fall and qualify improves, outcomes improve. Annette recently had a finding in a study that she did, and she went to the Cochran Corroborating Center in Ottawa, which is a global center of analyzed studies. She studied experiments on patient involvement in decisions about surgery.

As you all know, the patient is much more activated in deciding what, when, and whether to have an operation. The summary statistic I remember reported that when patients are actively involved in decision making surrounding their own surgeries the rate of surgery falls, it doesn't rise. Costs go; down 20--I think it was 23 percent reduction in the cost of surgery and better functional status outcomes and satisfaction

on the part of patients. And so patient activation does not look like a formula for increasing costs, it looks like a formula for decreasing costs. And I expect Jack will cover that when he talks with you.

CHAIRPERSON JOHNSON: Any last questions from our working group?

I have one, Dr. Berwick. You understand the purpose of the working group that we have. No--understanding that there are no silver bullets to improving the health care system, however, what would be one or two of your primary recommendations for us to focus on as we proceed in the future?

DR. BERWICK: I would have the following: Number one, set national goals for improvement of health care and ask for the President and Congress to take responsibility for their achievement. We need in health care quality something like the Clean Air Act in the environment, where we decide as a nation to get safer, more effective, more patient centered, and any gaol that means anything would be monitored over time at the national leadership level. So I would look for an assignment to Congress to have a congressional body with oversight responsibility for monitoring national progress toward those aims, as honest about it as we are

in any other sector. Those would be the first thing.

The second, I think we need bold experimentation in our country for our total system to be redesigned. We see a little bit of that in the restoration projects in the Medicare Modernization Act, but they're not big enough or not bold enough yet. And so I would urge the emergence in our nation of regions--and Jack may help us think about the size of such regions--but something like the Pacific Northwest or the Cincinnati metropolitan area, the aggregates of hundreds of thousands to millions of people, where we suspend the rules but they allow for a three- to five-year period the emergence of new forms of care that are fundamentally different from the ones that exist today.

To do that would require lots of relaxation of some of the payment and regulatory rules that cause fragmentation. Medicaid waivers for for a market area that would allow funding providers to come together in truly integrated packages of care would be absolutely crucial because the Medicare payment system certainly they care more than they probably should. I guess the--you know, in Harry Potter you're not supposed to say Voldemort's name unless you get hit by lightning or

something. There is a Voldemort here that we've got to name, and here it is, which is we've got to somehow in this country be able to rediscover the good form of management care. The term has been made radioactive, and I hesitate to use it even with you, but it is the right answer, not the way we did it but to set up integrated care systems as a national investment and help patients navigate through the complex world of care is really crucial.

I guess as a third thing that maybe--and the third thing I was going to say is get curious about other countries, so we weren't really closing our eyes as to what other countries were learning about these great systems. Generally when one raises that in a group such as you, you know, someone will say, "Well, you know, American's different and, you know, we're not Swedish and whatever." And I know that and I understand what your objections are, but there's a lot of lessons to learn here, and as a country we ought to be curious about how it is that, you know, 30 other western democracies are able to give care and they outperform us for 40 percent of the costs. So there are tremendous lessons worldwide.

I'm not sure if there are other good ideas

but that would be for starters. And the most important of them is let's decide as a nation to have an improved medicine division and certainly let's decide as a nation to have coverage for care be universal. It's long past the time we should have done that.

CHAIRPERSON JOHNSON: All right. Dr. Berwick, we thank you very much for your time this morning, and we'll adjourn from our discussion with you and thank you, and turn the meeting over to Dr. Wennberg. Thank you very much.

DR. BERWICK: Well, can I say as a favor to me may I just stay on the line for another 10 minutes and listen to Jack? I won't say anything more but I'd be anxious to hear how he approaches it.

CHAIRPERSON JOHNSON: You're welcome to do that. Thank you very much.

DR. WENNBERG: Thank you. It's a pleasure to follow you, Don. And usually you interrupt if you don't agree (laughter), and that's the way we get some sharpness on some of these points.

I think what I want to try to do today is provide then an epidemiologic frame that fits the formulation that you've heard Don talk about in terms of the IOM objectives, and, also, I want to introduce you

to some new data that we have which focuses not on regions but on individual provider groups within regions. And the reason I wanted you to have a chance to see what this is all going about is that this information, in contrast with the regional information, is actionable in the sense of pressures or decisions that might be made about individual--arrangements with individual providers.

And everything that I've told you about variation between regions is true within region when you begin to look at the individual institutions that are providing care. And I believe there's a lot of opportunities for reform in that information, some of which may not even be on the agenda today. And I'll try to spend some time on that at the end.

I'm going to begin with a review of what I call "unwarranted variation," and that's variation that's not associated with differences in illness rates, patient preferences, or the evidence of medical--evidence-based medicine. In other words, it's got to do with irrationalities from the perspective that the system's supposed to be producing health at an efficient way, and most of those unwanted variations are actually associated with problems on the supply side of

the delivery systems, not the demand side, although there's some point when they become difficult to distinguish.

Now, three categories of variation actually allow you, if you keep them in mind, to avoid the error of trying to get a solution to one category that rightly belongs to another. In other words, the remedy as well as the cause of the variation is different in each of those categories, and, therefore, it's important to keep in mind.

The first category is what I call "effective care," which is familiar to almost all of you, and to all of you I'm sure through the emphasis on doing the right thing when there's evidence that it works. And here we're talking about such things as beta blockers, all of the quality measures in our formally adopted group are in this category. That is to say they're categories of proven effectiveness, they don't involve a significant trade-off, and so anyone with a specific need should receive them. And, finally, a failure to provide effective care to a patient in need is a medical error. It's an error of omission. You could put errors of commission into the same category, call that "medical errors," if you wish, but I'm not going to bother today

about medical errors of commission.

Now, the interesting thing about the United States is that no matter where you look, as Don was emphasizing from the newer work of Debbie Quintz, we don't do enough of effective care, which is really quite surprising because, A, effective care isn't very costly, it's like giving a pill or drug, isn't it, and it works, so the fact that we have such variation.

Now, it's--just to get you framed in, each one of these little dots here on this on this cart represents one of the 306 regions across the United States, and I--it's a shorthand for sort of this particular thing as we call it a "turnip" because it looks like a turnip. It's really a patient distribution turned on its side. But in this case, for example, as late as 1999 and the year 2000 the proportion of patients who were receiving annual eye exams ranged from a little better than 30 percent in some regions up to around 70 percent in others, so a huge variation was found essentially, and characteristic of our system.

And what we can say about the use of effective care in this country is that in terms of benefits to patients we're not doing enough. And this would include immunizations, it would include also

specific interventions in the management of chronic illness, such as space inhibitors, beta blockers, and so forth, things for which the clinical trial world has thrown us work and for which there's not a lot of trade-off. You don't want to argue with a patient about preferences when it comes to a beta blocker or an aspirin, which we call the protocol of health care. But, unfortunately, it isn't, and it has to do--basically the problem of producing--I think the major focus is improving provider performance through data feedback, infrastructure building, and peak performance. An awful lot of our whole peak performance initiative focused on getting people to do things they ought to do anyway.

Now, I will argue, perhaps not so much today, but in my mind what we need to do is extend the concept of performance for the other categories that we're talking about, namely the "preference sensitive" and what I call the "supply sensitive" categories.

Now, here we go with the preference sensitive category, and it's the second category. And these are services which involve a significant trade-off. More than one treatment exists, and the outcomes are different. Evidence is sometimes and

sometimes not. Decisions should be based on the patient's own preferences but, in fact, providers' opinions often determine which treatment is used.

A very good example is for a woman with early stage breast cancer. For that individual two treatments are available, a lumpectomy or a mastectomy. The impact on life expectancy clinical trials tell us is pretty much the same. The problem, of course, is the other outcomes are different. Mastectomy involves the requirement of some form of dealing with a loss of breast either through prosthesis or maybe something else, constructive surgery. People who choose lumpectomy face the need for radiation, some people chemotherapy. There is a chance of lumpal recurrence, meaning that you're going to have to have further surgery. But, clearly, those choices are not choices that belong to doctors, yet all the practice variations we see says that the rates depend on the opinions of the physician whose advice the patient seeks. So we've got a real problem here in terms of the exchange of information that's happening at the doctor-patient level.

Now, I want to just spend a minute some information on back surgery and hip replacement and knee

replacement. And these standard diagrams here just show you that the likelihood of having back surgery is much, much greater around the country, liability distribution, than hip fracture. Now, hip fracture is basically what we're talking about, the fixing a hip fracture. Think about it for a minute. Everybody who has a hip fracture knows it, everybody who has a hip fracture goes to the doctor. Somebody has a hip fracture, you get hospitalized and almost all of them are treated with one form of operation or another. In other words, in this particular example the variation is pretty much driven by the incidence of illness, as would be expected under the classic model of how health care works. Most medical services, both preference sensitive and supply sensitive, do not follow that pattern. Knee replacement is much more variable. It depends on where you live what you get, not in what you have. The same is true for hip fractures, hip replacement, and back surgery.

Now, look at this difference here that exist between three Florida regions. Ft. Myers, the chance of having a knee replacement are 48 percent higher than the national average. Hip replacements 45 percent and back surgery 67 percent higher. Look at Tampa. It's 95 percent of a national average. It's all blown out. So in

other words, just going from one little community to another the risk of having surgery shifts radically and it shifts radically because the local providers have a different set of opinions about what is the right way to allocate treatments for these conditions, namely arthritis of the knee, arthritis of the hip, and back pain.

Now, the interesting thing here is that you might think that the likelihood of having knee replacement across the United States, such as the vertical axis here, number 8, would be correlated with a number of orthopedic surgeons. After all, orthopedic surgeons do back surgeries, they do hip replacement, so wouldn't you expect the supply to go with it?

In fact, the correlations for most of these discretionary procedures which we classify as preference sensitive because there's other options, are not correlated very strongly with the supply of the person who does it, of the specialist that does it. And the reason for this, it seems to me, is that if you get down into the fine structure of the market for surgery what you see is that individual orthopedic surgeons tend to specialize in one of two specific procedures. Maybe it's carpel tunnel, maybe it's sports medicine, maybe

it's backs, maybe it's trauma. But they do that to the exclusion of other things. So, in other words, there isn't any strong relationship between the overall supply and the actual procedures which are done, a very important point.

Now, what does predict your likelihood of having a knee replacement is in the year 2000 and 2001, which is the vertical axis, is the same rate and the same reason a decade earlier, no regressions of the knee. In other words, if you really want to know what the probability of having a knee replacement is if you live in Salt Lake City, all you have to do is ask what it was ten years ago. Well, we'll give you more current data so you don't have to do that. But the point is that these practice patterns are fixed attributes of regions and the fine structure of these causal pathways is a fixed attribute of the cohort of surgeons who have populated that region and that they're basically able to locate enough feasible things to do across a broad spectrum of risk of surgery to fill their week or their month or their year.

So what do we have to do about essentially that problem is what comes up next. We, first of all, don't know if we had a system in which patients were

actually choosing surgery with full knowledge or choosing their treatment with full knowledge, we do not know what that rate would be. So in this country we cannot say what the benefit of the marginal increase in surgery rates are across that spectrum that I've just shown you. We don't know whether the rate in the low region and the rate in the high region is the rates that would prevail under market circumstances where information were freely transmitted to patients and what the economic incentives or the structure of practice are like Don's distinction where such studies would have encouraged participation and shared decision making between patients and physicians for these kinds of things.

Well, reducing the misuse of preference sensitive care, the major focus is what we call "shared decision making" or "informed patient choice." And what's important here is that and Don mentioned Annette O'Connor's contribution--there has been a movement, I think is the right word to say, over the last decade to create decision aids that can actually be used in clinical practice. They're based on updated information, they're based on scenarios of presentation so the patients learn what their options are and the

patients learn that their decision matters. And when you use decision aids you get a very different kind of response in the system than you do when you don't.

Don was saying that the 23 percent drop in surgery rates, those were a summary of several clinical trials in which the control arm and the randomized arm were compared and there was a 23 percent decline in surgery across a large number of procedures.

Now, if I can just illustrate this with an early study that we did, I think it will make it clear to you why shared decision making and why patient preferences are such a fundamental problem that needs to be solved in our health care system, because unless we begin to actively involve patients in the decision process we will not know what they want.

So the BPH decision is essentially a trade-off between urinary tract and central function. People who have surgery do end up with a very strong benefit in terms of the urinary tract symptoms but they have problems with sexual function, both impotence and also most men end up with what's called "retrograde ejaculation." Basically, sex has been changed. Degree of bother, as opposed to how much the objective symptoms. Men do not--with the same amount of symptoms

are not bothered as much as other men, and some vice versa. So taking into account the strength of concern about a symptom is different than asking people how many times they have to get up at night to urinate, which is the usual objective of many urine symptoms.

The traditional test of urinary tract function does not correlate with symptom level, much less of bother. So, in other words, there is no biomedical test out there that allows us to adequately diagnosis when a patient faced with this condition really would benefit from their own perspective. So you're left with the problem of asking the patient. Learning which rate is right depends on sorting it all out at the micro level, the doctor-patient relationship.

Now, here is a study that we did a decade ago in two staff model HMO's, one in Seattle and one in Denver. And because staff model HMO's have defined populations we could actually calculate the rate of surgery in those populations prior to the initiation of a shared decision making experience--that is to say it had been made--and what happened afterwards. The blue dots are the background rates across all the United States among the 306 regions. So, in other words, when the study--baseline study, these two staff model HMO's

were doing surgery at about the lower 25th percentile in the United States. After surgery the rates dropped 40 percent, better decisions, more clear clarification of treatment choice. And the benchmark from shared decision making for these two populations was at the bottom of the distribution of the U.S. rate.

Now, unfortunately, this kind of study is rare. We do not have those benchmarks across more than the population base. But what this says is that at least from the perspective of one benchmark at this one point in time it looked like the amount of surgery that informed American males wanted, assuming that they were somehow representative of that, was less than was being given in almost every market in the United States. That is the kind of point that I hope we can drive home here.

Now, I'm going to skip over these other notes because I want to hit--the major focus, then, for reducing unwarranted variation in preference, first of all, decision aids and shared decision making, a new focus is on the measuring decision quality. Don alluded to this just very briefly, but the quality movement has essentially focussed on report cards of doing effective care. It is, in fact, possible, using a new design of report cards to actually ask patients essential

questions to find out whether or not in a surgical condition the surgical experience they had they actually knew what the historic facts were, what the facts were, and, secondly, to the extent that you can judge or measure preferences you can actually find out whether the decision was in the direction they want.

I'm not going to hold a promise for that. Certainly, it's easy, however, to document it. In the majority of cases in the United States patients don't get it straight about what their treatment options are for even major conditions. So what we need, then, basically, also, I believe, is the adverse economic incentives. The major problem we've had, I think, in getting shared decision making--well, there's two problems. One is the cultural problem that doctors aren't trained or don't believe the patients really have a role. I mean, they'll they say they do but empirically you can say that gets lost. Secondly, any time that you upset the current misequilibrium between medical opinions and medical supply and the rates of surgery it has an economic impact. So it was fortunate that this original study was done in a staff model HMO, where a decline in surgery was not costing the system. But if you were to put a 40 percent decline in surgery

rates at our medical center environment you would have a nightmare in terms of cash flow, in terms of how to keep the system going.

So when you think through your strategies and you focus on patient centered issues with major treatment options you're going to have to somehow figure out what to do or what might happen or what might be proposed for dealing with the adverse economic sense associated with this.

Now, let me get to the final category. And this is the most difficult one, particularly since we and I think that even Don and I have this, and Brent have this defect. We still think the system ought to be rational somehow. (Laughter.) But here is this vast domain of care where the frequency is governed by the assumption that resources should be fully utilized; that is, that more is better. For example, you don't see a lot of doctors sitting around waiting for patients to drop into their offices. Their nurses have busily rescheduled everyone so that office is always full, and it's extremely difficult for a new patient to even get in. That's one of the other problems we have. But how frequently should the doctor see the patient who has mild congestive heart failure, you say? Well, you might

think you could turn to a medical textbook or you could turn to experts or you should turn to academic medical centers, where sometimes experts reside, and get some clues. Well, in fact, medical theory, much less evidence, plays virtually no role in governing the frequency of use of physician services; associated with physician services, diagnosis tests, because they always do something when we see them, prescriptions for, you know, fixing some little problem here and there, hospitalizations for people with chronic illness specifically. How do you--when do you hospitalize somebody with congestive heart failure? You know, obviously, when they're about to die maybe, or maybe when--who knows? So in the absence of evidence and under the assumption that more is better, then available supply is based upon the frequency of use. That's what we're left with.

Now, here is another example of the association between bed supply among regions, that's the acute care beds, and the discharge rate. Now, for the hip fractures you'll see basically no association at all between the hospitalization rate for hip fractures. That's because hip fractures are determined--hospitalizations are determined by the

incidence of disease.

But for all medical conditions, chronic illness particularly, ambulatory sensitive non-ambulatory sensitive, whatever you're looking at, it's correlated with a number of beds.

The same thing here. The number of cardiologists--we just talked about this--and the number of visits. So cardiologists fill their time and, therefore, it's not surprising.

Now, here's the big question. Is more better? In other words, what is the evidence that if you live in Miami, where the rates of this kind of services are three times higher than if you live in Salt Lake City, is poor Brent out there rationing care and killing people or are the people in Miami simply inefficient? It's a really important distinction because if we come to believe that more is not better or if the evidence drives in that direction, which is a better way of looking at it, then we come closer to the concept that efficiency resides in the efficient and low-cost regions. It does not reside in the minds of the academic medical center, because they're all over the place, but it does reside in regions that for some reason or another have done a better job of constraining

supply and, I will add, to Brent's definite smile, better management of care. I don't think that necessarily goes along with it, but in a way it almost does, because if you look at the low rate regions they tend to be places that have been dominated by integrated medical centers. And we tracked the Mayo Clinic, Portland, Oregon, a lot of spill-over from Kaiser, perhaps, Dartmouth, the Mayo Clinic I mentioned, the Marshall Clinic.

In other words, there are pockets of places where benchmarks of efficiency exist that if they were widely adopted would accommodate, in our estimates, the 56 percent growth in the Medicare population projected. In other words, we already have enough resources in the market to do for them now what we're now doing to us in the now efficient regions. The problem is recovering the savings and figuring how to do it.

And the major problem is the over-investment in medical specialists in acute hospital care. It's the acute sector where it has been over invested. I will say that on the basis of this work that Fisher did, my son David, I've got to mention him--it's all in the family, so you may get a little suspicious of the enthusiasm for this (laughter), but basically this study

showed between a two and a five percent higher mortality rate for patients who were followed over time, that is to say, who had a hip fracture, who had a colon cancer surgical procedure, who had a heart attack. And those people we're solid because for those people we know the hospitalization records at a reasonable point of enrollment in the Cohort study, followed them up for five years. In the high rate regions between two and five percent higher mortality associated with care intensity, doing lots of visits, lots of hospitalizations.

When you think about it for a minute, why not? First of all, I think it's quite easy to convince yourself that there's no theory about why more is better other than the fact that we believe it is, so there is not a lot of medical theory engaged in that so you're not holding a physical procedure that somebody's been--all you're doing is not visiting the doctor quite so often. And, therefore, we have no strong hypothesis on that ground that more ought to be better. And when you add to that the medical error problem, namely, we do know that hospitals are risky places, we do know that people get in trouble when they have lots of doctors involved, cascading and all that kind of stuff, so you

can account for the differences in mortality that we're speaking of with a simple medical generic theory saying because you're doing more you have more chance of error and that's why it's happening.

