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MANAGING THE DELIVERY OF HEALTH CARE TO CONTROL MEDICAL COSTS

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1. Organizational and marketing strategies for health care delivery systems.
2. Current and future trends in medical care delivery.
3. Rate strategies and selection issues.
4. Benefit plan design and flexibility.
5. Regulation.

MR. HARRY SUTTON: This morning we have two very excellent speakers from different sides of the health care management spectrum to talk about management to control health care costs.

Our first speaker this morning will be Wayne Alberts, M.D. Wayne is the Medical Director of Kaiser Georgetown in Washington, D.C. He is also a member of the board of directors at two of the other regional Kaiser plans in Texas and Connecticut. Wayne is a surgeon by trade. But, in listening to him, I think you will find that he is a medical care manager. He would like to talk to you about Kaiser's philosophy, the management of medical services, and what directions Kaiser is likely to take in the next few years.

DR. WAYNE ALBERTS: I'd like to talk to you about Health Maintenance Organizations (HMOs) in general, and, in particular, the Kaiser Foundation Health Plan, or, as some of you may call it, the Kaiser program. My discussion will be relative only to group prepayment programs; not IPAs, not PPOs, or anything like that. They are really hybrids, and I won't discuss those. As you are all aware, prepaid medical care programs differ from indemnity plans quite considerably. I would like to just quickly review the basic factors that differentiate the two forms of health care coverage.

First of all, HMOs present an organized system of health care delivery. I stress organized system. Despite being one of the largest businesses in this country, medical care has never been systematically delivered in any organized way. To this day, it remains a classic cottage industry with no real organization. For this reason, I believe it is very costly and inefficient. This disorganized system has been allowed to persist, primarily for two reasons: (1) It seems to represent an altruistic goal of helping human beings, and (2) because of this society's faith in technologies.

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The second characteristic of an HMO is that it provides or arranges for the provision of medical care. In doing this, we provide a comprehensive set of hospital, medical, surgical, pharmaceutical, laboratory services, or other benefits. Rather than just acting as a conduit for the money, we actually arrange for, provide, and control the services. That conduit of money that the indemnity plans provide has an increasing pressure and the money goes out faster and faster. We see it as our job to control that. In addition, the services are provided to a voluntarily enrolled population, and HMOs do it for a fixed monthly fee.

What about Kaiser as an HMO? As succinctly as possible, I will try to outline the organizational structure of Kaiser Permanente. The organizational structure is very important to our management goal of controlling medical care costs. There are nine separate geographic regions: California, Hawaii, Oregon, and Washington on the West coast, plus Denver, Colorado, Dallas, Texas, Cleveland, Ohio, Washington, D.C. and Hartford, Connecticut. In each one of these divisions, there is a health plan. In each one, there is a separate and independent Permanente group of physicians. Together, these two groups form the Kaiser program in each region. The independent medical groups contract with the health plan divisions to provide all the professional physician services. Whether they provide it or arrange for the provision of it, we contract for it with the health plan. In several regions, we also provide additional services by contract to the health plan. In each of these regions, the regional manager and medical director bear the responsibility for the management of their region. We do have a central organization for staff facilities on the West coast, but each region is autonomous in that it must generate its own capital and have its own income. From an historical perspective, our original operation started in California in the 1930's to serve those Kaiser industrial workers in the steel, aluminum, cement, and ship building divisions. After World War II, the program of prepaid medical care was made available to the general public and has been existent in the same philosophical form since shortly after World War II. For many years, the base of operations of Kaiser was limited to California, Oregon, and Hawaii. Therefore, I think that's why we are sort of looked at as a parochial West coast phenomenon.

