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HEALTH CARE PROVIDERS SPEAK OUT

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Physicians and hospital representatives will discuss their views on health care reform, insurance companies and managed care.

MR. TIMOTHY D. LEE: I'm with Milliman & Robertson in Houston. Our recorder, Kathie Jankoski, is with Milliman & Robertson in Hartford. We have two guest speakers serving on our panel. Mr. David Page is the chief executive officer (CEO) and president of Hermann Hospital in Houston. Dr. Brant Mittler is a cardiologist in private practice here in San Antonio. I'm going to do a more formal introduction of these two gentlemen in a moment.

Our format will be as follows: Mr. Page will speak first, followed by Dr. Mittler, and then we will take questions and answers at the end of this session. Our session is going to focus on health insurance, health care delivery and health care reform from the viewpoint of hospitals and physicians. And that's a view that many of us don't hear too often. As health actuaries, we've worked with our clients to design the mechanisms to finance the delivery of health care. We've developed insurance products of various types, and we've even developed entire alternate delivery systems, such as HMOs. Many of the insurance products that we've designed have features that impact the ways that physicians and hospitals deliver their health care services and the ways that they're reimbursed for those services.

Product features such as utilization review, precertification of hospital stays, limited per diems in payments to hospitals, discounted fee schedules for physicians, and capitation payments for both hospitals and physicians are bound to affect the treatment decisions made by these providers on a day-to-day basis, if they have any financial awareness at all. The hospital industry and the medical profession in America are undergoing a revolutionary change. The entire economics of these businesses are changing. Indeed, the rules of the game seem to have changed. And anytime the rules of the game change, it's going to strike some people as being unfair. Those who have played by the old rules and prospered may find that they're threatened by the new rules. And who's at fault for that?

Well, for better or for worse, one of the interest groups that has contributed to the changes being thrust on the hospital industry and the medical profession today is the health insurance industry for whom we all work in one form or another. Therefore, we actuaries, who are integral to the management of the insurance industry, need to

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better understand the business of medicine and how hospitals and physicians view us. That's what I hope that we can get out of our session.

Let me first introduce our representative from the hospital industry. David R. Page is president and CEO of Hermann Hospital in Houston, Texas. He assumed this position in August 1993. Prior to coming to Hermann, David was executive vice-president and hospital director of Ochsner Foundation Hospital in New Orleans. He was with Ochsner since 1981. Before that he was at Memorial Mission Hospital in Nashville, North Carolina, where he served as associate director and chief operating officer from 1972 to 1981. Other positions Mr. Page has held were at Childrens Mercy Hospital in Kansas City and Duke University Medical Center in Duke, NC. He is a Fellow of the American College of Health Care Executives and a member of the American Hospital Association for which he served as a regent at large from 1988 to 1991 by representing teaching hospitals. He's the past board chairman of the Metropolitan Hospital Council of New Orleans and a past board member of the Voluntary Hospital Association of America. Mr. Page received a bachelor's degree in economics from Davidson College in 1962 and a master's degree in hospital administration from Duke University in 1964.

MR. DAVID R. PAGE: Let me start out by sharing with you what I intend to do in the brief time I talk. I certainly hope what I do in this time provokes what I think will be the most productive time, which is the exchange period at the end of the session. It says in your booklet that at the conclusion of the session attendees will comprehend concerns of others affected by health care reform—I think we might make some progress on that—and comprehend providers' views of insurers and actuaries. I need to get that out of the way first, because that's where I'm on the thinnest ice.

Tim also wrote me a letter with a fairly lofty set of objectives that have to do with talking about my institution's mission, how it's changing in the marketplace, and the concerns that I may have as we deal with the changing topography in the health field, so far as the quality of the services that we're offering. I think we might be able to touch on that at the tail of this.

First off, where I'm on thin ice, the point of my initial comments will be to let you learn a little bit about the perspectives that I have. I'm going to give you perspectives on insurance companies and actuaries. I'll start by talking with some fairly deep-seated conviction about health care reform, the managed-care marketplace, and insurance companies. Certainly you all know more than I do.

Arguably, I think the insurance companies are a significant contributor to the current health care problem. And the reason I think that is because of the things that you understand very well and that I understand in a very cursory fashion: group rating, community rating, mutual insurance companies, full-profit insurance companies, preexisting conditions, portability of benefits, and cancellations. The basic concept of insurance, certainly back in the 1930s when the first Blue Cross plan was started, what it was intended to do, was to take care of the health care needs of the teachers whom it covered. So my view of the insurance companies is, at best, that they are as culpable, if not more culpable, than many of us in the health care system. By this I mean they are major contributors to the problems we find ourselves in. That's all I'm going to say about insurance companies.

From a health care institutional management point of view, I think there is clearly a newfound recognition on the providers' part about the value, the importance of, and the need for actuarial support in what they're doing. Only five to eight years ago, the actuarial need in the health care industry, from the standpoint of managing a major institution, was very low.

Actuaries worked in my benefits group, in my own employee health group, and maybe even in some other aspects with my employee group. Related to the products I took to the marketplace, the actuarial need was fairly low. Now I'm faced with rates per thousand, admission rates, days per thousand. I'm faced with dividing up a capitated dollar, knowing how that capitated dollar is going to come to me initially, and how I should expect to spend that. Recently, the countryside was, unfortunately, fairly littered with backyard grown HMOs that didn't understand actuarially what they were taking the risk for. I learned a few years ago, in an indelible fashion, what the term *incurred but not reported* (IBNR) claims stands for. And I can tell you that lesson is still being learned. So the insurance companies have some significant culpability, in my view, for the rest of us in the health care industry and for some of the real problems that we have. I think actuaries are kind of newfound experts, consultants, and maybe even in some instances, partners in health care systems.