I not going to dwell with that further, but what it does in our formulation is that we believe that for supply sensitive care the United States is actually on the descending limb of the of the benefit patient curve, particularly when one looks at life expectancy. In other words, it's not rationing in Miami in--I'm sorry, in Salt Lake, it's inefficiency in Miami. And if we can make that point clear we have a huge amount of latitude for rationalizing care without deriving people of their access so, anyway, this is overuse and waste, not under use and health rationing.

Now, this is another point why this is so important. You see here that Medicare spending in the year 2000/2001 in the green zone. These are the regions now, and the 15 percent below are green and the red are 15 percent above. Miami is third or fourth. So it changes. Salt Lake is fourth or fifth from the bottom. The Mayo Clinic area's fourth or fifth. Maybe they're not quite that far down. But my point is that the green zones are the zones of 15 percent or more below the

national average in spending. And here's what we see. When we increase reimbursement, green zone to red zone 56 percent increase in Medicare spending, on average, across the top four groups effective here is not effective, basically. You don't get more effective care in Miami. In fact, if you look at it really carefully you get the--it's negatively correlated with lots of interventions. You don't see it in this particular slide.

You don't get more surgery in Miami than you do in Minneapolis, on average which most people would probably not have thought was so. That's not that surgery doesn't vary and it's not that there's a lot of costs associated with it, it simply isn't correlated with the underlying driver of--between regions costs, which is mostly what's happening to chronically ill people on the medical side of the equation, not the surgical side of the equation.

So what we're saying here is that if we went, "Well, this is what happened in the last six months," it's a good time to measure things, because everybody had the same prognosis, meaning they're all dead, so people don't argue about whether they're sicker in Miami than they are in Minneapolis, at least not very

often. So what you get are you get more days in the hospital, more medical specialist visits. You actually see lots more doctors. That's another problem, because seeing lot of doctors does inversely correlate with effective care measures. You get too many people involved in care, somehow somebody forgets to give you the beta blocker or your aspirin or whatever.

Okay. So reducing over use of supply expensive care meets two-fold tiers. It means basically at the treatment level in the active chronic disease management. I use that word "chronic disease management" because I'm not ashamed of it, because Brent does it and a few place do it a little bit but not very much. And there's a huge opportunity set for rationalizing care if we focus on that topic. And there is definitely interest in doing so in Washington and the private sector, but it's just beginning.

At the systems level I'm not sure that control and capacity gets over very well with the American public, but basically what we were saying is relative to the population that you're serving you need to have some mechanism of essentially keeping capacity in relationship to that supply. And this, of course, is the secret of staff model HMO's. They know how many

people they serve, they know what prevailing prices there are in their regions, they know that they have to be competitive, they know how many doctors and nurses and mortgages to take, you know, out in order to meet that, people, at a price that they can remain competitive. So they practice what's called "side effects of health planning." And that is something which I hope you'll look at as you move along here, that, again, the major impediment of adverse impact on providers, how do you basically deal with the excess capacity in the system when you're into the bond market, you're into the equity market and you've got all those labor problems if you have layoff people. It's not an easy deal. But there may be some ways through it, and this is where the provider-specific data begin to play a role because now we can go into any market in the United States and locate efficient providers on the measures that we're talking about, on the management of chronic illness, the actuarial costs of chronic illness. In fact, the provided specific level is now available information. And we can begin to serialize what might happen.

Well, let me first go through these differences between academic medical centers, because I

don't want anybody to walk out of here and think there's a group of experts out there who know what effective care is when it comes to chronic disease, that is to say the frequency of management of the use of resources.

So these are the 77 best hospitals in the United States, according to "U.S. News & World Report" and we use that sample as our first publication for our hospitals and specific measures because well, because we wanted to see how the best could be when the best were all the best. So we picked those that were noted for being good at geriatric care.

So what it says, basically, is that in the last six months of life patients who eventually use these academic medical centers, and that was determined by a follow back for two years--had striking differences in the numbers of days that people were in the hospital. So in the top place it's 27 days per person in the last six months of life who had a serious chronic illness was hospitalized, compared to around ten or, in part, about a 2.8-fold difference.

Now, would anybody wish to guess which--either--both New York and California and Massachusetts hospitals, does anybody want to guess which one's which? No? I'll just show you. But there

we go.

So if you--Stanford University Hospital keeps its people--or hospitalizes its patients about ten days, on average. NYU is 27 days. UCLA is 16. Remember this is the same system in California, same places. Mass. General 16.5, Mt. Sinai 22. So its all over the ballpark. And, of course, it doesn't matter whether you have cancer or congestive heart failure. No matter what disease you have, when you go to NYU you have about a 2.7 full higher probability of being hospitalized than if you go to Stanford. It doesn't matter whether you have cancer or congestive heart failure. In other words, this is a systems attribute reflecting the behavior of the clinician at the micro level, and that's why it's so important to keep the focus on both the supply capacity and the actual chronic disease management strategy so that you have a clinical note.

Here is another interesting example. This compares non-black Medicare to black. And, yes, the black line is equality, so blacks are getting actually more care at the same hospital than whites or non-blacks because most of the dots are above the parallel line, right, or the 45-degree line. But what really decides how much care you get is not your race but it's where

you go. And we could go on and a demographic or other form of patient variable that you would be interested in, like age or whatever, sex, and it's always the same. Conclusive and essentially the threshold for that institution, clinical decision making regarding hospitalization.

Here's another one, physician visits. If you are at NYU you receive 76 visits per person in the last six months of life, compared to 22.6 at Stanford, UCFS 27, UCLA 44. Pick your poison. And you decide whether you would prefer, seeing the doctor 76 times or 22 times. I dare say that we've done this now for the medical center level, say for all the visits you're not getting any benefits. You can say, "They're all dead anyway," but we say, "No, this is the instrument with which we measure relative intensive care, taking all this into account," and then we apply this information to those cohorts.

It's not that we're saying people are living longer and we're dead in six months, but we're saying, basically, this is an illness independent actuarial estimate of utilization costs, hospitalizations, etc., because these people are all about equally ill and nobody yet has justified this serious argument with me

from these different stations. They just don't believe that people are deader at NYU than they are at Stanford (laughter) so...

And here's another important point. Put somebody flat in the back and they're going to get a lot of visits, so having a lot of hospital deaths is not independent of--it's not independent, it's actually--because, you know, if a patient sat in the bed for 27 days, on average, much more chance to be visited than if they're only in there for ten days. It makes a lot of sense when you think about the opportunity to produce. And everybody who's in a teaching hospital knows that you will always be visited by doctors and referrals and so forth and so on. This is the percent seeing more doctors, so Stanford has a much more conservative practice pattern than other places.

Now, the interesting thing about Stanford University Hospital, which I'm not going to show you the bid but I'll tell you the story, is it has two different faculties. It has a group practice called Falwell Attendance Foundation that's as large as everybody else, and we're looking now at the relative intensity of care for those two sub-populations within Stanford. Having finished that study and the similar studies that we've

done have had similar shows, that those patients managed by primary care physicians have much lower resources than those measured by--or managed by the specialists, so...

Now here is another important point. It's not end of life care we're talking about it's the intensities over time with which these cohorts are interviewed upon. So here we're looking at Medicare payments 19 to 24 months prior to death for the same people that were looking at payments in the last six months of life, so obviously in the last six months of life payments were going between 10- and $35,000 per person. And in the previous period it goes only from 2,000 to 69- or 72,000--7,200 per person but it's highly correlated. In other words, a place that treats people intensely in the last six months of life does so in the previous period, it's, again, a fixed problem of the institution and its relative--the relative size of its population relative to the amount of resources that it has acquired.

I think I'll skip over this just to say basically this is some new data that we have from California that--let me just spend a minute--

Do I have any more minutes?

CHAIRPERSON JOHNSON: Just a few, and then we'd like to take a few questions.

DR. WENNBERG: Yeah. We have now generated the data, like I've shown you, for every hospital in the United States over a five-year period between 1999 and the year 2003. We're trying to update this data periodically and to make it available generally on our website. What will happen to it depends on--we don't know that, but what we do want to do is stir the base about ways that one might begin to do the incremental steps that David talked about.

Now, I think it's a real interesting and incremental step from Los Angeles. Los Angeles, by the way, is where most of those ten hospitals are. It is extremely costly. It's the third ranked region in the United States in terms of this particular time of life. And there's not a hospital in Los Angeles--well, maybe there's one or two out of the 920 we looked at, that has a cost below the average for Sacramento just to give you an idea. So they're really, really expensive. If you take the Sacramento benchmark and apply it to Los Angeles on a soft experiment saying that over that five-year period the prevailing rates in Sacramento had applied how much less money would have been spent it's

$1.2 billion for inpatient care alone, and that's big, big money.

So here's L.A., and L.A.'s got an earthquake problem. We're trying to rebuild all these hospitals. What would happen if Medicare started to put up a commission to begin to look at cost variations among hospitals in acute sectors and asked about efficiency? What would happen? Could they get their money from the bond market? Could they get their money from the equity market? I don't know.

The point is there's other ways of beginning to bring pressure for change if we can focus on the acute sectors, because the acute sector is, first of all, exposed because it's locatable in a very specific place and there's different things going on. Los Angeles just happens to have the earthquake problem.

And we've just been thinking about other models based upon paper performance and other ways I'll preview, begin to activate change in these places. But that's just one thought that comes up.

And the differences here, as you can see, this is just spending in the last six months of life, and we have examples of hospital over $55,000 in the tenant system which were not even recognizable to me.

Some of those actually came to the attention of the Attorney General and there was some work done and subsequently it divested itself of about half its hospitals. But, interestingly, if you compare the ones they divested to the ones they kept they didn't distinguish this parameter of utilization which is per capita costs, because you see no one knows what their per capita cost is because no one has a denominator until now, until now.

And what it had turned out--here's where Clinton comes in again. It's the volume, the one unit you can track. It's the volume. Now, in California there's a few exceptions to that but basically this is the volume difference in hospital days per decedent. And you'll see within all these systems, the University of California, HCA, Sutter, huge system variability. The Kaiser data should be really discounted because it's based on a bad sample because they don't do much of this, but Kaiser will have variations, and they know it.

But the point is that here's another focus essentially for reform, namely, the budget neutrality revisions that are part of the 646 demonstration drives. And the 646 demonstration drives is one that Brent and I have been working on for a long time which offered

practices--organized practices--the opportunity to propose to CNS for reform in the repayment system. So what we're trying to bring to people's attention is that we actually know the actuarial costs of Sutter in '95. Well, it happens to be here in the adjacent page. But we have the extent of its money.

Sutter, in a budget neutrality argument, as a unit could clearly manage costs down in it's higher cost place, meeting this neutrality model and also doing a public service, so long as they don't sell their hospitals. In other words closing debt becomes a really key part of this and having a financing system that protects hospitals that want to do the right thing from defaults on their bonds, problems with their stocks, etc., etc., is something you might want to think through because I think in that colonel of an idea there is an opportunity, conceivably, for clearing some of the acute sector past it.

Tenet itself might have such a--excuse me. When it saw what the impact of this might mean to them they might like to become more efficient but for Tenet to become efficient they've also got to become higher quality, because the quality problem doesn't necessarily run along any of these parameters. In other words, we

can show in California no relationship between quality measures, as patient rating the hospital actually turn out to be--people in Los Angeles do not like their hospitals, if you look at the California Health Foundation surveys, which are very interesting.

But, generally speaking, we do not know enough about these places just to say "You're okay," so what I would sort of argue for is essentially that we ask providers to do something more than just send them patients or send them awards, basically that we ask them to eliminate the enemies of effective care.

In other words, we take the IOM model and you could basically reframe in this L.A. and do the same thing, but we ask them to reduce medical mistakes and we provide them with infrastructure opportunities. Because, remember, if you can suddenly have some sort of a guarantee on your historic costs for managing inpatient care and you can convert that into resources for doing new things. You can buy an infrastructure for collective management of the population, you could figure out how to reduce medical mistakes, you can learn about work, the outcomes of research.

I must say that we showed them the data that I've talked to you today about to the University of

California, CEO's of each of their hospitals and their chief medical officers, and they understand that they've got to do something about this, they just need some more pushing. But basically they cannot not get engaged in questions about "What's the next step?"

We can tell you what the population at Miami is not doing better than Stanford or Los Angeles or anyplace else, but what we can't say is "How do we rationalize this huge black called chronic disease management"? You can't. We need to motivate our academic medical centers more.

Finally, we need to assure informed patient choice, shared decision making. We need to achieve effective and efficient management of supply sensitive care, targeting chronic illness, and, finally, achieve efficient allocation of resources geared to the size of the population served. And remember the benchmarks from the most efficient but lower cost markets with high quality whose practices are the best we have. And, to my mind, they are the model towards which we should drive the system. But it would be--I'm sure Brent will tell you this, it's just part of really doing a good job in the long run.

Thanks.

CHAIRPERSON JOHNSON: Thank you. We have time for a couple of questions. Do any of you, as a working group, have questions that you'd like to raise?

Go ahead, Aaron.

DR. SHIRLEY: Aaron Shirley. In regards to the variations, regional or local, in my experience, which is not scientific, that I have experienced some variations even within practices and I have seen some scientific studies which also indicate some variations within practices, usually--sometimes related to race and sometimes related to pay scales. Would you have any comments on that?

DR. WENNBERG: Right. I think there is definitely variation within an organization, even. The question about whether it's associated with a patient characteristic or whether the characterization of the physicians is a really interesting question. And we have been pursuing the question about whether blacks and non-blacks at the same hospital or the same group of doctors are they treated differently, and for the purposes I've been talking about, the chronic disease care, that blacks actually get slightly more. I believe that may be traceable to the fact from their opportunities for taking care of people in the

outpatient may not be so great, maybe need driven, but it's still the system that drives this, not so much the distinguishing features.

In terms of the surgical variations, again, the region explains more than the racial characteristics or the sex characteristics of patients. But there are definitely some procedures for which blacks get less and some for which they get more, and it's hard to--the variation is so great within any of our ethnic groups that I--that's what compels me to--to wonder about it.

DR. BAUMEISTER: The comparison between NYU and Stanford, does that have anything to do perhaps with the affluence of the environment around the hospital and the alternatives for hospital care and the work systems that people might have outside of the hospital, that make the end of life care more--perhaps more private than the availability of nursing homes and that sort of thing?

DR. WENNBERG: That would imply a rationality that I don't think is there, in the sense that we don't see trade-offs between sectors. Like places that have a lot of nursing home beds don't necessarily have lower hospitalization rates.

NYU is an interesting place because it's

very like Stanford, it only picks rich people. You know, it really does. You can't get in there if you're on Medicaid. You go to Bellview. I was advised about that. So to be quite honest with you, both Los Angeles and New York suffer from a plethora practice of hospital beds, if you just look at them. And they have a lot of small-ish hospitals in Los Angeles, compared to northern California. And so I go immediately back to the capacity that's been built into that system over years, and the causal reasons for that are very difficult to disentangle and they're probably very much based on a particular set of circumstances. Like in Boston it was pretty easy to see what was going on because they would treat academic medical centers--every time one gets thing, sort of an expansion, the other gets the same. So there was this institutional competition going on.

The best place to be if you don't want to have a lot of extra inpatient care is where there's a group practice that's making the dominant decisions about how much you need or what demand side is. And I don't think it's any coincidence that the most efficient regions in the United States are integrated health care systems or group practices, Billings Clinic, you can just make a list of them. And the question, and a great

question facing the country may well be how do we make those models the standard of care across the country? They're not easy because they're based on culture, they're based on people talking to one another and going, you know, I mean, "Oh, I've had a lot of influence from group practices in the way it practices."

Portland is down with--I should have mentioned it, but it's a good benchmark. I like that. If the rest of the country looked like Portland we wouldn't be worrying about at least projections on costs.

CHAIRPERSON JOHNSON: That's all because of our partner and working group member Mr. Frank Baumeister, I'm assuming?

DR. WENNBERG: Right. Right.

CHAIRPERSON JOHNSON: Dr. Wennberg, thank you for your time. You have shared a lot of information. We're a lot smarter than we were before you came. But we have a lot more questions and we'd like to spend more time with you. Unfortunately, our time is limited today. Would you be able during the break to take some questions?

DR. WENNBERG: When's the break?

CHAIRPERSON JOHNSON: Right now.

DR. WENNBERG: Oh, sure.

CHAIRPERSON JOHNSON: Okay. We'll take a ten-minute break and then we'll reconvene with our next panel. Thank you very much. (There was a short break taken.)

CHAIRPERSON JOHNSON: While we're dealing with our computer input we have an update on our agenda. We'd like you to be aware of that. In addition to Stan Huff and Scott Williams making their presentation, Eric Pan will be joining us by phone. Eric is from Brigham and Women's Hospital in Boston. And then we've been notified that Senator Hatch will be joining us at 2:45 this afternoon. And some of us on the working group--most of us on the working group have already met and heard from Senator Hatch in the past. He's accepted our invitation to join us and share a few of his words and updates this afternoon, so we'll look forward to that, as well.

While we're--there we go. While we're getting settled we'd like to introduce you to Scott Williams, who has advised us his kids are in the car and ready to roll on vacation. And I noted, Scott, that you start your bio by saying you're the father of three teenage boys. So we won't ask you which is the greater

challenge, serving as a physician or serving as a father, but I'll bet you by the end of your tenure of fatherhood and physician you'll find your satisfaction greatest with your boys rather than your work, as I have. And we'd like to welcome you.

And, Stan, the same. Professor of Medical Informatics at the University of Utah and Senior Medical Informaticist at Intermountain Health Care. And we would like to welcome both of you.

We've already received a kind of an alert that you are really well developed in your knowledge of information technology, and we'll look forward to hearing from you.

(Telephone connected.)

Okay. Dr. Pan, we're just getting started.

DR. PAN: Great.

CHAIRPERSON JOHNSON: My name's Randy Johnson. Can you hear us okay?

DR. PAN: Yes.

CHAIRPERSON JOHNSON: Okay. And we're going to put you on a speakerphone so you can be heard, as well, okay?

DR. PAN: Thank you.

CHAIRPERSON JOHNSON: Okay. Dr. Huff and

Dr. Williams, have you determined who would proceed first?

DR. HUFF: I think I was going to go first, so--

CHAIRPERSON JOHNSON: Okay.

DR. HUFF: But I could go either way, so that's fine. Okay.

CHAIRPERSON JOHNSON: What we'd like to do is ask each of you to speak for about 15 minutes, and then we would like to take questions at the end of your presentations. But we'd like to leave an opening--a significant amount of time for questions by the working group, if that's okay with you.

DR. HUFF: Yeah. Thanks. That was my intent to sort of raise the significant issues and then let there be a lot of free discussion, so...

Just to start off, just to acknowledge that the information I'm going to present is actually the work of a lot of different people, and I want to recognize those folks. That's in the handout so I won't go through the list, but just to recognize that the systems I'm talking about have been developed over 30 years with significant effort from a lot of individuals.

Again, I'm a clinical pathologist by

training but I have been doing medical informatics really since I completed my residency, so I'm not an accomplished pathologist anymore. I tell people, "You don't even want to come to me dead" (laughter) because--so... But I've worked at Bell Laboratories, I've worked at Intermountain Health Care, where I'm the system architect for the system. And I teach at the university and I'm involved in a number of standards organizations and other activities. I work for Intermountain Health Care, and, again, a not for profit organization that's based here in Salt Lake City, 22 hospitals, 1.8 million patients were members that we care for. We have inpatient facilities, ambulatory care clinics, a health plan division, physician division, so it's a fairly heterogenous kind of health care provider organization.