Recently, we have changed. At this point, there is absolutely no connection between Kaiser aluminum or steel and Kaiser Foundation Health Plan. The only possible connection is that occasionally some of their employees belong to the health plan. In the late 1960's, the program added the Denver, Colorado, and Cleveland, Ohio, areas to its operations. For over a decade, no expansion occurred, and to some of us that's rather strange. We don't know why we waited ten years. Then, in 1980, Washington, D.C. was added, followed rapidly by Dallas, Texas, in 1981, and Hartford, Connecticut, in 1982. These expansions have made Kaiser a more national organization, and we are now just short of 4 1/2 million members nationwide. Many people have asked me and have asked the organization, are we in an expansion mode? I don't think we have made any secret of the fact that we are indeed looking to expand to a more nationwide presence. Within the next several months, we will announce our next expansion to another geographic region and intend to expand to a minimum of three additional geographic regions in the next several years. Much of our recent expansion have been strongly encouraged by those large nationwide employers seeking to make our program available to their employees on a wider basis. Many of our employer groups feel that we limit their exposure to health care costs and have been very encouraging in giving assistance and giving us a built-in member base when we go to a new region.

I'd like to have a little time to go deeper into the organizational structure of Kaiser Permanente and give you a few more historical highlights, but time really doesn't permit that. Instead, what I'd like to do is highlight our long standing organizational beliefs relative to HMOs, and evaluate their validity in the face of the rapidly changing health care business, and in view of the more recent experiences we've had in our newer Kaiser Permanente regions.

There is one tenet that is absolutely immutable throughout our entire organization: We provide one thing; we provide high quality medical care at a reasonable price. I'll come back to that later. One of the other tenets of our organization has been prepayment. A simple, virtually all-encompassing, fee for all services is prepaid monthly by our members. We have very few copayments, very few deductibles at this time. I'll go into our changing philosophies because of the changing marketplace, later.

Another one of our tenets that we will not ever abandon is one of dual choice; each individual electing to be a member in our program joins voluntarily. They have a choice of another relatively comparable program open to them. In this way, no one is forced to be a Kaiser member; they do have an alternative.

Another of our guiding principles is that of group practice, and you all know what that is. But the next one is probably one of the critical areas. That is the partnership between medicine and management. We also refer to that as physician involvement in all aspects of the program. This is really critical to our being. Although independent corporations, the medical groups must agree to virtually every facet of the operation of Kaiser Foundation Health Plan. They must agree to membership forecasts, building programs, capital generation programs, benefit levels, and indeed, literally every aspect of the operations must have physician involvement and concurrence. When one recognizes the power of physicians in the medical system of this country, anything else is absurd. After all, physicians, and I'm one of them, are the only ones who can practice medicine, admit to hospitals, order medications, and all the other things that we do. There is some move to change that, to allow physicians assistants and nurse practitioners greater latitude. But I think that those are going to have a short life because of the certified physicians coming up. The physicians are going to be more and more protective of their turf. So, our guiding principle is that without physician buy-in, any medical care system is in trouble. In Kaiser Permanente, physician participation is an absolute must and I think one of the reasons for our success.

I said I'd get back to high quality medical care. That is our absolute. We will never do anything to injure that. But the second part of high quality medical care is at a reasonable price. But what is a reasonable price? With medical care being 10% of the gross national product, it is getting pretty hard to define reasonable, and reasonable to whom? The employee member, or the employer? In our society, where health benefits are often employer-paid or highly employer-paid, each considers reasonable in a very different light. The Kaiser Permanente program is cognizant that in the future, we must reduce costs for both the employee and the employer; not absolutely, of course, but relative to other medical care programs, we will. I think the reason for that is that we have an organized system to do it. It is evident to us that employers are attempting to lower their costs by imposing higher copayments and deductibles on their employees, thus forcing them to bear an additional share of the cost. This would seem to be somewhat contradictory

to another one of our tenets, comprehensive benefits, which is one of the mandated conditions in the HMO law. Within the spirit and intent of the HMO law, which limits copayments and deductibles somewhat, we at Kaiser Permanente feel we can adjust our benefit package copayments and deductibles to flourish in this competitive market.