Then to get into the subject, the basis of my talk and the thing that I want to really say today is that it's our belief that information technology, properly applied, can increase the quality of health care and decrease the cost of health care at the same time. And that comes from a couple of underlying premises. One of them is that people have limitations, so you have a choice in medicine. You can be a

specialist in a given area and you can become the best or very close to the best in a very specific area, in which case you do that at the expense of not knowing things that other more general practitioners might know. On the other hand, if you choose to be a general practitioner then what you're really saying is that in any given subject area there are things that there's probably a specialist who knows more about that particular subject than you do. And we continue to perpetuate the idea that we can make physicians perfect by just teaching them more, by improving teaching, and it's impossible. And any of you who practice medicine recognize that, that you can't remember everything that you need to know, nor can you read everything that you need to know and always bring it to bear on the patients at the correct time. And we believe that computer technology can help us there.

There's another aspect of this that says even if you knew everything you're not a perfect information processor, so if you're writing orders and you get interrupted you could forget something. So even though you knew the right thing to say if you do it again and again and again it's proven that people are not perfect information processors and they will, in

fact, for whatever reason, they will make errors in applying that knowledge. And so those areas are areas where we really feel that we can apply computer technology and improve the quality of care.

Another just small analogy: Advances in medicine in science, basically, have been based on scientific observations. And so when thermometers became available and people could make thermometers it led to an understanding of the heat in entropy ultimately resulting in the ability to the scientific and theoretical foundations for steam engines, etc. The same kind of thing when people were able to make batteries. They were really able to then understand electricity and understand electromagnetism. And you had Faraday and others, then, that could apply theory, and end up with electric lights and motors and computers. Measurements on the speed of light and other things led to the understanding of the Theory of Relativity both special and general.

And we're just in that situation now. We're in a situation where we need a thermometer for medicine. And for too many years what we've dealt with were compartmentalized paper records systems. And even if the information were computerized, which happens in some of

the most advanced systems, that data was computerized, and the codes inside the computers were actually different, so the data about patient care was either in paper records or if it was computer records it was used in a way that you couldn't transfer it to another person and have that person or computer understand the information that was in the system.

And so if we can take technology now and we can encode and represent the information we need to in the computer system in a consistent, standard way it will make the opportunity for us to see things and understand things about health care and to intervene in health care in ways that will be tremendously beneficial to patients.

So now more specifically to the things that I want to point out today. At Intermountain health Care we have a history of over 30 areas in using information technology to try and improve patient care. And that started with the health system that was created by Dr. Homer Warner and many other collaborators. If the help system was created as a comprehensive hospital information system and from the ground up it was built to support decision, support logic, the execution of protocols, alerts and other kinds of advice and

recommendations to clinicians who are taking care of the patients. We have 13,000-plus users of that system on a yearly basis.

We're in the process of the transitioning from that system to what we call Help 2, of the second generation of Help, which was an enterprise-wide replacement for that, and the technology is different but the intent is identically the same. And in that new system we have 5,000 users in the inpatient environment and we have 2,500 users in the outpatient environment.

But more specifically what I want to talk about is what we do with the Help system. The Help system allows us to do clinical decision support. And what I've listed on the slide are just some of the areas where the system helps clinicians take care of patients better.

So, for instance, in the laboratory area the system watches and every time a laboratory result is resulted in the laboratory it electronically realtime flows, and that result is examined to find out, for instance, whether that lab result has some implication for changes in the patient's medication. So we can watch, for instance, for people who have a low potassium level who are on Dejoxin [Digoxin?] and watch for any of

those kind of errors.

The other kinds of things, there are a number of things we do related to pharmacy. One of them is dose checking. So we can--the system knows the appropriate doses for a given kind of medication, and when orders are entered it says, "Oh, that's an improper dose. That's more than the recommended dose." It can look for drug/food interactions, so that if the patient is eating things or taking a medication that they need to change or watch the foods that they're eating it can suggest that. It does the obvious things like look at drug/drug interactions so that if the patient is on another drug that the drug you're prescribing is going to interfere with it takes care of that.

It looks for duplicate therapy, it looks for allergies, so if the patient has been reported to have an allergy against a class of drugs that are being prescribed it looks at that. It also does things like cost effectiveness things, where it says, "Oh, I see that the patient is now on an oral diet and we're giving them IV antibiotics that, in fact, could be given orally. Let's change the patient from the IV antibiotic to oral antibiotics, save us anywhere from 100- to $500 a day based on that change." So it becomes

progressively smarter.

There are some other things that we do; very specifically, our implementation of protocols. The kind of protocols that we've implemented are things like ventilators protocols. And the ventilator protocol is basically a weaning protocol that steps clinicians through the changes they have to make in oxygen concentration and title volume and all of those other things to move the patient from being on a respirator to being on breathing on their own on room air.

And all of the things that we've listed here, in fact, there are publications that show and describe exactly what was done. And, for instance, in the case of the ventilators, that the most recent one where we've been doing children, they document anywhere from 12 to 24 hours faster in getting the patient off of the ventilator with exactly the same outcome in terms of the patient's capabilities and discharge status.

There are other protocols for pressure ulcers that monitor and suggest when the patient needs to be turned and to prevent the creation of ulcers.

In infectious disease one of the most innovative programs is the Antibiotic Assistant, and the Antibiotic Assistant is a program that was created by

Scott Evans, and what it does is takes information that it's known at the time that you're prescribing antibiotics about what the patient's condition is, what their white count is, what their temperature is, the suggested or suspected site of infection, and then the system has a history that knows, oh, for a person who's 50 years old, community acquired infection, the most likely organism is E. coli or if it's a pneumonia maybe it's a streptococcus or...

And then for each of those organisms it knows that the history for both six months and a year of what the susceptibility pattern is for those most common organisms. And then it knows and understands the costs for each of those antibiotics. And so what's presented to the clinician, basically, it says "Oh, if you put this person on genomyacin and penicillin it'll cover 95 percent of the of the likely bacterial agents and it'll cost you $75 a dose or whatever it is," and then it'll go down and it'll say, Oh, but if you put them on these two antibiotics, put them on Tobramycin and third generation cephalosporin, that'll cover 99 percent of the things but it's now going to cost you $150 a dose or $150 a day. So the clinician can very quickly make an assessment and make the most cost-effective and, in

fact, the most beneficial suggestion to the physician about what medication should be given to the patient.

Another kind of thing that we've done is the adminstration of pre-op antibiotics. And, again, what the system does is watch the surgery schedule. It knows evidence-based medicine from the literature, as reviewed and implemented in programs by clinicians, and says, "Oh, in this kind of surgery you should give this antibiotic and you should give it ideally 30 minutes prior to the incision." And we've automated that so that we went from a rate of achieving that of somewhere in the 30 percentile to over 90 percent of the time now we administer pre-op medications appropriately for the patients. And that has been associated, then, with a dramatic decrease in post-op infections. And then an unexpected benefit of that is that the system also watches and if at 24 hours or 72 hours after the surgery the patient is afebrile and there are no signs of infection then it also discontinues the antibiotic so that you don't have the ongoing expense when people forget to stop a prophylactic antibiotic use.

Again, I could go into more detail, and we can during the discussion, if you want, but that gives you an idea of the kinds of things that we're doing to

the health system.

In the new Help 2 system we're doing active monitoring of anticoagulation status. One of the things that is hard to do is keep on top of all of the patients who are on anticoagulation for--because they either have a heart condition or other conditions. And we'd watch all of those patients now actually, and the system watches that.

Again, we have the pediatric ventilator weaning protocol, we have a number of other programs related to bilirubin management, adverse event reporting, etc., all of which, in fact, improve the quality of care and decrease the cost to the patient.

One of the other things we do is just make information to physicians right as a part of the care process. Associated with the data entry screens and the border entry screens is what we call an info button, and if you click on that info button, you will look at the medication you're ordering and take you immediately to reference information that will tell you what are the indications for use of that medication, what are the proper dosing, what are the possible complications, what are the contraindications, what are the interactions, etc. And this graph is just showing a steady increase in

the use of that kind of information to aid clinicians in making the most cost-effective and most beneficial decision for the physician.

So, again, without going into any further detail, the point that I want to make is that the proper application of information technology can increase the quality of care at the same time decreasing the cost of care, and that's because you reduce--you don't give wrong therapies, you stop therapies at the time that they should be stopped, and you have better outcomes because people are receiving the proper therapy for the illness that they have.

So the recommendations, basically, are that we should continue to invest in research and dependence of health care information systems, EHR or EMR systems, depending on the terminology you're using. We need to add incentives in ways that are appropriate, the cost effective use of electronic health records so that we're getting the base data that we need that is that--if you will, the base thermometer kinds of readings that allows us to understand what's happening within health care, and do that in an automated way so we're not dependent upon manual chart review in order to understand what's happening within medicine, and then fund creation of

standards that allow sharing of data and allow sharing of decision support logic so that the kind of things that are being done at Intermountain Health Care, in fact, we can do everywhere throughout the country and in small hospitals, large hospitals throughout the country.

My last slide just indicates some of the standards that, in fact, are necessary if we're going to achieve what kind of interoperability between systems and really achieve that vision of being able to use the automated computer data to assist in patient care and to provide population-based statistics and other kinds of capabilities that will improve the quality of health care within the U.S. And that's a lot of detail there, but to indicate that the important at least standards that enable that kind of capability.

So I'll stop there.

CHAIRPERSON JOHNSON: Okay. Thank you very much. Should we go to Eric next? Would that be okay with you if we do that, Scott? Thank you.

Eric Pan from Brigham and Women's Hospital in Boston.

DR. PAN: Thank you. Good morning. Can you all hear me okay?

CHAIRPERSON JOHNSON: We can.

DR. PAN: Great. My name is Eric Pan. I'm the associate fellowship director and pena analyst at the Center for Information Technology Leadership or CITL, for short, which is based at Cartis Health Care System in Boston, Massachusetts, where I'm also a internist on the staff of Brigham and Women's Hospital, and I'm on the faculty of Harvard Medical School.

Thank you--I want to first thank you all for this chance to speak with you. I do appreciate being invited to talk to you about important topics. The invitation asked me to be here today to talk to you about the potential cost savings associated with health care information technology, specifically relating to our research on exchange of medical information between health care providers. As this is a topic in which I deeply care about, I'm very excited to discuss.

I believe you've already heard from earlier discussions, including the previous speaker, about how the entire health care environment is under tremendous pressure to address a host of problems, including medication errors, rising costs, inconsistent quality, and unwarranted variation in care, inefficiencies in care delivery, and declining job satisfaction among health care professions. The problems that I think we

all experience is that addressing these issues, while they lead to better health care but seem to be a very complicated, overwhelming process. Thankfully, many of us have found solutions in applying information technology to health care in addressing meeting of those issues. I personally believe that application of health care information technology is central to transforming the health care in this country, and, therefore, I have dedicated my informational life to studying and quantifying how information technology may improve health care delivery.

And we at CITL also believe the application of health care I.T. is critical to our future here at Cartis Health Care System and Harvard Teaching Hospital, and certainly our CEO's number one priority. Studies we have performed here frequently analyze the value of health care I.T. for individual doctors and health care systems at large. In our study of ambulatory computerized provider order entry systems, or actually CPOE, we found that if every clinic in this country adapts that system in our classification with a CPOE system that has the critical support system to it, similar to what the previous speaker discussed, within our electronic health care system, can potentially be

saving $44 billion per year in the United States health care system. These savings are achieved through reducing unnecessary and duplicative ordering of tests and procedures, better medication utilization, and reducing medical errors.

However, what was unsatisfying about that study was that studying each system independently within the clinics would be similar to analyzing the value of the banking system without taking into consideration of how banks exchange financial information and how the ATM lives--or network makes all our lives easier. So, therefore, that study really didn't address the value of which comes from doctors being able to exchange information among their hospices, hospitals, and how the entire system can securely and reliably share information. If that will lead to $44 billion potential savings, it's really an under estimate of what we can potentially achieve. It states every single individual health care provider can easily access and integrate information about their patients and have all the information at their disposal.

Therefore, we proceeded to study the value that arises, focussing on the patient providing encounter. When different clinics and hospitals can

share information among--also with peers, labs, imaging centers, and the public health system. And we titled the study "The Value of Health Care Information Exchange and Interoperability," or HIEI for short.

The HIEI study really refers to what we capture--technologies that enable electronic flow of patient information between various health care settings, including the doctor's office, the hospital, the lab, the pharmacy, the admitting centers, and the public health department that I already discussed. We did not address further exchanges from the patient, for example, between pharmacies and peers, which yield additional savings. And we feel that at this stage in our health care system, while individual organizations are making progress in digitizing their transactions and providing critical information to clinicians within their organization, the electronic exchange of clinical information between different settings is practically nonexistent in our health care environment. Therefore, to model and determine the value in adopting HIEI we added the value of transactions among these stakeholders the key ones in our interpretation in patient care, and we projected value from each transaction and each connection at different levels of sophistication.

The primary finding was that when we, as a society, as a system, move to standardize information exchange it would yield $77.8 billion dollars in annual savings in our U.S. system. Let me repeat that again. By helping our whole system move to standardize exchanges of clinical and administrative information, even when we just focussed on the immediate ring of stakeholders, based around the patient-provider encounter, then the U.S. health system could--would save $77 billion per year. And this is in addition to the savings that arises in the digitization and information within individual organizations such as hospitals and clinics. But we can achieve this high savings only if each of the institutions involved are a modernized information system or a integrated information system internally. And, in addition, we need to abide by a national center, data centers, transmission centers, vocabulary centers, in exchaining--while encapturing and exchanging these health care information.

Again, I would argue that these potential savings that we estimate are conservative because we do not find that rigorous economic studies which we rely on to reflect the potential that we can achieve as a society will improve disease and central surveillance,

bio- terrorism detection and response, improve polled marketing surveillance for new drugs, and the type of dramatic improvement that one can envision for clinical research if we have such an interconnected system. And these are all issues I think of critical importance as we move onto an era with personalized care.

Other key conclusions from our HIEI study include that, first, our study really demonstrated that standardized information exchange provides quicker and more dramatic return than nonstandardized exchange; that is, what is practice around the country today is to provide custom work in connecting various systems as the institutions enter into various relationships. Our analysis show that that is not the solution for the U.S. health care system. In fact, continuing in that fashion is a money loser because of the gigantic amount of custom work that needs to be done to enable to the various systems to communicate, if we do not create and abide by data centers for health care.

Second, we believe that health care providers, that is, physicians and hospital systems, once we have built a system, will achieve annual savings upwards of 30- $30 billion per year once we have full implementation of these systems. Other stakeholders

such as labs, payers, pharmacies, imaging systems, and public health would also benefit from standardized information exchange, although we feel that our analysis is less complete in those areas because we do not investigate additional secondary tranactions from arising vocation encounters.

Since the original U.S. study that I have described to you we have continued to work on assessing the value of information--health care information technology and incomparability. What we have done included assessing the value of incomparability for the Canadian government on both a national and provincial level, assessing the value of incomparability for the state of New York and other states, and collaborating with the Indiana Health Care Information Exchange to project and to actually measure in a working health care environment the value of interoperative abilities; in fact, what we've projected to what's actual experienced by providers. And yet I will emphasize that experience to date suggests that while variation in the patient demographic and the local health care financing environments do affect the relative returns for individual stakeholders and the system as a whole, but overall returns for every single system we now see is

always overwhelmingly positive.

I will conclude my presentation at this time and thank you, again, for letting me present to you. I have to say that I'm very eager to see standards being created and our health care system enter into this era of open communications and full collection of patient information, not just because I'm a physician but also because I see myself both as a patient and user of the system. Thank you very much.

CHAIRPERSON JOHNSON: Thank you. Thank you, Eric. And now down to Scott Williams, if you would.

DR. WILLIAMS: (Slide 1) Thank you. Glad to be here. I think my talk can go fast because some of my slides summarize what Eric just talked about. I thought of changing my bio to say that I'm a son of two 85-year-old parents, because as a health care consumer that's a little more relevant to me right now than my three teenaged sons, although I'm frequently in the emergency room--not that frequently but frequently enough. I'm in kind of the third phase of my career. I started as a pediatrician serving in populations that are traditionally considered under served, urban American Indian children, the children of migrant farm workers and also inner city youth.

And almost all of the time when I was taking care of those kids I didn't have the information about their health that I needed to take good care of them. And so we got very used to just doing the best we could and considering that good enough. But I always knew in the back of my mind that I didn't think it really was good enough.

The second phase of my career was in public health. I served in the Health Department here for 12 years, for the last 18 months as executive director, which included oversight over the Medicaid program. And our efforts directed at many of the issues we dealt with in public health, trying to reduce low birth weight, improve the immunization rate, reduce medical errors or surveillance for bio-terrorism were limited by the lack of timely, accurate, complete data. For example, in the traditional disease reporting process to the department, those reports of infectious disease come in often a week to a week and a half after the diagnosis has been made. So when you think about doing surveillance for bio-terrorism you can see how limiting that would be to have that kind of delay in reporting.

(Slide 2) And now I'm in the third phase of my career, and I work for a company called HealthInsight

which is the Medicare Quality Improvement Organization for Utah and Nevada. One of the things we do is administer the CMS Doctor's Office Quality- Information Technology or DOQ-IT project for Utah and Nevada, which is CMS's effort to add reimbursement incentives for small and medium sized primary care offices to adopt electronic medical records.

At HealthInsight we believe that technology is one of four aspects of transforming health care, the first being transparency, the second being working on leadership and culture change, and the third being aligning incentives for the outcomes we want to achieve, aligning the financing, and then the fourth being technology which we're addressing through DOQ-IT.

I also work with the Utah Health Information Network as the director of the AHRQ-funded development of the Regional Health Information Organization in Utah. Utah Health Information Network, or UHIN, started in the early '90s as part of what was called the CHIN movement or Community Heath Information Network movement, and it's one of the few CHINs that actually succeeded and survived that initiation. UHIN exchanges— or transmits claims and remittance advice between providers and payers, as well as eligibility information

on enrollees, and they're currently bringing up a module to do credentialing for physicians so that all credentialing is done through one portal for hospitals and all health plans. UHIN also provides coordination of benefits information and electronic fund transfers into physician bank accounts. We're using that platform and that background to develop our clinical information data exchange which includes lab, pharmacy, and clinical notes and reports.

(Slide 3) There are several issues related to health information technology that are actively being discussed around the country right now. To UHIN, because of their experience the last 12 years and what made UHIN successful, the most pertinent of these discussions is around the value. "Who benefits from implementing health information technology and who pays for it?" And we divide that into two areas. One is the automation process, which creates efficiencies in the health care system or changing the paper and human processes to electronic processes. And the other one is improving outcomes, which is the transformation process. So there's automation and transformation and the cost-benefit model of those are fairly different, so we need to consider them separately. Once the value is

determined and it's clear who benefits and who's going to pay, that this is a good investment, these other issues (on the slide), tend to fall into place because they're necessary components of making this work.

(Slide 4) I'm going to divide health information technology into three components. The first is electronic Medical Records, which is the idea of having a paperless hospital or office, one of the things I hear a lot from physicians is "Don't give me an electronic medical record that still requires me to maintain a paper record system, because that just adds to my overhead, it doesn't improve my efficiency." The EMR also allows the existence of the personal electronic health record, which you talked a little bit about earlier, this idea that once health records are electronic it's now easier to have the patient participate in their own care because they then have access to their medical record in a much more convenient way.

The second part of health I.T. is Health Information Exchanges, which Eric mentioned, the ability to move health data between providers in different organizations.

And the third one is Clinical Decisions

Support Systems, which Stan talked about, and which Intermountain Health Care has been a pioneer in developing.

(Slide 5) Well, the UHIN experience is that currently UHIN transmits 17 million claims per year, and that's just the claims that go from providers, meaning hospital and physicians' offices, to payers. They all go into a central switch or network router and then they get delivered out to the addresses they're intended to go to, kind of like a post office.

And this electronic data sharing capacity has allowed significant improvements in efficiency in the administrative side of health care. When claims were being processed on paper, an adjudicator could process about 100 to 150 claims a day. Once claims became electronic under EDI, that improved to 700 to 800 hundred claims per day. And then when the information was interpretable by the computer, not just packaged but actually the computer could read the data and make the automatic decisions, 60 percent of the claims no longer required an adjudicator at all. In other words, the computer could tell that this was a claim, move it through the system, and allow it to be paid. So you can start to understand the savings that accrued through the

system.

When paper was being used by the health insurance payers it cost about 6- to $10 just to bring the claim into the system. That didn't include all of the other processing. It's now under a dollar. On the provider side there haven't been the same kind of analyses because this is spread across many more providers. But the belief among providers is that their payments are received faster, they have far fewer rejected claims, and it takes less staff time.

So when UHIN set up its fee structure what they determined, just sort of as a gestalt among the group of the stakeholders, and I'll talk about the governance in a minute, was that about 70 percent of its value would accrue to payers about 30 percent would accrue to providers. So the fee structure is set so the payer pays a click charge, and there's a cap on that of $230,000 a year. So once you get to the large enough volume you pretty much have support of the system at the level that's needed to support your activities.

The providers wanted a more fixed budget that they could predict, and so small providers, single physician offices would pay about $100 a year subscription charge, whereas the large hospitals would

pay as much as $2000 a year subscription charge. And with that financing system UHIN has been able to be self-sufficient, and both providers and payers believe they saved money by subscribing to this network.

(Slide 6) As we look at UHIN and what made it succeed over the last 12 years when many other CHINs didn't succeed, the things that we've come up with is that, number one, it had a champion, that we've had the same chairman of the board for the last 12 years and it's the chairman of the LDS Church's insurance company, which is a self-funded, self-administered plan that doesn't complete with any other plans. He was previously the director of the state health department, so he has broad experience. And he stayed with this project over the last 12 years to make sure it succeeded.

The second principle is that every functionality UNIN has implemented has been based on the agreement among stakeholders that there is value to all participants in moving forward. So there was clear analysis that all of the stakeholders, providers, and payers felt that there was an improvement to them, and that's driven all the priorities as well as the business model in UHIN.

UHIN is governed by a community governing board that governs by consensus. In other words, if one of the stakeholders says, "This is going to create a burden for me," there's a reconvening until it works out that the value accrues to everyone. And then it's standards driven, and there's no secondary uses of the data without complete agreement by the governance board. In other words, if this data is wanted to be used by a public health department or for a community profiling of providers that use would require a consensus of the entire community board. Otherwise, we'd have people disengaging from the system.

(Slide 7) In terms of electronic medical records, the first component of health information technology, a recent CDC study showed that 17 percent of physician offices currently use an electronic medical record. It's higher for hospitals. The two major barriers that HIMMS found when they did their survey last year in adoption of the EMRs was the lack of interoperability of its health information exchange as well the improving the business case, which I just talked about.

(Slide 8) That value proposition is critical to getting people to invest in this kind of technology.

The Massachusetts Medical Society did a survey and also found that the initial capital cost, as well as the time, were the two highest, most frequently cited barriers among 423 physicians for not wanting to adopt an EMR. 85 percent of these physicians felt that EMR's would improve health care but 45 percent of them said that they didn't intend to invest in an EMR at that time.

(Slide 9) The value proposition for physician, the theoretical ones that we believe, are that it improves the efficiency of their documentation processes, it reduces transcription costs for dictating notes, it eliminates of lot of the forms that they have to keep track of, telephone calls, and other processes, but in order for those things to occur it requires the redesign of work flow in the physician's office. If they take an EMR and try to practice the way they've been practicing with a paper chart they may not see the kind of benefits expected.

They have to redesign the way their office works. If they do, they will have lower overhead because they need fewer FTE's and less space, and they have the potential for better reimbursement because they don't drop as many billing codes. The EMR and the

practice management system, if they're connected,can optimize their reimbursement.

(Slide 10) A study that was done recently showed that for physicians investing in an EMR, if you assume that 17 percent of the patients are capitated and 83 percent are fee for services, the mean savings are around $50,000, with the high end being $85,000. The average investment they have to make in year one and year two would be about $22,000 the first year and an ongoing investment of around $5,000 dollars. That results in a return on investment, even in year one, the first major capital investment year, of $28,000 for most physicians and an ongoing return on investment of about $45,000.

The problem with this is that most physicians still don't believe it yet because this is a large investment and they don't see in their reimbursement structure where they're going to get directly reimbursed for this electronic medical record, so they have to go through the business modeling to see where they're going to reduce costs in their overhead and processes.

(Slide 11) This slide shows what happens when you adopt an EMR. This is from Alan Wenner, who

speaks extensively on this subject and illustrates several clinics that he's associated with. When you first have to combine both EMR and paper your costs actually go up for a period of time until you get to the paperless environment, when you actually have lower costs. One clinic that tried this in Wenner's practice actually opted out after a couple of months because they went from a general profitability in their clinic to losing money for two months, and because they didn't redesign their work flow they panicked and got out of the EMR and returned to profitability. This was considered an EMR failure in their system.

(Slide 12) They had another clinic that was losing money as an enterprise. They adopted an EMR, went about redesigning their work flow, stuck with it for the time it took to get rid of the paper and transition over to the electronic, and started seeing a much greater profitability with electronic medical records than they had with the paper. And, in fact, their profitability eventually exceeded that of the clinic that abandoned the EMR.

(Slide 13) Health information exchange, Eric has talked about that. I'm going to skim over these slides a little bit, but it may be helpful for you to

have the information Eric presented to you actually on slides.

(Slide 14) We know from a study in Colorado that in 13 percent of primary care visits there's missing data, and about half the time that data is outside the system that the primary care doctor works in, so it isn't something that you can manage internally with an electronic medical record, you have to get it from some other system. Anywhere from 40 to 50 percent of that time that lack of data adversely affects care or delays care. It's more likely among specific populations, and interestingly this happens less often in rural areas than it does in urban areas, probably because in rural areas there's fewer providers and more data resides in a smaller number of places.

(Slide 15) So what we're trying to do is create a way to move this data around the system economically and efficiently. This is what would happen, this picture on the left, if we all had to create a connection with each other in order it make this work. On the right is the model of what's being called a regional health information organization or RHIO, as I described with UHIN where all this data goes to a central hub and then that hub distributes the data

out to where it needs to go.

(Slide 16) This slide just summarizes the value proposition that Eric talked about if you have machine interpretable data. In other words, the computer can tell what this data element is and can put it with like elements in the record. The slide shows how nationally, you can achieve, after full implementation, $77 billion a year in value value.

(Slide 17) This slide shows where the up-front benefits come from, that is from which components of the health care system, and then what components of the health care system are asked to pay the costs. (Slide 18) And what the Center for Information Technology Leadership found is that providers and payers share equally in the value of participating in health information exchange with a decreasing value going to laboratories, radiology centers, pharmacies, and public health departments.

This is also something that providers I don't think yet quite believe, that they are going to be the economic beneficiaries of participating in the health information exchange. There's a general belief that it's the payers who are going to accrue most of the benefit, and I'll tell you why in just a minute.

(Slide 19) It's hard for most of us to deal in $77 billion figures. At an average community hospital, what this means is they'd have about a $2.7 million up-front investment to create the capacity to connect to and participate in a RHIO, and then about a quarter of a million dollars annually in maintenance and would accrue about a $1.3 million benefit in transactions savings every year from then on, according to the CITL model.

(Slide 20) What we are doing in UHIN is taking this idea and building it on the platform of our administrative data exchange, and then we're doing what we've always done, we're looking at where the value proposition is, we're looking at things like prenatal and newborn records, we're looking at laboratory transactions, we're looking at clinical documents that are required to support the billing claims, and then we're going through our regular process of vetting this through our technology and financial model and then convening standards development and adoption processes.

(Slide 21) Well, the clinical decision support that Stan talked about I'll just touch on briefly. I noticed, in his statement today that Dr. Berwick has increased the potential benefits that can be

realized from clinical decision support from 30 percent to 40 percent of health care costs, so this just keeps going up. But there's a fair amount of spending in the health care system that has been contributing to that outcome, and the ability to capture that is probably dependent on our ability to do what Stan says and to help doctors think and make better decisions.

(Slide 22) Eric talked about the benefits that accrue from ambulatory computerized physician order entry and decision support, and these are some of the studies that have been done that show exactly where those benefits accrue when you give physicians these tools. (Slide 23) They fall into specific categories of reducing errors, reducing redundancy, improving diagnosis and treatment. And among the three elements of information technology that I mentioned you can see that most of the value accrues in the clinical decision support and improving medical knowledge. But you have to have an electronic medical record and health information exchange to really optimize the ability to do clinical decision support.

So what happens is about 50 percent of the cost comes in implementing EMR and health information exchange with only 20 percent of the return, the rest of

the return coming in doing the kinds of things which Stan mentioned.

(Slide 24) This slide shows you the detail on Eric's study that talks about the $44 billion that can be saved if you do this computerized physician order entry just in an outpatient setting. Slide 25 And here's the difference between electronic medical records and health information exchange and clinical decision support.

With computerized physician order entry the vast majority of the savings is captured by the payer, whether that's the employer or the patients themselves or the health insurance company. So physicians, believing that electronic medical records and health information exchange exist primarily to serve clinical decision support are reluctant to have the investment placed on their back when they see this kind of return going to help payers rather than back to them.

(Slide 26) So what could this committee recommend to the federal government? Some of the things in yellow I've listed on this slide are I think being done actively right now by the Office of the National Coordinator for Health Information Technology in Health and Human Services. There's a few things that I think

could be done either more or better. One is to confirm the business value models and have a discussion about how to align the incentive so the investment and the return are more proportionate. The second is to improve the coordination of the implementation of all this among federal agencies. That includes the Veteran's Health System, the Indian Health System, Medicaid, Medicare, CHIP, the Federal Employees Health System. There isn't really a well coordinated strategy among all these health oriented providers in the federal system of approaching this in a uniform way.

And then the last one is if we do save all this money, as is projected, somehow there needs to be incentive for it to be reinvested in improving health care, whether that's expanding access or investing in quality initiatives or whatever, because it easily could get lost in the system or go back into the pockets of the original payers. And some of that probably should occur, but we will lose an opportunity to improve our health care system if all of these savings slowly evaporate away from the health system.

CHAIRPERSON JOHNSON: Well, Stan and Eric and Scott, thank you very much for your insightful comments. In looking at improving quality of care the

Clinton administration recommended and actually implemented an organization called the National Quality Forum to approve the improvement standards for quality measurement. I have two questions regarding what you've just been discussing. The first is do you see a similar kind of a body or do you see the government establishing quality standards, and, secondly, where would you suggest the data be stored, and who should be the owner of the data?

DR. WILLIAMS: Why don't you talk to Stan--Stan's the expert on standards, so I'll let him address that one.

DR. HUFF: There are already initiatives underway to standardize the care, so there's a new committee--the Committee for Systemic Interoperability that is charged with that. And then under Dr. Brayler's office there have been two new RFP's. One RFP is focused very specifically at this issue. The first RFP is asking for basically groups to bid that would form--what it would do, basically, is create a place that was an authoritative standards adoption agency, if you will. And so those, you know, the responses to the RFP has just returned within the last two weeks, in fact, and so that's ongoing work. So that would be--

CHAIRPERSON JOHNSON: That's a a nongovernment body?

DR. HUFF: It would be a nongovernment body that was really regulating government bodies in a sense because what that's made to do, basically, is say that the standards that are adopted are standards that would be used by CMS, by the FDA, by Center for Disease Control, all of the government agencies and departments. It doesn't directly obligate or mandate that Intermountain Health Care or other private or public--all of the public things are obligated but all of the private health care is not obligated. But the thinking is--and I think it's good thinking--is once those are established for the government agencies there's no reason that Intermountain Health Care wouldn't subscribe and follow those same standards, follow the lead of the government in this particular area.

CHAIRPERSON JOHNSON: Okay.

DR. WILLIAMS: Regarding your second question about who should know the data. I put this slide (Slide 15) back up because what this shows in the right side of the slide is that the data flows through the health information exchange but the ownership of the

data remains where it originated, so the UHIN model does not include a central database where the data sits. When the data is needed it can be accessed from its source of origin, but we think it's pretty important that the data stay and be owned by the originator of the data.

CHAIRPERSON JOHNSON: And last, to build on that question, is it, then, regional storage locations for data, do I understand that correctly, or national storage bank?

DR. WILLIAMS: We're not proposing any storage of the data in any sense, in a regional or national warehouse. And most of the other groups that are doing similar things to UHIN in other parts of the country have subscribed to that philosophy. I think this technology creates concern along the public that there's a big database somewhere that has all their health data, and we don't be believe that's a necessary component technologically to make this work. There may be secondary uses of the data where, say, a quality improvement organization or a public health department would get a carbon copy of the data as it flows between me as the physician and Brent, the referring physician. And we may have directed as a provider organization

that any piece of data that includes a communicable disease that needs to be reported would be carbon copied to the Health Department and then they would have that. But that's already legally done on paper. UHIN would not, itself, hold any of the data, it would just help move the data where it needed to be.

DR. JAMES: A quick question I think mostly for Eric but perhaps also for you, Scott. As I read these estimates

(inaudible-not using microphone)

I just want to be clear. As I understand it the $77 billion would be obtained through (inaudible) operational costs with 44 billion on top of that as an additional costs. Is that right Eric?

DR. PAN: Yes.

DR. HUFF: Yes, it is.

DR. JAMES: Now, the other thing--

DR. PAN: Now, you say--excuse me. The 77 billion is largely reducing, if you will, the inefficiencies associated with exchanging and managing information flow along providers and other health care stakeholders, whereas the 44 billion can be characterized as reducing the inefficiencies in our clinical practice.

DR. JAMES: Now, the second part I guess is for you, Stan, especially after listening to Jack Wennberg. My impression is that the 44 billion is for outpatient medicine and there might be a much more extensive opportunity, if I heard that right, than was covered in this particular study, so this is a lower bounds. Is that the right sense of it?

DR. HUFF: Yeah, I would agree. You know, they looked at very specific things that there's a good cost model for. And the kind of things that we're doing, for instance, I don't were considered--there wasn't a clear idea of how you would measure those cost savings for the use of the antibiotic assistant or, you know what is the true cost. I don't think they considered the cost savings for protocol weaning or, you know, a lot of the other things that can be done and should be done.

DR. JAMES: That's what I heard Dr. Pan say, that he thought this really was lower boundary, and I just wondered if I had that right.

DR. PAN: It's definitely a lower balance, in fact. First, obviously, it does not include inpatient, it's clearly a outpatient study, and, second, we were focussing on approaches and strategies that are already being documented in various academic and

industry experiments. There are many other sorts of savings that various leaders have calculated but which were not yet quantified, that we did not include.

MS. MARYLAND: Patricia Maryland. I would like to know a little about outcomes in terms of your experience here at the Intermountain health Care system. One of the greatest contributors of costs to health care is that of inappropriate use of emergency department, and I notice that you have 14 emergent care clinics and you have 22 hospitals that probably all have emergency departments. Have you been able to interface information among the hospitals and the urgent care clinics to be able to track the type of resources that are being consumed by individuals that use the emergency department?

So, for example, if an individual--a patient comes into one of your facilities and a Cat scan is done. What tends to happen is you have some patients who inappropriately use the emergency department, they shop around and they go from one, you know, E.D. to another E.D. Are you able to pull up, for example, to say that this patient within the last week had a CT scan or this particular blood work, and it's not necessary now to redo that?

DR. HUFF: Yes.

MS. MARYLAND: Is that something you're able to do?

DR. HUFF: Yeah. I probably could have shown more detail. The way our record is constituted anywhere that you receive health care with Intermountain Health Care that's made part of our clinical record. So if I go to LDS Hospital here in Salt Lake and McKay-Dee Hospital in Ogden, all of the data, all of the lab data, all of the radiology data, any pathology reports are simply part of that record, and I see that complete record when I'm seen at McKay-Dee Hospital. So it's very obvious.

And, you know, that one side of it is inappropriate care. The other one is gaming of the system. As we installed this system, for instance, it become very apparently--obviously the unusual case, but basically drug abusers who were going to the emergency rooms soliciting narcotics, it became absolutely obvious that, oh, this guy asked two days ago for the same kind of prescription from another one of our facilities. So that's absolutely a part of it.

Now, we could probably capitalize on that more. See, I mean, that's an area where you could

actually apply decision logic again, you know, as another one of those kind of things that you could apply in the future, as well.

DR. WILLIAMS: But even with very simple approaches. In Delaware there's an agreement between the Christiana Hospital System and Blue Cross/Blue Shield of Delaware. They have a data exchange where the emergency room can query the administrative database of Blue Cross to see what services the patient's had. So if the patient's been in for a cardiac workup in the last month and they come in with chest pains they may not repeat that workup because it's already been done. Blue Cross believes that if they can prevent eight chest pain admissions a year they can pay for the whole project. And that's just one type of clinical indication. So even at the very simplest level of getting a little more information you can make those kind of decisions.

CHAIRPERSON JOHNSON: We have time for one more question.

Mike.

MR. O'GRADY: Yeah. I guess if there's--I think I have about three or four questions. I can only ask one.

CHAIRPERSON JOHNSON: I suppose it's going to be a three-part question.

MR. O'GRADY: (Inaudible-not using microphone.) No. I wondered--you had in here in terms of your last--your second to last or last--and I hope (inaudible) I just want to ask you a little follow-up there. You have the idea of confirming the business value and aligning incentives. Now, I get a little about that, and certainly as I go from meeting to meeting (inaudible) and then the actuaries or whoever else, you know, and I'm the loser. Well, this is a confrontation about "I'm thinking about--well, you know, I think it really works and I think it really works well, and I think it really saves money," and, of course, actuaries and other financial backers are going like, "Yeah, right, can you show me some," as an attempt to build a body of evidence. But I guess it's also true in terms of when you talk about align--well, at this point you've talked about enough--a number of studies that have talked about (inaudible) outpatients and different things like that. Presumably what you're setting on the table is, you know, somebody needs to donate this money and, you know, somebody needs to look at the--you know, when you think about where it is to be

(inaudible). Is that a proper interpretation of what you meant?

DR. WILLIAMS: Well, I think if you look at this by--what I was thinking of when I wrote that is that if the federal government pays for 40 to 50 percent of all health care and this slide is accurate that the benefits of ambulatory CPOE accrues to the payer, then it would be helpful if the federal payers would confirm that there's a business value to the payer for investing in ambulatory CPOE and then align the payment incentives to the physicians so that the investment return ratio is more favorable for physicians wanting to jump into this.

And Medicare is doing starting to do this now with DOQ-IT. That's really what DOQ-IT. is about. But the primary purpose of DOQ-IT. , as we sort of break it down to the operational "What are we going to do today and tomorrow," the message from CNS is that what we really want these EMR's for is so that we can get the quality data back into our data warehouse.

There has to be I think a bigger vision about the benefits of this than just "We need this as a data feed into our system." There has to be a recognition of these larger benefits that Eric and Stan have talked about and that all the federal payers are

going to see a benefit, a savings from this. But I think that needs to be confirmed and subscribed to, this notion that Dr. Berwick talked about of "We're going to transform health care. That's a priority in our country." There has to be a belief that these savings exist.

MR. O'GRADY: I guess in inference to Randy's point, you know, when we think about major investments and moving into an area certainly making a business case for it is a very important precursor to some people, especially in the area where you're talking about here where the people who would make at least the first round of investment are not necessarily those who would reap the greatest reward, and that certainly causes a number of business problems with incentives. It also means that a number of the examples you gave were areas where there was this sort of integration, there's either one large plan, one line of employee--some of these different things where we--you know, when you talked about Delaware, you know? A harder market is where we see that we have a really tooth and nail competition between five different health plans that all have, you know, 20 percent market share or, you know, that kind of a thing.