It is obviously the role of our actuaries to apportion the probabilities and adjust the premiums and copayments to continue our fiscal security in the changing world of health care coverage. But there are many scenarios in which we can remain highly competitive in the face of the proliferation of low premium plans with high deductibles, or cafeteria-style plans with widely varying benefits. In the preceding session, Harry mentioned the Xerox plan. We think that we will do extremely well with those sort of plans. We think that the public has come to accept health care as an absolute necessity, and that basic full coverage is an absolute necessity. We think its going to be very hard to change the public from that notion.

One of the other things we've always done that the actuaries look at very carefully is community rating. This has been, and remains, our policy at this time. However, we have evaluated the option of community rating by class, but have not yet elected to use this. I think when we talk about community rating, or HMO rates, it's a good time to bring up the question of skimming. For years, Kaiser and HMOs have been purported to have primarily the healthy in the community as members, thereby gaining a favorable selection. Anecdotally, as a practicing physician, I can categorically state that my patients are just as sick as anybody's. Either that, or I make them as sick as anybody's! However, as a manager of a medical care group, speaking to the Society of Actuaries, I think I need a little better evidence than my own personal observations. I know of absolutely no study that substantiates the claim that Kaiser, a long-standing HMO, enjoys a healthier population. In contrast, our own studies show that we have a slightly adverse selection of members measured by several different categories. If they are measured by their own assessments of their health, they think they're sicker than those covered by indemnity carriers. All my comparisons are only with indemnity carriers, not with the unemployed, not with the Medicaid population, or anything like that. If what has been claimed is true, and we do have a more favorable selection in HMOs than in a comparable population outside HMOs, why is that? The typical reasons cited by everyone, and probably all here today, are that sick people have established relationships with physicians that they do not wish to leave, or that the sick are not as well employed as HMO members, and group coverage is less available to them. Those are the two most popular reasons. The reason rarely cited is that HMOs are made healthier by their membership in prepaid groups. If we could prove that, we would have everybody in the world belonging to Kaiser Foundation Health Plan! But unfortunately, we can't show that, either. We think we have a very equal group.

There are several things that are on the other side of the fence that would lead us to believe that we have somewhat of a sicker group. Because our benefit package is so much more comprehensive, we could indeed attract a much more adverse selection. But our actual data has lead us to some conclusions. When measured by restricted activity days per year, which is the measure that we use for both acute and chronic illnesses, our membership appears to be about 10% sicker than the members covered by indemnity plans. Now when we look at those individuals with chronic limitations of activity, meaning chronic illnesses, we again show that our members in Kaiser have a slightly higher morbidity than those comparable individuals with indemnity

insurance. I really think that you can show that those members who go into HMOs initially probably are favorably selected. But I think that favorable selection ends very early, and it is foolish to base rates on a one-year experience.

One of the other tenets is integrated facilities and services. We sort of abandoned this really, and I'll tell you why. Traditionally, Kaiser Foundation Health Plan operated integrated facilities, with hospital and physician offices in common buildings or common grounds. This allowed us to accomplish efficiencies in the joint utilization of all those services that are utilized by both offices and hospitals (laboratory facilities, X-ray facilities, pathology departments, pharmaceutical units, physical therapy, custodial services). We gained a great advantage on those carriers who were paying for care that was delivered in an office and then delivered in the hospital separately. Our recent experiences in our new regions, where we don't own or operate hospitals, has encouraged us that we don't have to do this. This is no longer one of our guiding principles that is an immutable business strategy. In Washington, Dallas, Denver, and, most recently, Hartford, we have found we can effectively operate while purchasing hospital services. As each of you are very well aware, these areas have a surfeit of hospital beds. Our ability to contract with hospitals for our patients leads us to favorable cost arrangements, both for us and the hospitals. Obviously, we get reduced fees; we're not making any secret of that. The advantages to the hospital is that our guaranteed utilization of that hospital allows them to reduce their average dollar bed costs by increasing their efficiencies through increased occupancy rates.

I wouldn't want to leave you with the thought that we would like to operate without our own hospitals, because the main disadvantage to us is our lack of total control of all factors. Some of those factors that we cannot control when we don't own and operate our own hospital are the same type cost problems that the indemnity insurers are dealing with all the time. For example, hospitals' exclusive contracts with subspecialty groups like anesthesiologists or radiologists prevent us from internalizing these services. In Washington, we have 110,000 members and our current cost for anesthesiology per year is about $1,600,000. If we internalized it with our own physicians, we know we could do it for just under $400,000. That's where the money goes. They also require us to use their laboratories (they tack on a fee that is more than the cost to do the studies) and their x-rays. In my opinion, we operate hospitals far more efficiently ourselves and less expensively than others. We are also not under the pressure that other hospital managements find themselves. We do not find it necessary in our hospital systems to duplicate very costly subspecialty equipment found in adjacent hospitals, such as CAT scanners and nuclear magnetic resonators that cost $1,500,000 or $1,800,000 each, and we don't have to duplicate neonatology units, all just to cater to physician staff demands to compete in those technology wars between hospitals. How many of you know about hospitals directly across the street from one another, maintaining parallel services that are both inefficiently utilized and underutilized? Kaiser Permanente is an organized system in which physician managers are involved in all the decisions, and plans can be made to centralize services on a rational basis rather than to keep up with the "St. Elsewhere" mentalities you see at other hospitals that are not in an organized system. Again, all you have to do is think about your own city or your own home where there is one hospital right across the street from another. All the hospitals get together, it seems like. They all are built in the same area; they all have parallel services; terribly inefficient.

The real answer relative to our owning or contracting with hospitals is that in the last several years, we have found that we can operate an HMO successfully in either mode and be very successful at it from a capital generation standpoint. As Kaiser Foundation Health Plan, we are a non-profit 501(C)(3), and, therefore, we don't have profits, we have capital generation. This has considerably widened our future opportunities for expansion, as I am sure you are aware, because hospital construction or purchases require considerable capital expenditures. Now that we know we don't have to make those to still be profitable and viable in the competitive atmosphere, we feel we can go to many other areas.

Harry has asked me to comment on my thoughts as to the minimum size at which an HMO could be profitable and comment a little bit on the investment necessary. I think, despite what Harry said in the opening session about things selling at 150 times earnings, investor-owned HMOs, if you feel that its ethical and proper to make money in that way, could be very successful. For many years, Kaiser operated only mega-HMOs. Northern California has over 1,800,000 members; Southern California has almost 1,750,000 members. All of our other regions had over 100,000 members, so it was very difficult for us in Kaiser Permanente to say how small you could get before you could be profitable.

With our geographic expansion to Washington, we found we could operate a 55,000 member health plan spread over five small, widely-separated centers quite favorably. Our ability to generate capital at this size was very gratifying. We had never thought we could operate successfully at that size in our organization. Then, in 1982, we acquired our ninth region in Hartford, Connecticut. We were expecting a relatively prolonged period of negative financial results because of our small membership of just over 15,000 people in the Connecticut region. Surprisingly, but to our great pleasure, the Connecticut region became consistently profitable in its operations within months. Again, I use the term profitable to mean that it generates capital. Both those Washington and Connecticut regions were sustaining major operational losses upon our assuming responsibility for their operation. The only factors that were changed that brought about profitability were management, and an organized system that rapidly introduced the most basic business principles like productivity standards, utilization reviews, staffing ratios, and rational contracts for outside services. Nothing with whistles and bells; just things that you ordinarily ought to do in a business.