It also strikes me that, in terms of Randy's point about talking about quality form you're almost down to a notion of individual people, citizens notion of what the role of government is, and that what you do have is a situation where the government, both feds and state are in 45 percent or total and the private sector 55. And so what we've had in the past, especially in areas like this, the private sector has certainly moved the standard. They're moving in terms of payment and billing systems and things like that. And the feds come in and say, "Oh, well, that's all well and good but, you know, we're going our own way," and then all of a sudden your providers are going, "How am I paying (inaudible-not using microphone)" and then "How am I paying CNS (inaudible)"?

So I think when we talk about this and think about what the (inaudible) does, that is a model, then, for other areas to think about. It is something where the feds and their state partners are 45 percent of the market here. (Inaudible.) They are a big player and they want to see the statement. At the same time, they can't simply set up their own table if you're going to have this sort of effective (inaudible) in the way you want to go. So I think that is sort of a question. How do

you delicately come to some sort of consensus where you've got both the federal government and private sector. But my friend here to my right, you know, represents a large employer--not today but in other days, and so when you have this sort of "Who's going to make the big investment," you do sort of have the feds standing--you know, "the feds" meaning employers and other carriers out standing at the edge of the pool, and it's, "You jump first," "No, you jump first." (Laughter) And, you know, we can hold hands and we can jump together. But we we can talk about it, but one of the the big gaps there is "Show me (inaudible) investment." Both--you know, we can jump together if we know that this isn't going to be another good idea that we've seen any number of times and it sounds good but we hit whatever (inaudible) budget office says this doesn't save $100 billion in costs, and then we're dead in the water.

I guess there was a question in there somewhere.

DR. WILLIAMS: Yes. (Laughter.)

I would agree with everything you said. We really are relying in Utah on the success we have had on the administrative sides that this is going to succeed

on the clinical side as well. On the administrative side we made a decision early on to participate in the ANSI standard process in X12. At that time CMS, or HCFA as it was then called, was going in different directions. They did come around. X-12 became the standard. We participated actively in that and were able, because we were so engaged, to get standards that met our needs.

And, yes, all of our payers did join hands and jump into the pool. I'd like to say it's because there was just an absolutely hard inarguable business case presented to them, but there was a level of trust and cooperation and that leadership that championed, that really was the final push.

CHAIRPERSON JOHNSON: Unfortunately, we're going have to adjourn this portion of our hearing. My sense is that we have a whole bunch more questions. Unfortunately, we're not able to extend longer. But I'll ask if you would be able to take a few more questions during our lunch break, if you'd be willing to stick around for a couple of minutes in the event that there are those who'd appreciate that.

We are jammed from a time perspective, and our working group has about 40 minutes for lunch right

now. And on the other end of our next panel we're going to have flight schedules, so we want to give appropriate time to the next panel, and so I'd like to ask each of our working group to be back at around 1:12 or 1:13 so we can begin promptly at 1:15.

Okay. Go ahead.

DR. BAUMEISTER: One comment. Everything you've heard this morning in several pieces, they're all talking about the same thing in different ways. We're talking about a set of problems, and these guys are really talking about ways to get these savings, and we're talking about something that's probably on the order of 40 percent of the total cost of health care in this country. I just wanted to make that comment that they're directly tied.

CHAIRPERSON JOHNSON: Okay. (The lunch break was taken.)

CHAIRPERSON JOHNSON: Good afternoon. We'd like to welcome you back this afternoon. We have a couple people who haven't returned yet but we know they're on the way. So rather than delay and then miss part of your discussion we'd like to have it.

And we're pleased this afternoon to have with us Peter Lee, Betsy Gilbertson, and David

Blitzstein. Just in the order of our agenda, Peter Lee comes from the Pacific Business Group on Health, where he's the president and chief executive officer. A long history of working with health care, and he's been instrumental in leading a number of organizations in addition to the Pacific Business Group on Health. And we welcome you, Peter.

Betsy is a director of strategic planning and public policy for the Hotel Employees and Restaurant Employees International Union Welfare Fund. And about a year ago I had an opportunity to hear one of Betsy's colleagues and found that she and her folks who are running that organization are way ahead of most of us, at least in the private sector and the public sector. And we just wanted to make sure that we're able to hear your comments this afternoon.

And then in addition to that, David Blitztein has been director of the United Food and Commercial Workers International, Negotiated Union Benefits Department, since 1990. And, Dave, we're pleased to have you here, as well. Excuse me. Similar to Betsy and Peter, we've heard really innovative things about innovative things that you've been doing, as well.

And after listening this morning, starting

with David Walker, who talked about the condition of the United States financial system and how health care plays a part of that, and then hearing our worldwide quality gurus and our technology colleagues, we're looking forward to what you all have to say this afternoon. What we'd like you to do is take about 12 minutes to 15 minutes, NOT more than 15, but 12 is better, to give a presentation of your material. And we have found that the real rich part of hearing you is the opportunity to ask you questions. When we get to five minutes before the end of our time I'll just put this up and we'll try to conclude, okay?

Peter, since you're first on the agenda and your material is here why don't proceed.

MR. LEE: Great. Randy, thanks very much. It's a real pleasure to join you with some of these these obviously huge talents. A year and a half or so we certainly were starting off late. The (inaudible-microphone not working) today certainly with the quality issues you have--

And now my mike's on.

And now wrapping up your day-to-day in how can purchasers, whether that means private employers, trust funds unions, actually drive better value health

in health care. And that's what I think this panel is going to be shooting to do.

I think you all have copies of my material and you also should have copies of a little booklet which actually describes in concrete terms what some cutting edge private purchases and public purchasers, including calipers are doing. And I'd encourage you to look at this and you can certainly ask questions later. But I will try to heed Randy's advice and keep it under 15 minutes. And I will know when he puts his thing up it's not to be called on but to wrap up pretty soon.

So I may run through some slides quickly to give you the opportunity and questions later. What I'll be doing, though, and you'll see my material, is basically saying the same thing three or four different ways because some people like data, some like charts, some like lots of words. But it's basically about how purchasers can both count value, meaning both quality and efficiency and then they can count giving tools to consumers to make better choices to draw value and actually align incentives, as we talked about this morning, in terms of rewarding providers that are actually doing a better job. That's my basic story. You'll hear it told in 19 different ways.

PBGH, we are a purchaser coalition. Our mission is about improving value in health care. We have a whole range of activities. At the last side is our website. You can go to and find out about the nifty things we do. Now, they are in the whole range. For 15 years we've been doing quality measurements. We started out looking at hospital measurements in California. We have initiatives that look at physician measurement, hospital medical group, etc. But it's about taking that information and making it usable for purchasers in what they buy and consumers and the choices they make. So you'll hear about that again and again.

Who are our members? They're both very large purchasers, national in scope, even though we're anchored in California, so whether it's Bank of American, Chevron, Calipers, University of California. But PBGH also is the parent to a group called Pack Advantage, and Pack Advantage is a small employer purchasing pool based in California through which about 10,000 small businesses with two to 15 employees get their health care. So our view of health care is not just the mega-purchasers but it's also very anchored the real world of small employers that are struggling with do they offer, what do they offer. So that informs what

we do. So we're, on the buy size, large to very small.

I think you've heard this morning from Mr. Walker about cost pressures being a huge driver and had a very good background on what this means on the sort of meta level in terms of the GDP, etc. The thing that I bring from an employer perspective, if you look at these jaws, premiums have come down a little bit this last year, 2004. Estimates are about 11 percent. But the main thing that I call your attention to is the gap in the jaws between what health care costs are and workers' earnings. So workers' earnings have been relatively flat, going down somewhere around two to three percent. That gap is eating away at what real workers' earnings are going to be because employers are generally saying they aren't going so swallow all that difference. So that gap is one that is, again, taking a bite out of, on the one hand, what workers are earning but it's also taking a bite out of what we are as a country in terms of our competitiveness because that difference is something that we're feeling where we're placed in the rest of the country.

Quality, I would not pretend to keep up with Jack Wennberg and Don Berwick in talking about quality issues. You heard all morning about this. I will note,

though, that from an employer perspective they've been seeing over the last, in particular, seven years costs increasing dramatically. They say, as they generally say, "What am I getting for my money? Am I getting a lot better quality care, as we've seen cost increase almost 60 percent over the last three years or four years?" And the short answer is no.

This data is from work done by Ram. This says basically your likelihood, your employees' likelihood, your union members' likelihood of getting the right care at the right time is about a coin toss. About 55 percent of the time our patient's getting the right care, based on evidence, based on guidelines, what they should be getting. And when you look at this, you know, the, quote, unquote "good news" is for breast cancer 75 percent of the time. And that's the good news. Now, think of the flip side of 75 percent. It's 25 percent of the time there's a very common condition that we really know what to do people are not getting the right care.

That's the good news. The bad news is you look down at hip fractures. Hip fractures, only getting the right care to the full range of what people should be having happen to them, when they have hip fractures,

less than a quarter of the time. That is a value disconnect for employers. And so when they look at what they want to be doing they want to be addressing not just the cost side but the quality shortfalls that they're seeing.

So what are employers doing? Well, I'll be the first to admit that generally the average employer is using what are very blunt instruments. They are not saying, "Boy, there's some real quality shortfalls. Let's address those and be sophisticated purchasers." They're saying, "Costs are going up, let's figure out a way to shift them." And that is a blunt instrument and generally not a smart instrument, but it's what the average employer is doing. And so of you look at this range of the vast majority of employers 96 percent are using copayment and coinsurance for office visits and not using that in a way that targets encouraging people to use one office versus another, just shift the costs.

Worker contributions for premium, the vast majority are using that. It's not until you get down to the very bottom of this chart and look at tiered cost sharing for position visits or hospital stays. And tiered cost sharing is saying you're going to pay one thing to go to Dr. X versus another for Dr. Y because of

a value depression. Very few employers are doing that today but more and more are starting to. And that's the issue we look at what employers should be doing, of thinking about value. We're seeing them step up more and more, though it's not where they've been focussing in the past.

So what does "value purchasing" mean? And again, I'm telling the same story in four different ways. Some folks like images. And you hear a lot about consumer driven care. Often when you hear about consumer driven care what that means is it's a high deductible spending account that is a pure cost shift game and nothing else. That's not my vision of consumer driven care. What consumer driven care should be, and I think what for many employers it is, is providing tools that go from your choice of plan from hospital to medical group to physician. And that's a pretty good speedometer. Right now we're giving a little bit over in the health plan world. We give tools to consumers to choose Plan X versus Plan Y. And that's driving five miles an hour. It's not the level of choice that consumers really care about, it's not where where the big differences in the quality of care are. The big differences are at the physian level, at the hospital.

We need to be moving the speedometer up.

If you look at the gas, the gas in the tank to moving the health care system is, first, valid performance information. We need to know how the doctor compares to other doctors, how the hospital compares, but then the gas is benefit design, if you're an employer or a health plan, of how do you encourage consumers to make better choices? The other gas in the tank is provider incentives. Let's not just have dollars thrown across for volume, but let's reward differentially better providers.

So when I think about consumer driven care, again, the consumers are the hands on this wheel. What we as a health care system have to do is provide the gas so they can make a decision.

For those that might not have caught the words this is the same story. You can read back at this. But what does it mean to be an employer making better choices? This first column is about counting value, and this is what many of our members how they structure their purchasing. They say, "We need to count value first of our health plan." Employers do not want to be direct contracting with doctors generally, with hospitals. They look to health plans to the

arrangements. So they start with counting the value of their health plan. "What is my health plan doing to contract better," "What is my health plan doing on disease management," etc. But let's then also count the value of individual providers, provider organizations, "What is my hospitals that are in my network doing," etc., "Let's look at disease management." But counting value isn't enough.

How do we make value count? We provide consumer support by choice tools, we provide benefit design, we supply financial incentives, and we move money for providers, which it provides differential payments providers. That's the structure that we need throughout the system. Whether it's Medicare, whether it's Medicaid, whether it's a private employer, this structure is one that works for value purchasing.

Now, for those that like numbers, what are we trying to look at in terms of some of the savings? And this is data that was done for the business roundtable to look at. If a health plan does their job right what are the savings available? And this is separate from what we heard earlier today, the $70 billion-plus savings from waste and delivery. This is actually doing health promotions right. If done right,

keeping well people well can save, over two years, a employer five percent of premiums. Done wrong you get nothing.

Health disease management, which is for people that have illness, keeping them as well as possible, five percent off premiums. Shared decision making, this is to help people choose if they have a diagnosis of breast cancer what choice to make can actually save resources as well as be better for that patient.

The big dollar piece, here's provider options, is some doctors, some hospitals are more effective. We want to be channeling people to those better providers.

So some like graphs. Okay. So this is, again, different ways to learn the same messages, and this is an actual scatter gram of doctors. Every one of these dots is a doctor. This is from Regent Blue Shield up in the northwest. And it plots on the horizontal axis efficiency. Longitudinal efficiency means the total extent of caring for a person with a condition or a hip replacement, etc. If you go to the right it's more efficient, okay? And efficient doesn't mean the least cost on a per-piece rate, it's the overall care

for that episode. So going right is more efficient. The vertical axis is quality, and in this case it's looking at outcomes and adherence-based medicine, okay?

Today your likelihood of getting care across this mix, throw a dart. That's where you're going to be. Your likelihood of being what I call in the nightmare land of the bottom left of lower quality and low efficiency is as likely as being in the upper right, of high quality and high efficiency. Our challenge as a health care system and what purchasers are increasingly trying to do is to move the system up and right. It's about rewarding physicians and providing them information so they know where they're placed so they want to move up and right. It's giving tools to consumers so they understand when providers are up and right, and so providers themselves will say, "Boy, consumers care about this, I need to move." But it's not about saying, "We're only going to have all the patients go to that upper right quadrant." You do the math, you won't fit. You can't have a solution that says, "Let's have all the patients go to those good doctors, those good hospitals in the upper right-hand quadrant." They can't serve everyone. So or agenda has to be one of quality improvement, has to be one of value improvement

and having provider incentive, consumer incentive that gets the whole system moving up and right.

So the tools we use as purchasers really are very parallel on the consumer side and the provider side. For consumers we want information and tools so consumers can make better choices, which is they can--if they have a diagnosis who do they see, where do they go? Parallel, we want to provide doctors, hospitals, medical groups with the information so they can have quality improvement efforts parallel.

Next tool, for a consumer, and this is--you'll see benefit designs out there that are network ones that are saying, you know, "Okay. You can only go to these doctors." Ties, there is a closed system. In essence, that's a network limit. PPO systems say you can only use a doc. in the system. That's in incentive. It's a closed way to do it, but that's an incentive for a patient on the provider's side, that's a way to channel volume. It's parallel incentives in many ways.

The last one is value pricing and price differentiation. And this can come through tiering, etc., which says to a patient, "We're going to have you spend more money to go to this worst provider on quality

and cost." On the physician's side or the hospital's side we need to upgrade performance. We've got variable rewards based on performance, parallel tracts in concept.

In my next five or so minutes I'm going to run through that gas tank from health plan to hospitals, etc., and give you examples concretely of what some employers are doing in each of those areas, but I do want to start with where health care consumers are generally because I do think that we are nearing a tipping point of consumers using information and absolutely seeking information. This is data from last year, and it asks Americans how much saw quality information and then how many used it.

Okay. Now, I'm going to--health plans--almost a third of Americans if they saw quality information on health plans 13 percent use it, 27 million. Remember, the vast majority of Americans, particularly the small folks don't have a choice of health plans. Larger employers offer multiple plans, but just a lot of Americans seeing information about--and using it about--health plan quality. You go below that, though and I'm going to talk about physicians for a second. One out of ten Americans said

they saw quality information about their physician. One out of 20 Americans said they used it to inform their decision. There's lousy information out there today. I don't know what they're using, and I live in this world. And Dr. James could comment on this, others could. We are at the infancy of giving consumers valid information to make physician choice. They're making choices today based on poor information. One of the things the health system has to do is give them better information because they're out there looking for it, they're using thin information that isn't the right information to identify providers that are in that upper right quadrant. There's a huge demand and that in the end I think is going to be a huge driver of health system improvement.

So if you look at what employers are doing, they start at the health plan level. I know that that's at the low end of the speedometer. There's a lot of tools out there. When someone says, "These tools aren't very good, they're just sort of static report cards," they're getting better. Wells Fargo is one of our members. And what we're doing today is starting where consumers are with, surprise, surprise, is where a lot of employers are. They start with cost. They say, "You're giving me three plan options? What's it going

to cost me," saying not just "What's my premium going to be," "What's my out-of-pocket going to be over a year because I have a chronic condition?" And so this health plan chooser tool starts about with you, describe yourself, say that you've got a chronic condition, you use a lot of meds, then says, "Here's what your likely costs are going to be, including not only your share of premium but what you'll spend out of pocket." But then it takes them to quality. And so it leads people down the path of thinking about quality, where if, instead, we gave every consumer in America the HITA score they're going to go, "Huh?" That's not where consumers start, that once-a-year choice, they start by saying, "What's it going to cost me?" But this engages them in that quality decision.

Another one of our members, the University of California, does something else besides providing a very similar tool. They actually have differential contributions for their employees based on income levels. And this is one of the issues that I think is a challenge before us that we have to face to absolutely head-on. If we have contribution strategies that are the same 20 percent or an X dollar amount regarding of an employee's income it has a very, very different

effect. The University of California says for those people that make over $120,000 their contribution for their premium is going to be about five times people who make about $40,000. Why do this? It means those employees making $40,000 are more apt to stay in the game, they're more apt to make sure their family's in the game in terms of are they going to cover their whole family? If we aren't sensitive to these differences I think it's one of the challenges we're going to have about increasing under insurance.

The other thing I point out on this chart is the different between Health Med and Blue Cross. The University of California sets up a benchmark plan. In this case it's Kaiser, which is the lowest cost plan. But an employee sees the full difference in the cost to UC between Kaiser to Health Med to Blue Cross. It's not a set amount of premium. They say, "If you want to pick this more expensive plan you as an employee pay the full difference," rather than be it a percentage. And those are both value purchasing strategies that I think employees are increasingly looking to.

Let's move beyond plans to hospitals. Again, we're moving up the speedometer a little bit. And remember where that speedometer was on that picture? It

was somewhere over in the health plan world. We've got good tools in the health plan level. At the hospital the good news is there's tools out there. In California--and this is from pushing private employers--virtually every health now has a hospital user tool that their enrollees can use. This is an example of one used by Blue Shield of California. The first thing it says is, if I need to have a hip replacement, can get information for three hospitals in their area, how they rank, looking at volume, mortality, complications. Nice baby steps, but I can tell you we've reviewed these tools in detail and I give them a C minus.

Some of the measures they use are standardized. We're making progress nationally to develop national standards for hospital performance. They don't exist today. Some of the methods used by different vendors shouldn't be used, but it's a step that employees, consumers are looking for tools like this. They want tools, they're acting on these tools. We need to be making we have better performance information, that gas in the tank that gives them good information to make choices.

We've talked about quality. The same issues

apply on efficiency. This is just data to note for Blue Shield the variation of relative costs for eight hospitals in the Bay area. And you'll note Hospital 1 versus Hospital 4, on a risk adjustment basis, costs almost two times as much. When you think about what a Blue Shield does that has tiering, they marry both quality information as well as costs and they're making that show through to employees. Move up the speedometer, medical group, this is a value network that PacifiCare, one of the plans in California, recently swallowed by United, offers. Well, they haven't been swallowed yet, they're in the digestive process, I think as to how you call it in the acquisition world. But what PacifiCare has is, by medical groups, it says, These groups--in this case it picks up and left instead of up and right, but PacifiCare, you know, switched it on us, but, if the quality score is going on the vertical axis the cost, which is "PMPM," lower cost on the left. By having a quality network they have better quality scores and, on average, a network can cost between about five to 15 percent less than having all the groups in the system. That's the sort of benefit design that we we're seeing employers again and again asking for their health care plans to offer.