Our experience shows us we can generate capital at 15,000 members. My personal opinion is that with proper management controls, the minimum size for capital generation could be well below 15,000. This, of course, assumes that you're going to lease for a while rather than purchase your structures and that you have favorable contracts. You have to have an area that has a lot of doctors. You have to have an area that has excess beds so you can go out and contract. But there are not many areas that do not have too many doctors and too many beds right now.

I think I better bring this to a conclusion. How do we save the payors money on their health care? There is little secret that our hospitalization rate per 1,000 per year is substantially lower than the rate in the fee for service system. I think it is because we do not have the incentive to hospitalize. If you look at most office visits for internists and pediatricians, you find they are loss leaders to get people in the hospital, where you really make money

as a physician. We don't have that incentive. Our physicians are basically salaried with some incentive programs. They don't have the incentive to hospitalize. We utilize outpatient services more effectively. No matter how you look at it, when corrected for any age/sex distribution, we hospitalize at a rate of about 70% of that of a cohort population served by fee for service physicians. At current hospitalization costs, it certainly does not take an actuary to know that we are saving a lot of dollars. I must emphasize once again that we never deny appropriate, necessary care to members to accomplish this reduced hospitalization rate. There is no study in existence that can show any deficiency in Kaiser HMO care to members. The American Medical Association states, "To the extent that various factors used in quality assessment have been used to measure care for HMO enrollees and for comparable fee to service population, the medical care delivered by HMOs appears to be of a generally high quality. Nothing in the literature indicates that HMO savings result from enrollees receiving less care then they need." That is from our best friends at the AMA. Of a total of 27 separate studies undertaken in a somewhat biased journal, The Group Health Journal, 19 found that the general quality of health care was superior in HMOs and none found that it was inferior.

Obviously, we are more efficient because we have those integrated facilities and because of other things. I don't think we make any money at all on office care because of that one other thing I haven't mentioned, preventive services. I think our office care may be slightly more costly than in the fee for service area. Our preventive services, we feel, save us money in the long run. But right up front, I do not think they do.

The final question and bottom line to you as actuaries is will the prepaid practice system force competition within the existing system that will result in changes in the cost of the health care delivery system? The answer you have is yes and no. HMOs, particularly Kaiser, definitively lower the total medical cost to members. A family in our plan knows that its costs for all medical care for a year will be $2,000. Will it lower the cost for employers? I really don't know. It depends on what percentage of that the employers pay. Will it lower the cost generally? I think there are some unusual facets that I ought to just quickly mention, and I'm running out of time here. If we as HMOs take a segment of the general employer group population and reduce total care costs for those workers that come into the HMO, we may inadvertently increase the cost for other workers for a short period of time. In doing so, we may increase the cost to the employer. The reason for this is not that we are skimming the good risks and leaving the bad risks to the indemnity carriers.

Let me try to illustrate a possible cause for this. As you are all aware, physicians account for, or more accurately are responsible for, 75% to 80% of all medical care expenditures. Although we don't get that percentage of the money, our actions in hospitalizing, prescribing, referring, x-raying, and testing account for those expenditures. And, as I mentioned earlier, physicians, by law, are the only ones who can do all those things. With the current over supply of physicians, and the impending enormous oversupply of doctors, we see an interesting paradox in Washington, where we have gained 55,000 members in just a little over 18 months. We take all these people out of the population, leaving a smaller population that are not our members for the physicians to deal with. Rather than the law of supply and demand taking place, we see a paradox of M.D. fees increasing. We are all aware that doctors leave their training and have an expectation of substantial income. Despite declining volumes of patients seen, operations done, and procedures accomplished, per

physician, we see an increase in unit price to preserve the expected standard of income among those physicians. In fact, the Federal Government has noted in print that the Washington community is currently adequately served by physicians. Each new physician that enters practice in that community adds $300,000 a year to the community's medical costs, without serving a single need that was not previously met. So, the net result is the same if an HMO removes a large number of patients from a closed population decreasing the patient/physician ratio. The individual procedure cost for those outside the HMO rises rapidly. You see it in the next year's experience rating with the indemnity carriers, and there is increasing indication and evidence that physician-induced utilization increases as the physician surplus grows.

The challenge in the 80's remains finding a mechanism to contain costs. I have already run over, and I'll stop here. But I think HMOs represent a remarkable opportunity to control the costs because we have the organized system.

MR. SUTTON: Our next speaker is Glen Wegner, who is a Vice President of The Health Data Institute. Previously, he was Corporate Medical Director of Boise-Cascade where he managed the health care and insurance coverages in 40 different states and countries for their 30,000 employees and dependents. Earlier, Glen served on the White House staff and was Deputy Assistant Secretary for Health Legislation at the Department of Health, Education, and Welfare. He also had experience serving as the head of a statewide PSRO. In addition to corporate health care cost control, he is also interested in environmental health and medical legal programs. He is a pediatrician and, interestingly enough, an attorney. Glen would like to talk to you about his activities at HDI.

(Dr. Wegner's talk was an extemporaneous condensation of what is normally a three-hour presentation. His remarks relied upon a large number of slides, many of which were proprietary in nature. For these reasons, it was not possible to produce a transcript of his portion of the program.

In general terms, Dr. Wegner's presentation focused on the appropriateness of health care: How can you get hospitals, doctors, employers, and employees to change their behavior and use only truly necessary medical services? He described the research that his firm has carried out and the software programs that they have developed to collect and analyze the information needed to understand and control the behavior of health care providers.)

MR. SUTTON: After listening to Wayne talk about Kaiser's organized system and looking at the complex problems of getting data, let me ask Glen a question: Isn't it just easier to organize an HMO and not worry about all that?

DR. WEGNER: It certainly is in certain areas. I should mention in four states that's going pretty well, and we endorse that as well as preferred provider organizations (PPO). I think this PPO thing is going to go even more quickly than the HMO, although I see problems with that. The problem you have is that doctors are entrepreneurs, too, just like insurance companies and corporations. Many physicians do not want to be grouped; they want to do their own thing and have their own control. Until recently, most of these doctor-groups, other than the closed panel ones, have not had much ability to get at some of these tough issues of when enough is enough and how to provide incentives to themselves. I think that is going to be one of the changes we will see in the next three to five years.

MR. SUTTON: Are there any questions?

MR. RICHARD ULLMAN: How much of health care can be taken out of the hands of doctors and be delivered by paramedical personnel or nurse practitioners?

DR. ALBERTS: Well, we find very little really. We find that our membership wants to be cared for by physicians and does not really want to be cared for by nurse practitioners nor paramedical personnel of any sort. We just do not offer those services. We very carefully screen the providers. If we find a high utilizer of ancillary services, x-rays, laboratory, EKG, we want him to work for somebody else. His brand of medicine, as Glen so aptly pointed out, is probably no better and maybe a little worse than the fellow who appropriately utilizes.

DR. WEGNER: You cannot always find the appropriate provider, but the systems described this morning can certainly identify the unpreferred provider. Those folks really stand out in these systems. A good place to start is to find out who you do not want to do business with.

MR. TONY HOUGHTON: Assuming that 30% unnecessary treatment in hospitals is a good estimate, how much of that is identifiable in advance, and therefore, can be eliminated through pre-admission certification?

DR. WEGNER: I don't know, Tony, if we could give you an absolute percentage. It's certainly a significant percentage. In our view, pre-certification is a much better way to go than second opinion unless it's really a focused issue. We found that there is a lot of waste with second opinion. Another way to look at this is with a corporation that has a high volume in a particular hospital or group of hospitals. You can go in with the chart audit techniques and, on retrospective data, establish the percentage of inappropriate care and deal with it up front for future patients. I think there will be a lot more of that in the future.

MR. JAY RIPPS: Given that claim data tends to be garbage if it is unscrubbed, have you done any testing to identify the error rate once you apply MEDLOGIC to the claim data?