You're also increasingly seeing this in the physician world. You see most of the large national plans it launches narrow networks--Aetna has these, United has these--where you don't get all the physicians in the network. There may be tiers. And I think you'll be hearing in a moment from Betsy talking about a really spectacular way to run such a program that the United--Union Trust has done in Las Vegas probably--a great model of how to do that right. But you're seeing this done by virtually all of the major commercial health plans.

I want to wrap up with two points on payment. I know that the gas in the tank is performance measurement, consumer tools, employers have talked about their benefits design. Two examples of payment rewards. This first one is in California. Integrated Health Care Association brought together seven of the biggest health plans in California to say We're going to reward the medical groups in California differentially on the same basis for qualify. We're going to have rewards for clinical quality which gets 50 percent out of the way, for patient experience, using the same patient experience survey. So it's not a matter of doing better, it's the same measures.

And also for adoption of I.T. we just heard a wonderful set of panels on how we improve the health care system requires us to invest in I.T.'s in ways we haven't. We need to do that in the business case. This has helped provide the business case. Last year over $50 million in payments on these common methods were paid out by the health plan to the medical group. We've heard again and again and we've had come in and talk to us leaders of medical groups saying, We're investing in I.T. in ways we never were because there's money on the table, there's performance awards for I.T. investments.

Another model is the Bridges to Excellence model, which is actually at the physician level, and this uses NGQA-based recognition programs. There's three out there today, one for Physicians Office Link, and we heard earlier today about the DOS I.T., which is the CMS-based program working that I.T. measures that CMS is working. Many of those measures track directly to the Physician Office Link, where there's been actuarial work to show doctors that have these systems in place, that have clinical information systems, that have patient education support, that have care management actually deliver more cost effective care.

So you have employers in a number of areas

around the country that are saying, If a doc's certified and says they're doing anything we're going to give them an extra $50 PMPY, which is shop talk, "Per Member Per Year," on top of whatever they're getting. And that is payback to that employer because they know that doctor's providing more cost effective care.

Similarly, there's Bridges to Excellence programs for diabetes and for cardiac care. And these are each models where physicians are getting paid on top of what they're getting paid otherwise because they're delivering care, they're showing they have systems of care, that on the actuarial side have been shown to have value, which I think is a good cue off from the discussion we had earlier today about, you know, "How do we align these incentives and what do we do?" There are examples of private employers doing that.

I think I've gone virtually over and Randy's been trying to give me--and not raise his flag. But I look forward to our discussion. I do think the issue of aligning incentives is probably the most central one of actually helping the region and the health care system, and I'm really, for one, thrilled about the work that we're seeing that Medicare is doing as the biggest of purchasers, which I think is going to be the key driver.

So thank you.

CHAIRPERSON JOHNSON: Thank you, Peter.

Betsy.

MS. GILBERTSON: One second here while we do the technical transition.

CHAIRPERSON JOHNSON: Okay.

MS. GILBERTSON: Okay. The first slide is one you've seen before. It was just sort of--this is the best summary of the problem that I'm familiar with, so I'm just going so skip it and keep going here.

What I'm going to talk about is an approach we've tried in Las Vegas which adopts some of the principals about which Peter has just been speaking, but we did it some time ago and we actually have results. So I want to share with you both what we did, how it works, and what the results we got are.

First, I want to start by telling you who we are. We're the Taft Hartley Trust Fund, the Labor and Management Trust--our trust fund is national but in Las Vegas we cover 120,000-plus people, about 50,000 employees and their families. And we have a comprehensive plan of benefits that's fully paid through the trust fund for both workers and their families. There are low copays at the point of service. We cover

the full range of services.

Our total annual medical debt is $235 million. You can see our demographics. We have a very divorce population. They're all in one County in southern Nevada, and it's a very isolated place. We have a physician network of 1800 physicians who we pay on a fee for service basis. It's a contracted network. And as you see the rest of the presentation bear in mind that we are paying all of the physicians in this network in each specialty at exactly the same rate. So what I'm going to talk to you about is the enormous differences in costs are not about differences in price.

What we did was restructure our physician network. When we did this we left out the word "network," so we didn't restructure the physicians, we just restructured the network. (Laughter.)

We profiled all the physicians in the network for efficiency, and we used the efficiency scores as a screening tool. We also profiled all of our physicians for even clinical indicators but profiled for quality.

When we made the decisions about how we were going to restructure the network we did not use the quality information do make those decisions. Instead, we

restructured based on a combination of efficiency, screening, practice patterns geography, language and culture, especially, covering call in the hospital, all those things. And we terminated 50 doctors in 2003. At the same time, for the doctors who remained in the network we created a gold star program. For the primary care doc.'s that rewarded them for clinical performance, and we gave them bonuses of up to ten percent of what they had made in the previous six months we'd been paid in to receive six months from us. That was the maximum bonus any physician could get, and the bonuses were based one quarter on efficiency and three quarters on quality, the bonus amount. And that was all new money. It none of it was from a year ago.

The result is shown here on this graph. You can see that going into 2003 our fiscal year, this is time going across the bottom and the cost per eligible employee, which is the cost for covering a family, along the left-hand axis. You can see that going into 2003 we had a trend of medical expense of 12 percent. And projecting that trend out for the next year, if we had, in fact, incurred the same medical trend, and which was the standard in the market and has continued to be since then--if we had experienced normal trends we would have

had another 12 percent. Our actual present was one percent for the year in which we rolled out this program. And the total savings in that one year were $26 million.

Now, of that savings a portion, and I'll come to that at the end, and was less than a third, actually 28 percent, was attributed to benefit changes we made at the same time. The balance--and we did an actuarial analysis--what we did the actuarial analysis for, the balance was attributed to the effect of having restructured the network.

So I'm going to walk you through how we got there. The traditional way of looking at health care costs, if you're a payer, is in buckets like the ones that are shown here, and we tend to think in these buckets which chop the services--chop health care up into pieces. But that isn't how health care actually happens. If you think about how it actually happens, what happens is a patient has symptoms, they go to a doctor, and the doctor makes a diagnosis, orders tests, perhaps orders prescriptions and creates a plan of care. And the cost of that total plan of care is actually what the payer is going to have to pay. Eighty-five percent of the overall cost of that plan of care for any

patient is driven by decisions the doctor makes.

The first example I'm going to give you to try and illustrate this point is about physician services. We're going to start with what the doctor does in his own or her own office that impacts that cost. And we're going to--I'm going to give you a case that was developed by a local doctor in Las Vegas that it was a typical patient who he would see in his internal medicine practice and then show you three different treatment patterns which he developed for us based on his knowledge of local treatment patterns, and not using any dates. This was just out of his head, applying our fee schedule.

So this is the case. This is mildly ill patient, at least his characterization of this patient was mildly ill, with the symptoms that you see here, You know, taking Advil, very mildly elevated blood pressure, very mildly elevated pulse, respiratory rate was high normal, very low fever, a little wheezing in the lungs. First doctor, Scenario 1, very limited treatment, cost $29. Second scenario, this is a more elaborate treatment, and this is a treatment pattern--a practice pattern for this condition that is currently being practiced widely in Las Vegas currently, you can

see what it is. The third on is extensive agreement. Now, the doctor who did this treatment had a more dyer view of the of the patient's illness and treated it in a much more elaborate way. None of these costs that are shown here include the cost of the prescription drugs that the doctor prescribed during the visit, they just include whatever happened at the visit. And any of these patterns of treatment might be appropriate for any particular patient. The trick is what is the distribution in any given doctor's practice of how they treat a patient like this?

So we're going to look at Dr. A, and in his this is the frequency, what we should be focussing on here. We're going to call this diagnosis viral bronchitis. And in his practice the way he reads that constellation of symptoms, has, you know, this very mild interpretation half the time. He would think the treatment was appropriate 30 percent staff and the extensive 20 percent, for an average cost per patient of $152.

Dr. B is about, you know, in even proportions, and so it's a bit more expensive, 223.

Dr. C has a much different approach, and in his approach two-thirds of the patients with these

symptoms have been treated with the most expensive treatment. And so you can see that the differences are really substantial.

Now let's go back to the doctor and take into account all the different services the doctor orders in addition to those that he or she prescribes herself. And now I'm going to give you examples that are actually taken from our data, and these are live examples, real data from our experience in Las Vegas. The first is the treatment for an ear infection. This is an uncomplicated ear infection. This is a family practice doctor. And remember, every family practice doctor in our panel is being paid at the same rate, so this is not about the price of the doctor's care, it's about what the doctor does. And you can see from the different colors on the graph that there are different proportions of the components of different kinds of things that the doctor did. Red is "physician," blue is "drug," yellow is "hospital inpatient," green is "other," and so forth. So the range was from $46 at the low end to $412 at the high end, and the low and the high are each either individual physicians or groups, small groups, because that's what we have in Las Vegas. We don't have big multi-specialty groups. But the

specialty average is everybody else in the practice. And I shouldn't say "everyone else" but everybody in the specialty treating that condition. So we might have, you know, 30 or 40 doctors in family practice, and so the average is 109 but the high is 412.

Acute bronchitis, another example. I don't know about you. I found this just stunning. The low is 89, the high is 771, and the average, again, this is family practice, this is several dozen physicians, is 150.

Urinary tract infection, the range is from 81 to 778, with an average of 140.

The surgical ranges were not quite as great although they certainly were noticeable, you know, from 2,727 to 9,383. This is for a knee arthroscopy, with an average around 4,400.

So when you roll up that effect what you get is the $26 million we saved at which 28 percent was attributable to something other than the--with benefit changes and other than the physician network restructuring. The rest is the impact not just in what we spent on physicians care but on what we spent for the things that physicians cause to be done. So it was a total of 26 million for the whole pie in the first year,

and then if you'll look at the graph again you'll see we had a $41 million saving against the 12 percent trend even with our trend going up.

We are rolling out version two of this program in this summer. But in the meanwhile we've had an up-trend, although not as high as the 12 percent which has been relatively characteristic of our market. So when you add the 26 and the 41, the savings over two years, it's 67 million.

The other outcomes of this expense, if you will, were that we were able to keep our comprehensive benefits fully paid by the employer for another two years with our same low copays at the point of service. The workers who were covered by the collective bargaining agreement that supports our funds got wage increases in each of the last two years. The average wage in this group is $13 an hour, and they got 55 cents the first year and 60 the second.

Those results were very satisfying to all of us who embarked on this undertaking. It's cost us about $3 million in investments. It took us, because we had never done this before and the tools were not as good as they are now, it took us about three years. And our trustee just struggled quite a bit to endure that

expense and that time before there were savings. But the scale of the savings has redeemed us.

So that's--I told you all the good news. The bad news is that you can only do this where you have a really large data set in a single market. And those kinds of data sets are very hard to come by. The large insurance companies have them. There are isolated circumstances in which other people have them. Medicare has a very rich data set, which if we were able to access it would enable us to replicate this kind of approach in many other geographies. And the public policy takeaway from this exercise, one of them I hope will be the importance of making that data set, which, after all, has been funded with public money, making it available to try to solve a problem that is about to take us down.

Thank you.

CHAIRPERSON JOHNSON: Thank you, Betsy. Very good.

David, next.

MR. BLITZSTEIN: Well, I think my remarks are going to complement the last two speakers and several of the speakers you heard this morning. Let me start by saying on behalf of the United Food and

Commercial Workers I greatly appreciate the opportunity to participate on this panel and share some ideas on how to enhance the U.S. health care system.

Specifically, I want to describe some work that the UFCW is engaged in that focuses on developing a new business model for health insurance plans based on directing employees to quality health providers and more aggressively managing care based on evidence-based medicine.

Before describing this new business model allow me to offer some background. The UFCW and the large organized retail food employers like Albertson's, Apple USA, Croger, and Safeway have nearly 50 years of experience and administering, delivering health benefits through multi-employer health plans. These are collectively bargained, jointly administered plans with an equal number of labor and management trustees governed and regulated under the ERISA, the Employment Retirement Income Security Act and the Labor Management Relations Act. The UFCW and our organized employers sponsored 70 of these plans nationwide, covering an estimated 800,000 fulltime and part-time employees, and paying an estimated $4.8 billion in annual benefits. Through these plans we've gained an intimate knowledge

of the detailed operations and the problems inherent in the U.S. health care system.

Our assessment is the current health plan business model is badly flawed. For decades health plans having been trying to manage the price of care versus actually managing care. Health plans have generally been unsuccessful in managing price for a number of reasons. First, plans are at a competitive disadvantage in price negotiations. Plans don't have the size to effectively negotiate with national and regional managed care companies and pharmacy benefit managers that often cover millions or even tens of millions of lives.

Second, plans are one step removed from the actual health care providers, the physicians and hospitals, and, therefore, are not in a position to influence provider pricing behavior. Plans are dependent on intermediaries like managed care companies to negotiate directly with health providers. In some instances the alignment of interests between the health plan, the managed care company, and the health provider may be conflicted and, in fact, broken.

Finally, the current health plan business model currently only pays lip service to issues of

quality and patient safety. In the final scheme of things quality issues have low or no priority, and employees are left on their own to navigate an increasingly complex health care system.

Influenced by reports like the "Institute of Medicine's" "Crossing the Quality Chasm," and the medical research of your two earlier presenters Dr. Wennberg and Dr. Berwick, we're in the process of considering a new business model for our health plans. This new business model was prioritized directing care to high performance, high quality hospitals and doctors. We would use health information technology and clinical outcome studies to measure the quality standards of these health providers. We further envision that access to health information technology will create stronger links between patient and physician. And, in fact, our goal is to support and strengthen the relationship between patient and doctor.

The new health plan we envision would also prioritize measuring and monitoring the actual health of the plan population. I know that sounds strange, but, frankly, public health standards are generally ignored in the management of health plans.

Plans would conduct data and technology

driven health risk profiling of the plan population to identify high risk and at risk employees. These targeting schools would allow plans to manage interventions in a proactive and aggressive manner, utilizing disease management, large case management, wellness products, and the best interests of plan participants. Participants would be assigned personal health advocates to assist them to successfully utilize these programs.

Finally, plan sponsors would consider benefits and design that would accommodate and facilitate this quality-driven business model.

This new health plan model attempts to challenge three costly myths about the health care system. Most health care users believe their doctor or hospital is infallible and that variation in provider quality doesn't exist. The research that you saw this morning from Dr. Wennberg and others suggest a very different reality.

Complications in mortality rates often vary two to 400 percent, while service fees and averages can vary 50 percent. Plan members also tend to believe that quality is proportional to cost, yet the data and the number of medical resource studies do not support this

contention. Quality is not correlated to higher cost.

And, finally, plan sponsors mistakenly believe that cost savings can only be recognized by reducing administrative expenses and decreasing benefit coverage.

The old health plan business model has effectively ignored groundbreaking research on provider variance based upon quality outcomes. What we are suggest here cannot succeed without the application of sophisticated information technology. The good new is that information technology products that support quality care decisions are now available on the market. Some of the earliest pioneers in this area, like the National Committee for Quality Assurance, the Joint Commission on Accreditation of Health Care Organizations, and the Leapfrog Group have helped set the stage for building this necessary quality outcomes infrastructure.

Most recently Medicare reviewed a website platform to its beneficiaries to assist them in selecting hospitals based on quality criteria. At the same time a number of private sector vendors have created various platforms to assess hospital quality. And several mortgage insurance companies are developing

sophisticated quality profiling of physicians.

An example of quality assessment technology appears on this slide and the next. Some of this information might look somewhat familiar to Peter and others. It demonstrate a search of hospitals within 30 miles of Salt Lake City based on abdominal, hysterectomy surgery, and colon surgery. Colon surgery is on the next slide which I'm about to show you.

The software ranks hospitals based on the number of patient per year that received the surgery. Mortality, complications left the state, and cost. Each category was given an equal weighing to determine a quality ranking. The data is severity assisted to avoid skewing the results for providers that treat more seriously ill people. The results are quite profound and support several assumptions stated earlier about the new base model first, it demonstrates the widespread variation and outcomes in place. The second strongly suggests that higher qualify health care is positively correlated with lower cost. In the case of the of a hysterectomy surgery the cost difference between the top hospital by quality, and the average is 25 percent. The difference between the top hospital and the most expensive hospital was as much as 48 percent.

Similarly for colon surgery. The cost difference between the top hospital and the average hospital was 37 percent. And the difference between the top hospital and the most expensive hospital was 53 percent.

Another important conclusion from studying results like these is that currently most hospitals cannot necessarily function as a first-year hospital for all procedures. A particular hospital may have a high quality cardiac unit on one hand and an inferior orthopedic department on the other. This suggests that the current trend towards tiered hospital networks, PPO networks may fail to deliver the real quality in patient safety to health plans and participants.

Some may question whether plan participants will set direction on health care decisions to the extent anticipated by this new health plan business model. Many of us recall the participant backlash to the aggressive managed care of especially HMO's in the mid-'90s and the demand for a patient bill of rights. But a recent survey conducted by the Center for Health System Change suggested a growing acceptance by employees to limited provider choice if it is perceived as a trade-off for lower out-of-pocket costs. Employees

are merely reacting to economic reality. They can't absorb too much more in health insurance cost shifting.

A study contacted by the National Employee Benefits Consulting Group, the Mercer Company--I think this might be the same study that Peter presented to us earlier--provides further support for the cost savings potential of this new health plan business model. This study suggests that administrative expense and benefit coverage reduction offered a small potential for cost savings for the U.S. health care system. In contrast, the cumulative costs savings anticipated for a more efficient care processing, care management, and use of more efficient providers averages 35 percent net savings over a three-year period with the low savings estimate of 17 percent and a high savings estimate of 48 percent.

There's also a strong business and public policy case to be made for this quality driven health plan business model. Health plans that promote healthier workers and patient safety, they have a direct impact on worker productivity, by reducing absenteeism, worker turnover, and work compensation claims. A healthier workforce could become a critical competitive factor in the face of globalization, enhancing economic growth, and raising workers' standard of living.

There's several actions that government can take to support a quality driven health plan model. We need good health care provider outcomes data. Currently 27 states provide only partial medical procedural data on Medicare patients. Data on all medical procedures needs to become publicly available nation-wide for both Medicare and nonMedicare patients.

In May of this year the Health Information Technology Leadership Panel, sponsored by the Health and Human Services Department, issued its report. The recommendations of this report, many of which were adopted in HR 22-34, titled "The 21st Century Health Information Act," introduced by Representatives Patrick Kennedy of Rhodes Island and Tim Murphy of Pennsylvania would greatly enhance the nation's ability to implement quality driven health plans envisioned by this presentation.

In the senate, Senators Grassley, Enzi, Baucus, and Kennedy introduced similar health information technology bills that past June that would reduce medical costs and eliminate clinical errors.

Finally, government must require more pricing transparency in the health care system consistent with the trend in financial and accounting

transparency throughout the international business community.

Purchases of health care must have access to hospital pricing and pharmacy manufacturing pricing, in order to create some rational competitive balance between the buy and the sell side of health care.

In our estimation the U.S. health care system requires dramatic change in an effort to arrest runaway costs that are directly responsible for expanding the ranks of the uninsured and the underinsured. Our health care system has broad inefficiencies that result in wide variations in quality and costs, an embarrassing record of patient safety. We have suggested a new approach to delivering health benefits through employer sponsored plans. We want to emphasize this model is dependent on a group insurance approach that requires economies of scale and rejects models that rely on individual responsibility.

Employees and their families need an advocate to represent to help them navigate the health system. Health plans need to play that role more than ever before.

Thank you very much.