DR. WEGNER: Yes we have, and I can put you in touch with our senior math folks to get you a precise answer. There still is an error rate. We found hospitals where the entire data base is so bad that we have to eliminate the hospital from the scrutiny. That does not mean you are through with the hospital; that is the hospital where you would go back with a chart audit technique. In other cases, you may just pend data for a certain portion of the analysis.

MR. SUTTON: When you have analyzed the data and you find Hospital C is abusive in their patterns of care, or physicians are ordering it, how receptive are the physicians or hospitals in looking at this data? How do you develop behaviorial change in the physician who thought it was a good thing or in the hospital that is very happy to have somebody pay for all those services that were ordered?

DR. WEGNER: Amazingly good reception. I happen to be a licensed attorney as well as a physician, and believe me, I understand the concept of notice; if they haven't received notice when I get there, they certainly have it when I leave. This has not tended to be an adversarial issue. They know what we

know, that there is a JCAH, there is a state licensing bureau for hospitals, a state licensing bureau for physicians. We go in and say, "Folks, we have some outliers here. Could you help us explain them, and by the way, our client wants us to come back in six months and keep tracking this." In some cases, the data are explainable. With five urologists, for example, four have an average length of stay for a prostate of four 1/2 days and the fifth one, say, nine days. Is that fifth guy wrong because he is the newest and the best from the university and he's getting all the tough cases referred to him or because he the oldest and getting more of his referrals from 300 to 400 miles away? It may not be proper, but at least you can explain it. We have even had cases where hospitals encouraged their review board to hire us because they were sure we were going to show that they needed more beds in the community. When we found they have 30% overutilization, they were just as glad to get this information because they were about to build some hospitals that were going to stay empty. I wouldn't want to leave you with the impression that these systems are perfect; they are not perfect. But I will leave you with the impression that more than $6 million of research and development and seven years of effort have gone into the building of these systems, and I do think they track health information issues better than almost anything that is available.

MR. SUTTON: Glen talked about PPOs and competitive systems, and at least one voice said maybe PPOs are the wave of the future, which remains to be seen. There is a lot of interest in the insurance industry about rate regulation in states. How do you fellows relate to rate regulation and attempts at controlling hospital costs by regulation, including the DRG system?

DR. ALBERTS: Well, with the Rate Review Commission in Maryland, it is our finding that somehow, someway, the hospitals and everybody else will find a way to keep the dollars coming in. I think they have been relatively unsuccessful in controlling costs. I think New Jersey has not been terribly successful either. All the government regulation has really not done much to control costs.

DR. WEGNER: I think I would conclude what you did, that regulation does not even apply in many cases because they can get around it. I think we need general guidelines and a spirit of cooperation, but I have never felt that the regulatory environment is the way to do this. We can build a system that works in a very competitive environment. I happen to believe that the federal government is going to have to make some major changes in the DRG system before they have something that works. I do not find that the groupings available under a DRG system can adequately track clinically what is going on. We know people who are writing software programs that we call DRG-creep programs because we see continued pressure to go through the system and list the highest oriented DRG since hospital administrators have the pressure to do that. Physicians who care about that hospital and their own practices are going to have pressure to do that. You are going to have these pressures to constantly reorient things, not really fraudulently, but right up against that so that you can maximize revenue. We think it's a generation behind the kind of stuff we have been discussing this morning in terms of what you can do to better track the appropriateness of health care.

DR. ALBERTS: I think that when you look at states that have the highest degree of regulation, they also have the highest costs. If you look at New York, California, and Illinois, they are the most regulated states, and they have the highest costs. The only way you are going reduce health care costs is to have viable, competitive systems. As long as you just completely reimburse

and pass through money, the physicians and the hospitals will all find ways to maximize their revenue. As Glen was saying about DRG's, people are writing programs to show you how to maximize revenue from these things.