CHAIRPERSON JOHNSON: Thank you, David. Let

me start with a question, if I might. Betsy, in your discussion you indicated that CMS data made available to you would be very helpful. Dave, I think you came relatively close to saying that, if you didn't. And, Peter, I don't think you addressed it. But, David and Peter, may I ask you to indicate whether or not you agree with Betsy or to what extent you would agree with her in that respect and why.

MR. BLITZSTEIN: Yeah. I think Betsy and I were saying the same thing, and I think it's just critical for plans to concentrate on using this clinical data to assess and profile health care providers.

And one thing that I didn't mention in my presentation because of time, and really didn't come up in any of the presentations today directly is the need to educate the American public, and which in my case union members planned participants. The information that you saw today somehow has to be distilled in such a way that the public can understand it, get a better understanding of how the health care system really works, and why plans have to change in the vernacular that I was using, change their business model to empower workers in their decision making process as they select providers for either a simple physical all the way up to

a very serious surgery.

MR. LEE: Yeah. I strongly support the use of Medicare data with private data. I think the key issue there is we have technical challenges of making sure we measure correctly physician, hospital, meta-group performance. The bigger the end the more we're going to get it right. I agree it would have to be crystal clear we're going to protect patient privacy in every step of the way, but to get the right measures we need more data. Medicare, if not the biggest buyer it's the biggest holder of information. So we absolutely need to have a way to bridge that information to enable valid views of good information.

DR. JAMES: I'd like to get particularly you, Peter, and I'm having trouble with names there--

MR. BLITZSTEIN: David.

DR. JAMES: David. --get you to respond to a couple of ideas. Now, and I mean these actually in a positive way, although it may not seem that way in the middle, because I'm a major supporter of these sorts of approaches. But two real things to lay out. Chapter 8 of the last August report on patient safety reviewed the science behind clinical measurement. One of the main conclusions is that the current data systems we're

using, especially claims cannot, not "they do not" but they scientifically cannot rank activity. Until we have something that's called a "positive predictive value," if you say somebody's very good or somebody's very bad it's about.25 to .4. That means they've misclassified it 60 to 75 percent of the time. There are ways around it. You'll see that in some upcoming reports, specific clinical topics for example, collecting clinical data, really good audit systems, one way around it Kea [phonetic] is probably the best example of doing it right that we have running right not. But we have a real gap there, it seems to me. We always have a history of the template that's failing, fairly spectacular, not once but, oh, ten, 12 times, because the enterprising young academics would take those ranking systems, measure with the precise tool, find out that they didn't do well, and then trash them hard down. And it led to their--okay. I'd just like your reaction to that.

And the number two item, I've seen the data--Peter, this is mostly for you, but I'd like some response from both sides, that patients say that they're interested in data about physicians and hospitals and they say that they've used it, but there's another body of evidence though just responding that they don't,

that--how to say it, medical outcome statistics have almost zero impact on actual choices as evidenced by where they go to receive care. Now, there are three or four parallel bodies of evidence that all point the same direction, so it's not just being serious, but he's evaluating impact of these data on hospital claims, for example, of various sorts. So it would be Mark Chatman with the New York State. With the Pennsylvania experience it would be Fenomyer's [phonetic] work on the mortality studies, for example would be some of the ones that are involved. This is what--it looks like Wennberg's follow-on. As he started to get patient shared patient decision data he discovered two things; that stories were more important than statistics. They had, initially, by the statistics faced outrageous choices and preference insensitive care, and it had no impact, and they went back to people who were in similar circumstances who then told what choice they'd made and why and what was said and how they felt about it. That worked, and that circumstance with the statistics didn't work, you see? The ranking table didn't particularly work. Now, since then they've added another element that matches up again with other bodies of research. You've got an idea that it all depended on relationship.

That people tend to find a personal advocate, establish the relationship and then they believe them. And a few simple words from that old controlling physician, let's say, it might be, or a nurse, overrides all of the reports pretty quickly. So one of the key things they have to do is establish the relationship between someone who is, how to say it, not biased, potentially, so that they have that going in.

So those two big elements, you know, what's your response? I'd just like to get your thoughts or ideas about those two bodies of work.

MR. LEE: I've got both. First, I won't get into a P value discussion but I will note this is first to the question of how good is administrative claims status, is it got enough? And as you know better than I, there's a lot of debate on what is good enough. The biggest point there, though, is that I think that we need to look at distinctions that aren't attempting to be granular of ranking a doctor 38 versus 39 but, you know, in the top half. And that's where you start looking at-- or the top for four tiles [quartiles??]. Then that's where can say administrative data, from what I've seen, can be very effective. And also, by using the data the data will get better.

DR. JAMES: That's true. Let me refine that a bit.

MR. LEE: Okay.

DR. JAMES: One of the things that happened to me on data systems like that is you can game 'em like crazy.

MR. LEE: Oh, gaming is--

DR. JAMES: I'll throw that into your consideration.

MR. LEE: We're going to be here all day. And what it is is I think the issue about gaming is it's an incredibly important issue and it really comes around. Risk adjustment becomes an issue about how do we have, in essence, I mean, we have systems that make sure the doctors or the hospitals don't, in essence, cheat. I mean, some of the concerns in New York were that physicians avoided sicker patients. Now, of course, that's what we call "bad doctoring. " In many ways it's trying to store better. We need systems that adjust value for risk we need to have that be in the system, and have the honest reviews to avoid gaming, absolutely.

But I think the issue about the administrative data is how do we get good information

that's good enough that is value so that it doesn't discriminate more than it really can or should but it's better than driving blind.

On the second issue around what do we know about use, I have actually two responses. The first is--and I hear very often about the "Chasms" work, etc., that consumers don't use the information to choose hospitals. This is reports from Pennsylvania, I believe, as well as New York--that had better risk adjusted outcomes. But why aren't consumers using it? They aren't using it because they aren't given a tool is one response. And I absolutely think it's a key piece. To have something that comes out once a year in a newspaper saying, Here's a hospital's report," and when you get sick you aren't using a tool it's a very different experience. And I'll note that just this last year PBGH piloted in California physician choice tools where consumers that were going to go into a medical group had a choice and were being referred to a pretty good practice site with nine physicians in that practice site. For patients that did not have a prior relationship with a physician, incredibly important point, they didn't know who to choose. We gave them, with working with the doctor that knew this was

happening, scores on patient experience. What patients said their experience was amongst those nine doctors.

Those nine doctors were all over the bell curve. They reported very differently. Patients use that information to choose the doctors.

And the issue about tipping point is you don't need, from my perspective, to have 90 percent of consumers using this information. You get five percent you get the main drivers of change, which is the doctors, looking at it. This is what happens now. That's my second part of my answer. The point of tipping point of consumers isn't a matter of having a huge portion using. The primary consumers of provider performance information is the doctors themselves. I think that's what we're seeing again and again, is that, you know, physicians don't want to be at the bottom of their class either, so...

MS. GILBERTSON: I would just like to respond to the general issue that you raised about the adequacy of the tools for doing these kinds of sorting exercises. I would be the first to agree with you that these tools are not optimal, but I think that whenever we're considering whether or how to use them we have to take into account a balancing concern on another--from

another dimension, which is that there is--there is a very clearly demonstrated cost to uninsurance, and if the effect of the--continuing to do what we do and not trying to measure is that uninsurance increases and continues to increase as it has and we have reduced access to care and more uninsured patients, the result of that is clearly toxic to health. And so when we were faced with struggling through this decision our response was to say we'll use the tools that are there, we will do the best we can to use them in an extremely responsibility way. And we will hope that by virtue of promoting the results we've gotten the market for these tools will get larger and there will be more investment in them and over time they will get better.

CHAIRPERSON JOHNSON: Michael.

MR. O'GRADY: Thank you very much. My first question has to do with--(not using the microphone)--sorry about that. There was a discussion brought up in terms of the way you do things at the Pacific Business Group--it sounded like that you had a fair amount of success--I guess this is a two-parter here--in terms of going through physician groups. It sounds like that was a fairly good way to do it. And it seems to me you had two goals there. Part of it had to

do with health information technology but it seemed that that was a process to get you to a final goal which was what we think of as "pay for performance" or something like that. And I guess my main question is as we try to go to scale as you start to move outside of a particular environment like California, where you tend to have physician groups that are of a concern critical mass, once we start thinking about it, especially rural areas or even that sort of two physicians practice, you know, on the eastern shore of Maryland or something as we go eastward we tend to find less and less of the group practice model. Is it that we're trying to reach something that has to do with getting to "pay for performance"? I mean, I guess what I'm saying is that I can see how I.T. is a very powerful tool if I'm talking 350 doc.'s all sort of working together, but if have two internists in that kind of a practice on the eastern shore of Maryland or along the cape of--you know, is that the way to get to "pay for performance" or is it there's some other tool you do there? You know, you said, no, this is back room to pull all the files on all the diabetics and you find out when they had their hemoglobin A1T. So is that sort of how you think of this--I guess what I heard, and I don't want to put

words in your mouth, was the result is where we want to get to and that help I.T. is a very powerful tool there, but I guess when we think of federal programs you see success, and then the big question is always how do you take that--

MR. LEE: That is a great question, and the real reason I talked about both the IHA, the Integrated Healthcare Association performance model of California and then also the Bridges to Excellence model, which is an east coast model--and the Bridges to Excellence model is about individual doctors, it's about very small practices, and I think the issue from our perspective, "pay for performance" is not an end unto itself. It's a matter of aligning incentives to reward better performance at all levels. And I would expect and my hope is that in 10 years we are doing nothing to reward differential I.T. because everyone has it, and in 10 years we're only rewarding better clinical outcome and processing. Today we need to encourage investments in I.T. so we could have paid performance that doesn't just reward clinical performance but rewards I.T.

And there's absolutely models saying, "What do you as a one-person office have in place," is, you know, whether you're in a 40-person office or one-person

office you will be relying only on paper to know who all your diabetics are. That's not good medicine. And so "pay for performance" absolutely is buildable to scale today in terms of what are some of the standards that a physician office link is one of the models that's going around to small offices.

MR. O'GRADY: One last thing, because it's come up a number of times, too, is that in terms of the sharing Medicare data, in terms of the sort of--and Randy is setting me up a little bit on this one--the feds certainly have every interest in doing that, especially this came up with implementation of Medicare drug bill and some of the changes there, where we're trying to encourage regional PTO's and some of these other things. And so if you're asking clients to move into new areas one of the real empirical bases is here, "Well, what's your claim history in that new market that I don't currently have anyone in?" Our understanding is that the Privacy Act kind of set the standard for--in terms of privacy--the privacy of the doc.'s keeps [claims?]--and the sharing it to the level that we feel really we can do at this point. Otherwise, you'd have to think about changing that relationship. And people just tend to be more sensitive about information the

government holds on people than they tend to be about private entities.

MR. BLITZSTEIN: Yeah. We really didn't have a chance to touch on this, but you know, the privacy laws were embedded in HIPAA and were implemented over the last several years, which is a federal statute. And I think it's an example of an over regulation, where the costs of implementing the privacy provisions of HIPAA on plans probably was in the billions of dollars, and that came out of money that should have been spent on benefits, not on administrative expenses.

I've been a trustee of a plan of some level of health plan for over 20 years. I have never given up private information on claims that I've looked at, and yet now we have to put up a series of Chinese walls and we have to hire a consultant, and we just created an employment act for a whole new industry. But these are things that need to be looked at because we're sending money on things that we truly don't need to spend money on.

CHAIRPERSON JOHNSON: Richard.

MR. FRANK: We've been talking a lot of high tech. I want to go low tech for a minute and I want to tell you about my mother's dentist and get you to react.

(Laughter.) My mother's dentist has an Apple 2 Plus in his office. He's an elderly gentleman, and I don't know, I think he just plays games on it. But, anyway, every month when my mother goes in for her dental--or every year when she goes in for her dental checkup as she leaves out--as she leaves the office the receptionist says, "Would you write your name and address on this index card," and then she puts it into this accordion folder for that month. And then six months later my mother gets this card saying, "It's time for your new appointment," and that's how she keeps track. Now, my physician has an electronic medical record and somehow cannot manage to do that. (Laughter.) And so I think it's got something to do with things other than technology, and the design of work and what matters to a practice and values, and I'd just like to kind of see how do we intend those things? I think the key point of that is when we talk about providing incentives I.T. can be instrumental. What we want to be rewarding is better performance, which is we want to be rewarding that move to the primary care, is that diabetic getting regular checkups that they should be getting, or the dental, are they getting the checkup? But we think--instead of just measuring the I.T. system

for that dentist, is it an appropriate measurement of does he or she provide, you know, every six months, reminders to come in? You can measure that. And so the issue of I.T. is a means to an end, I don't think so, that in the end health care is too complex to say even the best intentions smart people can do it all in their heads or on index cards. So I think that to, I mean, I guess the point it is about working redesign, it is about all those pieces, but without I.T. I have another example--whether it's on the pad or otherwise, they can't know what's going on. There's too many changes. So I want those I.T. systems in place but I think they need clinical reminders.

MR. BLITZSTEIN: My question is not about the value of I.T.--

MR. FRANK: That's what--but it is more than that. (Multiple voices.) It's the ultimate performance that we should be looking at, as well.

CHAIRPERSON JOHNSON: Other questions?

Montye.

MS. CONLAN: Mr. Blitzstein, I was interested in you mentioned about the personal health advocate. Who are these people? How do they interact with the participants, and do the participants actually

make use of them?

MR. BLITZSTEIN: There are--it's a growing village industry of vendors out there. Typically they're staffed with a combination of health care professionals and nurses. And they work case by case and they work actively with the patient and help the patient manage their care and manage their care situation.

I've had very little experience with them, but from what I've seen, and from the referrals I've received they can be very effective, and it's something that people like. You know, I don't know if you've had the experience, most likely you have, where you need information and you're frustrated in the system because you can't find the right person to talk to. These people take on that responsibility and make sure that the participant gets an answer to a question that's important to them.

MR. LEE: If I could, increasingly we're seeing large employers, even if they're negotiating with health plans, still fulfill their expectations. "I want to know what's the ratio of health advocates." So their job is not to be a gate keeper but a gate opener for all of the employees that we've got. Bank of America, when they deal with their plan, says, "Okay, tell me how you

are going to have someone with this job description." This is data noted. Is it the job is for people at this level, help them get through that care management? But even for lower level issues I can't figure out, you know, what this formula means. So that the level of engagement depends on what the issues are. But that assistance with navigation at different levels is a key need that I absolutely relate as part of having that new breakthrough health plan that we all need.

CHAIRPERSON JOHNSON: Any other comments?

Well, Peter and Dave and Betsy, we're appreciative of your coming this afternoon and sharing your thoughts. We would invite you to stay a few minutes after, if you have the time, to chat on individual questions that our working group might have. But I think we're going to move to the next point in our agenda, and so we'll thank you very much.

MR. LEE: Thanks very much and good luck in your proceedings.

CHAIRPERSON JOHNSON: Okay. Thank you.

We'd like to acknowledge--Senator Hatch is entering our room. And, Senator Hatch, I didn't know if you'd have an opportunity to join us. Sit down right here, if you would.

SENATOR HATCH: Well, first I'll say hello to all of you.

(Shakes hands with all panel members).

CHAIRPERSON JOHNSON: If I might, I might just take a moment to say a few comments, if I might, Senator Hatch. I'm sure people in this room know, more than even we do, that you're the senior senator from Utah, and you've been the leader in health care for many, many years. I can remember years ago when I was living in Michigan when you were active in health care, and I've followed that all throughout a significant part of your career. And as a working group we want to thank you for cosponsoring the legislation that's resulted in the Citizens' Health Care Working Group.

In addition to all of that, you've been a gentleman as you've represented Utah and represented others in the United States as well. And, in fact, the person from the other side of the aisle said of Senator Hatch, "He's a sweet man." So that is very positive. And we welcome you this afternoon and we'll look forward to any comments you have.

SENATOR HATCH: Well, thank you, Randy. I appreciate that, and I appreciate what you're doing. You know, when Senator Wyden and I decided to do this

together we had real qualms about whether this was going to work or not, but we decided that it will work because of good people like you. We wanted a working group of people who could listen to the real people out there who really have the problems. And I was very happy to hear the latter part of this program and realized that you're discussing some very, very interesting and important aspects of health care.

And, you know, everywhere I go in Utah or the rest of the country I'm finding that some of the major issues of today involve health care. People are worried about whether they can afford insurance, employers are worried about whether they can continue to provide insurance. I remember four or five years ago I had dinner with the chairman of the board and CEO of IBM. That probably was seven or eight years ago, and he was complaining because they were paying $5-7,000 a year for health insurance for each one of their employees. And he just flat out said, he said, "If it goes up any more we're just going to give them the $7,000 and tell them to go find it themselves." Now, fortunately that hasn't happened at IBM, as far as I know, but we're now well over $1,000 in many places and going up every day, and it's one of the fastest rising aspects of our

economic lives, and many, many people are unable to afford health care; and even if they could, it isn't available to them in some areas. So these are very, very important issues that you're dealing with.

I'm really pleased that we have Brent James on this group. He is without peer in his specialty. He understands health care as much as anybody in the world. And I think a lot of you will observe his abilities. He's nonpartisan, he is not going to advocate things on a partisan basis. And I think you will find that you can invest in his expertise. But I would say the same about each of you. This is a terrific panel. Senator Wyden and I are tremendously impressed. And I think when I've chatted with you back there at NIH I basically said, "Don't pay any attention to Wyden or me. We want you to do the job. We want you to pay attention to the people out there."

Yes, I've had a lot of experience in health care. You can take some advantage of that experience when we talk about some of the things that have made a real difference in cutting costs of health care that I specifically was working on. I raised the issue of orphan drugs way early in my Senate service. I decided that these population groups that had diseases that

affected a population list of less than 200,000 people had nobody trying to help them with some critical therapies, and the reason was because it cost so much to do a pharmaceutical drug. It takes up to 15 years and almost a billion dollars to come up with a drug - 6,000 research misses to be able to do that. And you just can't afford to do it for the population groups of people who have diseases that comprise less than 200,000 people. And so we decided to try an experiment, and we came up with a Hatch bill called the "Orphan Drug Bill." It only cost 14 million bucks, as I recall, back then. It provided some economic incentives, some tax incentives, and it gave prestige and it also gave special patent treatment. Almost immediately pharmaceutical companies started to do orphan drugs. Today there are over 300 of them. And some of them are drugs that are just tremendously beneficial to those population groups.

But they also found that if they could benefit a population group of less than 200,000 people sometimes these drugs have extrapolated benefits that became blockbuster drugs. So they have benefited tremendously from the Orphan Drug Bill.

And we gave them some patent term

exclusivity. Now, sometimes that's what we have to do. We're now facing that with Bioshield II. That's the Hatch-Lieberman Bill or Lieberman-Hatch Bill, where we're going to try and give incentives so that these pharmaceutical companies will get involved. And that includes these unlitigation incentives so that they can't be sued during certain periods of time while they're trying to come up with drugs that will help us during these days of terrorism.

The Hatch-Waxman Act created a modern generic drug industry. That bill has saved at least $10 billion every year since 1984, and some say it's much more today annually. What that told us is that we have to match the two interests. And the only reason I'm telling you this is not to say you've got a good senator; but that you can, by thinking about these types of things, realize that there are free-market, free-enterprise, decent political ways that you can give incentives that will make things work much better and get people to cooperate and participate.

Regarding Hatch-Waxman, Congress gave the pharmaceutical companies, which were losing 15 years of patent life, the ability to recoup some of the money that they spent to develop their drugs. Fifteen years

is not very much time. So the companies wanted patent term extensions because of the slow approval process of the FDA. And, of course, the generics wanted to be able to market drugs right off patent and borrow the patents of the pharma companies; whereas before, they could do their own generic drug but they'd have to do all the research again themselves and most of them couldn't afford to do it. In fact, none of them really could except for one of two of the large companies that might have had a generic component. And so on the one hand we wanted patent term expiration, on the other hand we wanted drug price competition. And that's what happened. We blended the two together, and it's been considered one of the greatest incentive bills in history.

Now, the reason I'm telling you these things is because that led to another thing. And see, not only do we have to worry about legislation, but you have to worry about physical plants, you have to worry about incentives that work, you have to worry about a lot of things that might help alleviate the pressures on the health care system.

And let me give you another reason. Because of that we came up with what was called the FDA

Revitalization Act. And we passed that. The FDA Revitalization Act addressed the fact that the FDA existed in about 50 different locations just in the greater Washington area, not counting in each state. So the supervisors spent all their time traveling between these various locations. It was very inefficient and didn't work well. Now, we did that around 1989 or 1990, I can't remember the exact date. It would have cost $1 billion to do that central campus with a state of the art building, state of the art equipment, and they just started it just a few years back. I've been there for both dedications-- we dedicated the first building in late 2003; and just a little over a week ago, with the Secretary of Health and Human Services, we dedicated the second huge building.

Now, the reason we wanted to do that is because it would make it more efficient. We ought to be able to cut down unnecessary process at times so that the employment companies that are spending all these monies to develop these very important drugs could do so in a more reasonable, more cost efficient manner, etc.

That's an example of one of the bills, but there have been dozens of Hatch bills on health care that are working very well. And I just mention these

because these are bills that save money but also work.

And I would suggest to you as you travel around that you listen to people, and you will want to find ways of saving money as well as making the system not just cost efficient but actually medically efficient, also.

Let me just mention one other bill. It was a grand and massive, difficult thing for do. And that was the Children's Health Insurance Program, the CHIP Bill. It's now called SCHIP. Now, when we did that bill nobody thought we would succeed. We had one governor in the whole country that supported the original bill that we wrote. Now, the original bill was too much - too liberal, there's no question about that, - it would cost a bit more, but we had to do that to get the liberal groups to come along. But I always told my partner that in this bill, it wasn't going to be in that form, it was going to be in a much more efficient form. He'd say, "Oh, yeah, yeah, yeah." He didn't think we could get it done. But he would use me to say that "Republicans don't care about health care--Orrin does but the rest of the Republicans don't." And that's what he would do.

Well, I won't go through the whole thing, but it was a miracle how we got that bill through

Congress right at the last minute. And that bill, oddly enough--now I want to inspire you--that bill became the glue that passed the first balanced budget in over 40 years. The Democrats didn't want to vote for a balanced budget and some of the Republicans didn't want to vote for CHIP. Some were very hesitant. And when we blended the two, the Democrats had to vote for the balanced budget and the Republicans had to vote for CHIP. One of the leading Republicans--I was standing there during the vote, and he came up to me, looked me in the eyes--and we had great mutual respect--and he said, "Orrin, I hate this bill," (laughter) and then he voted "Aye." It tickled me to death. I'll never forget that. Today he claims it's his bill, and it is, because he voted for it. The fact of the matter is I don't care who gets the credit and I don't think you should, either. What you should care about is that you have a responsibility and an opportunity that no one in the history of health care has had. I think what you've got to do is do what's right. And sometimes doing what's right means conservation and freedoms and being careful with money and making sure things work efficiently; and sometimes it means compassion, wherein we develop safe drugs. These are really important problems that would not

otherwise be solved without this group.

Now, the purpose of this group, of course, is to do what you're doing here: to take information, study it, work it through your minds, work it through your discussions, and try to come up with recommendations for the Congress that Senator Wyden and I and many others will try and push through Congress. We'll have to see what you come up with. And I can tell you now, if it's too far left it isn't going to make it and if it's too far right it isn't going to make it. Why don't we forget left and right and just do what will work and what is really best? And that includes the best of both sides. It includes the compassion that I think both sides have but Democrats claim they have more than the Republicans. I don't believe that for a minute. I'm the one that's helped put these bills through, and they're highly compassionate bills, you see?

And then it also means being tough about your money and tough about how programs work, and being tough with the bureaucracy. You just heard a couple of remarks about bureaucracy today. And I thought your question was a very, very pertinent one. If we are going to go on-line, we'd better make sure it works.

Now, I had a friend who was building the first digital hospital in the world, before Health South went south. But I wanted to get that done because I felt that would possibly show efficiencies that would not have been seen up to now. Brent James works with one of the most efficient, effective health care systems in the world, and one reason for that is Brent James. You can learn a lot from him. But each one of you we can learn a lot from. And I don't mean to pick on him, but he's my constituent. I just want you all to know that. (Laughter.)

But let me just say this, I believe that what you have is one of the most important opportunities that any group has had in the history of the country. There are 44 million people in this country who have no health care. Now, some of those choose not to have it. They could pay for it; they just feel like they're indestructible. They're generally young people. But most of them simply can't afford it.

A lot of businesses are going out of the health care business and out of health insurance. They can't afford it. The largest companies are complaining about it. On top of that we have pension problems galore now, and we have all kinds of other pressures on

business that make it very difficult. We've become so high-tech in the field of medicine and science of health care that the costs are astronomical. My wife and, by the way, we wouldn't want to be without them. We're having debates about drug reimportation, which FDA says we can't do because we don't have enough money in the world to protect the American public from bringing in drugs that are dangerous. And it's silly because as you walk up today it's so easy to do anything to cheat. And yet the price of pharmaceuticals is very high and the large companies are continually being blamed. The generic companies, of course, want those large companies' drugs to go off-patent so that they can get these drugs into generic form quicker. However, without the large pharmaceutical companies spending that billion dollars and employing the 6,000 staff for drug research, there wouldn't be any drugs available for the generic companies to put on the market.

It's amazing how this system works. It's amazing what incentives do in these systems that government is concerned about.

Well, I just wanted to say to you that I don't know of anybody that I'm depending upon more than you folks right here to help us in Washington, and to

help the people in our state governments as well, to understand the problems of health care and come up with some of the solutions that will help us to get everybody health care. Your jobs are very, very important. And I, for one, can hardly wait until this process is through and see what you come up with.

On the left you want total universal health care. In all the time that I've known Senator Kennedy, and that's now 30 years, he has never once said, "Where are we going to get the money?" "How do we pay for this?" On the other hand, we want to make sure that we get our people health care, at least the basic health care. And I've had some people on my side of the fence who only think about the bottom line. And, see, both sides can be too extreme. There's no question that. We've got to come up with solutions here. And it is our hope that you can, through the series of town hall meetings that you will be holding, that you might be able to pick up enough real important information, coupled with incentives, and coupled with intelligence, which might help us to do a better job in Washington. That's what we're hoping.

And I, for one, want to congratulate and thank each of you because you're taking time from your

businesses and schedules; and your employers have allowed you to do this, they recognize the importance of this, as well. Some of you are top experts who are giving personally of your time. And this just means everything to me. So I just want you all to know how much I appreciate you.

And if you have any questions of me I'd be happy to take them.

CHAIRPERSON JOHNSON: Any questions?

SENATOR HATCH: And, again, don't pay any attention to Wyden (laughter) and don't pay any attention to me, either. Forget us.

CHAIRPERSON JOHNSON: Any questions for Senator Hatch, comments?

MS. CONLAN: I just wanted to thank you. I inject a daily drug that was produced as a result of the Orphan Drug Law. And for many MS patients like myself those drugs provide some hope. There is no cure but at least it helps to modify of my disease. I want to thank you very much.

SENATOR HATCH: Well, thank you. It's been my pleasure to help. As you know, I'm strongly in favor of embryonic stem cell research. I'm strongly in favor of adult stem cell research, of blood research and

embryonic stem cell research. I'm here to tell you that the Cord Blood Bill--the Hatch Cord Blood Bill, will have a House number on it because they've done a lot of work on it, too. However, the Senate added some necessary changes to the legislation. We changed it and we pre-conferenced it with the House. Now, there aren't many bills in the history of this country that have been pre-conferenced before they even come up on the Floor. That bill is going to pass. One of the leading core blood researchers in the world is Joanne Kirkberg down at Duke. I want to steal her for the Huntsman Cancer Institute and the University of Utah. I wish I could pull her out, (laughter) because we have some of the greatest geneticists in the world there. But she's had amazing transplantation successes, especially for African-Americans. That would never have happened but for cord blood research.

Embryonic stem cell research is farther off, and the top Nobel laureates and others who've talked to me about it, and I've seen 43 of them so far, will tell you that it's going to take upwards of 20 years, but we need to start now.

And it's been a tremendous political battle in Washington. I was hopeful that the Senate would

reconsider this issue. Is this boring you?

MS. MARYLAND: No. (Laughter.)

SENATOR HATCH: The Majority Leader of the Senate is trying. We have six bills. The first one would be the Castle-DeGette Bill, which I'm very strongly in favor of. It's also in the Senate, introduced by Senator Specter, myself, and others. And that bill, of course, would utilize the upwards of 400,000 eggs in fertilization and vitro fertilization clinics, with the consent of the donors, for the purpose of embryonic stem cell research. These eggs are going to be discarded anyway. Why would we do that without trying to help, because those children who have violent diabetes that make them lose their eyesight, their fingers, arms, and legs, why don't we do everything in our power to help? I've often said that being pro life is caring for the living, as well.

Now, these are monumental issues with very sincere people on both sides. We're having a rough time getting unanimous consent, because if we brought up embryonic stem cell research alone there would be there would be hundreds of them. Even if we got closer, and I think we get closer, we're possibly over 60 votes in favor of this bill, but some of the theory behind having

several bills on the floor at the same time is to draw away votes for the Castle-DeGette Bill. I'm willing to continue to fight for stem cell research and do what we can. Now, that is not to say that I don't recognize the sincerity of others.

But thank you for your kind comments. I believe we can make a lot of headway. Thirty years ago, having a knee replacement was a pretty tough thing to get done. My wife had one here last November, and it's a brutal operation and it's very expensive; but I was actually blown-away by how scientifically important it was and what a tremendous thing it was. And I hadn't known very many people who had total knee replacements, but after that it seemed like everybody I met had one. (Laughter.)

But, then again, think at the cost, it's astronomic. And that's something you've got to be concerned about.

Anybody else? Go ahead.

MS. MARYLAND: Senator Hatch, Pat Maryland. I want to tell you I really appreciate you coming today. It's wonderful to have you end on a note of hope for us. We've spent the whole day talking about the chasm between how much is currently being invested in health

care and what the outcomes are, and it's been sort of an overwhelming day in terms of the type of information, including issues in and challenges facing us. And to hear you talk is--and to look at what you've been able to achieve thus far and providing leadership into health care greatly appreciated. So thank you very much for coming today.

SENATOR HATCH: Well, you're so nice to say that. We just arrived this morning and now we're going to fly back tomorrow because I'm on the Energy Conference and I'm the author of the Tar Sands and Oil Shale Bill. We have the Saudi Arabia oil here in Utah and eastern Colorado and southern Wyoming. There's more oil in tar sands and oil shales than there is in all of the Middle East. People don't realize that. And I'm the author of the Geothermal Language, I'm the author of the Clear Act, which would create incentives for alternative fuel creation, alternative fuels, and alternative fuel stations. I'm also the author of a whole host of other very important bills that are extremely important for my state but also for this country as a whole.

And last but not least, one of our biggest problems is one that may involve health care, and that is they want to dump 4,000 casks of nuclear waste above

ground on concrete pads right on the tip of the Utah Test and Training Range where we fly F-16's and the F-35, the strike fighter, with live ammunition, where we've had 70 crashes. (Laughter.) And I just want you to know that I'm working to try and solve that problem. I may just be able to make some headway on that, even, in this. We'll just see. But there are other bills there, as well that are extremely important to the country as a whole, so I've got to go back and try and get all this done.

But I am so proud that you're here in Utah and I'm so proud that you're taking this time. And I hope that you're being treated very well and I'm sure you will be and are. But I'm so proud of all of you and I am so proud of your dedication.

And, Randy, for you to take this amount of time off, and Catherine, and all of you, to be able to take this time off, and your companies and businesses and employers to assist in that is really very, very important. And I intend to see that people in this country understand that there's a great deal of care.

Brent has to--IHC is supporting him in this, and, of course, each one of you can name the people who are helping you to fulfill these obligations. And I

just want to thank everybody concerned, again; it's in your court. You don't have to pay attention to anybody. Senator Wyden is so enthused about this he's going to be all over you all the time, and you have to say, "Senator Wyden get away. Senator Hatch says I don't have to listen to you." (Laughter.) And we didn't listen to him, either. He is a very energetic, good person, and really wants to do a good job. And if he could, he'd be sitting here at every meeting with you, I know that. But we don't want that to happen, either. If you'll notice, most of my remarks are not what you should do but what might be inspirational things that you can do. I haven't asked you to do anything so far other than be the best you can and do the best you can.

VICE CHAIR McLAUGHLIN: I wanted to echo one more--also appreciation for the optimism because we--most of us here have not participated in a political process before. We haven't tried to get legislation through. We've never tried to design legislation. We haven't worked for senators and seen the making of a sausage. And I think sometimes we are--

SENATOR HATCH: Thank goodness. You might get really bogged down by--

VICE CHAIR McLAUGHLIN: I-- exactly. But I

think that we actually do want to listen to you and Senator Wyden and other experts periodically, because yesterday we started talking about this exciting adventure, and I think that's how we all feel about this, going out to the meetings I think we're all chomping at the bit and we want to get out there. And we're, you know, being cautioned, "Well, you don't want to do this and you don't want to do that and you have to be cautious about this," and so I actually think we would like to hear from you again and in future, if you have time--

SENATOR HATCH: Well, thank--

VICE CHAIR McLAUGHLIN: --to give us some advice because we know that this is a political issue, we know that even though we aren't focusing on it, that's not our role, that's not what our expertise is or what we're trying to do, it's always sort of back there like a cloud.

SENATOR HATCH: It needs to be because if you don't take political concerns into your concerns and you just live in esoteric work you're probably not going to come up with anything that's going to work. I mean, it's--you have to take that into consideration. It has to be practical. It can't just be, like I say, esoteric

work, it's got to be practical.

But I believe you're going to find the more you meet with people the more practical you're going to get, too, and you're going to start to get mad about some of these things, and I think that's good, too.

CHAIRPERSON JOHNSON: We started our day with David Walker, who appointed us--

SENATOR HATCH: Isn't he great?

CHAIRPERSON JOHNSON: A very dynamic message.

SENATOR HATCH: Yeah.

CHAIRPERSON JOHNSON: And we end, for the most part, our formal hearing in meeting with you, and we're just delighted, as Catherine's already pointed out. When David appointed the working group he was looking for a diverse group, and we think we have that. What I mentioned to him this morning I'll also share with you. We have a very committed group, very energetic and I think it's really striving to do what can be the best to--as you and Senator Wyden pointed out, to make health care work for all Americans. So we'll continue on that and thank you very much.

SENATOR HATCH: Well, God bless all of you and thanks for all you're doing.

CHAIRPERSON JOHNSON: Okay. Thanks very much.

For the working group, we just have an administrative matter to take care of, so if you can give us three more minutes and then we'll be done.

Thank you.

CHAIRPERSON JOHNSON: Okay. The formal meeting is adjourned and I've just got an administrative matter, if we could, and we'll do that in 60 seconds.

(The hearing was adjourned at 3:15 p.m.)

CHAIRPERSON JOHNSON: One of the things that several of us have had conversations on, including Dotty, who chairs our Communications Committee, and Catherine, and George and I, is the consideration of an invitation from Frank and some desires that many of us have had actually since the working group was formed, to meet in Oregon to have what we're going to call a "press event," a "media event," but it will be also an opportunity for us as a working group to listen to what folks have done in Oregon, to listen to their public. Over the many years Oregon has had a program in place in which they have dialogue with their public, and we have some lessons that we can learn from that. So we have scheduled a meeting to be held in Oregon that will be

basically a day and a meeting. It will start on Monday--or on the Wednesday the 22nd in the morning with--and this is tentative [multiple voices]--September, I'm--thank you. It will start in the morning of September 22nd. And this is a tentative schedule but we'll try to work out the details, with this media event, in which we'll be listening to Oregon residents and leaders talk about their listening experience.

In the afternoon we will have either a group of committee meetings, I hope simultaneously, or a working group meeting. And then in the morning of the 23rd, if we've had committee meetings on the 22nd in the afternoon--let me get my calendar out.

VICE CHAIR McLAUGHLIN: It's Wednesday the 21st and Thursday the 22nd.

CHAIRPERSON JOHNSON: Okay. In the (multiple voices) we're going to meet on the 21st, in the morning, in the media event, the 21st in the afternoon or either committees or the full working group. And then in the morning of the 22nd if we have met in committees on the 21st we'll meet as a full working group. And if we've met in the full working group on the 21st we'll meet as a full committee on the

morning of the 22nd and schedule the afternoon for travel time.

So that would be the agenda, tentatively. And let me--before we just say, "That's the way it is," let me ask you for any input or observations or questions that you'd have regarding that. And, Frank, let me ask you to be the first to share any thoughts you have with our working group before we open it up to others.

DR. BAUMEISTER: I believe the timing is ideal. I believe that we're prepared to do it.

CHAIRPERSON JOHNSON: Okay. Go ahead.

VICE CHAIR McLAUGHLIN: I was going to say, also, I think now that I'm looking at this, I thought the timing was ideal, in part because the community meetings had started. And as I was listening to Senator Hatch I started to learn more about how we're going to go out there. And as I also looked at the calendar I guess I think we're going to be in Oregon when autumn comes in, so I think that's pretty good timing, too, you know? The mountains in Oregon, we'll be able to enjoy those.

CHAIRPERSON JOHNSON: Now, one last thing. If--unless anybody else has comments, there is an Oregon

Health Care Forum that's the day before, and Frank has indicated that he will see if he can get invitations to that forum for us to attend. There's a fee for the forum, and, of course, if you're to come an extra day earlier that would be a--what should I say--an extra night of lodging, and the lodging and the personal time we believe should not be charged to the working group or to the government. So you're potentially welcome to come, but you would not be able to be paid for an extra day of meeting time, and we would not be able to cover the extra lodging expense of that extra day. So that's--you're welcome to come, I believe. Frank will work with us to get that invitation, but, in fact, it's not part of our meeting. That meeting is on the 20th, and it's just--it just happens to be held coincidentally the day before.

Yeah.

MS. HUGHES: So if you have a four-hour flight, you--X number of hours flight to get into Portland, and we have lodging that night, it's not charged to the committee.

CHAIRPERSON JOHNSON: No. What I meant to say, it's not an extra night of lodging just to attend that meeting. So if you're to attend that meeting you'd

end up having to come in Monday with your four-hour flight.

MS. HUGHES: Okay. Thank you.

CHAIRPERSON JOHNSON: Thank you.

I think we have some who are catching a taxi, so we'll take a few other comments and then we're going to adjourn.

MS. WRIGHT: I just have one question. I know that we originally Oregon was one of our (inaudible-not using microphone).

CHAIRPERSON JOHNSON: We are actually having conversations regarding where our next meeting would be and we'll work on a calender with you, but we're looking at the possibility of an announcement in lunch in early October. We're trying to look at October 6th or 7th, but we have to think through those dates and we were trying to work Senators Wyden and Hatch. We're meeting in Washington, D.C.

Do you have more on that, George?

GEORGE GROB: Only to the extent Senator Wyden (inaudible-not using microphone.)

CHAIRPERSON JOHNSON: Yeah. And then we're also thinking after a meeting about a month later, Chris. Potentially we're going to investigate Indiana as

the place to hold that, and we'll share more information as we are able to think through the timing of these.

So thank you very much for your time the last two days. We appreciate it.

(The Citizens' Health Care Work Group meeting was concluded at 3:20 p.m.)