I was in a meeting in Washington during the first part of the year, and someone pointed out that health care reform really could be boiled down to, for the American public, what prices are you willing to pay for a Big Mac? The point of that, of course, is that the work force at McDonalds is largely a transient, part-time work force, for which there are no health care benefits. And some of the health care reform plans intend to deal with that. So if you say that's what health care reform is headed toward, I think that you can see similarity in the issue of lemonade being $35 a glass.

Well, that should get us to the right point of view. As far back as 1949, government-appointed assemblies worried about the catastrophic implications of health care problems for the American family.

I'm going to intermingle my discussion of health care reform and managed care, but I will make sure that we understand the distinctions. In my view, as a provider, managed care represents a spectrum of things, including gatekeepers, precertification, second opinion, standard length of stay, pressures on discharge, full risk assumption, and, I hope, actuarially based business deals. Health care reform is a governmental answer to a problem that hasn't been clearly defined. Unfortunately for many of us in the provider sector, it's an approach that we view primarily as a way of managing the rise in the cost of government spending in the health care area.

We have managed care. Health care reform is going to come to us. The managed-care view that I see as I look out over the terrain is a marketplace interested in buying my services, on one basis and one basis only. It's price, price, price. I see the buying public, I see you, a room full of the buying public, being unable to differentiate in the quality and the value of the health care services you may be buying.

I was speaking to a group in Houston on a similar topic. In the question-and-answer series, one of the questions from the podium to the audience was: how do you go

about selecting in an open-enrollment period a physician to give your family care? Far and away, the strongest answer was: geographic convenience. So with a marketplace that's asking me to sell my services on a price, price, price basis, the purchasers are not in a position, not only through their own difficulty of understanding, but also through my reluctance and maybe unwillingness to help them, to understand how they will make the measures of where their value of the quality is.

Next I want to talk about the evolution of the managed-care market. You go from the indemnity-supported marketplace, with high utilization rates, and you start moving to discounts, then per diems, per diems with insurance companies coming in and offering a managed-care product and shadow pricing and taking the profits out of the provider sector. I've been in an indemnity market, and I moved to a discount market as pressures were brought to me by large group buyers. Then I start to go into per diems, and a broker, maybe an insurance company, will write a per diem contract with me, shadow price the high end of it, driving my utilization rate down, and take from the provider sector the profits created by its providing the utilization management. We'll talk about that later. That's an evolution of where the managed-care market is going.

I guess when this is over, I'd really like for you to be able to hold onto three things. Through the implications of the transition from a revenue center to a cost center, think of the magnitude of change it's going to drive into the provider sector. Consider the conversion of the revenue centers to cost centers, ultimately the conversion of the entire provider, a hospital, as a cost center in a capitated system, and what that means, from the standpoint of how that provider will deal with you as a patient. The implications are tremendous in the provider sector that's taking care of you.

I'd like to have you challenge me or else embrace my point and think, yes, he's right, or the guy's crazy, I've got to ask him a question. I don't think you'd have any trouble with the first one at all. The changes in the managed care marketplace cannot be done by themselves. In order for the health care system to get where it needs to go, we're going to have to have some governmental intervention. There are many people who have roles similar to mine, who would throw overripe fruit at me for hearing me say that. But the bottom line is, the marketplace is moving. It's moving very fast, but it can't move alone. And the reason it can't is that the price, price, price approach in the marketplace will not sustain medical education, graduate medical education, or research.

A reasonable, prudent-acting benefits manager, buying benefits for a large or small company, would not logically say, "Well, I have a societal responsibility here." Or "I want my five-year old daughter to be able to go to medical school when she grows up. And I want the school to be there." He or she wouldn't do that. He will act on a very logical basis, on a price, price, price basis, and that will not sustain the academic teaching centers. They have a lot of delivery problems, but right now, they're the only thing we have. As far as the creation of the new frontier in the health care area goes, we have to have some governmental activity. It's hard for me to say that, but it's true.

Here is the second point. From both your and my view of the marketplace changes and the governmental health care reform as we look at it, it will differ tremendously

by how we're asked to look at it. You're asked to look at it possibly, as I joked, as a purchaser of a Big Mac, or as a taxpayer, or as an insurance premium payer, or as an employee benefits manager. And those are all fairly logical ways to look at the implications of managed care and health care reform. What happens when you're asked to deal with health care reform or managed care from the perspective of being a patient? It does give you a different spin on it. And right now, there's not a lot of that being done, because all of us are going to pay taxes. I hope all of us are going to continue to have health care coverage. It's inevitable, but we deny the inevitability of our need for the use of the health care services as patients.

So the second point is on approaching these changes. It changes significantly when you approach the question from the perspective of how it should work as a patient. It also sets up the classical problem that you can't have it all. You can't have your cake and eat it, too. Yes, I'd like to have the best possible care for my grandmother who's 83. But I'm not willing to pay for it for your grandmother who's 83.

The last point is probably the most controversial point I'm going to say; if you don't challenge me on this you're wimps. From my view, and this is conviction of 30 years in health care, the dangers and problems inherent in the indemnity-insured, procedure-oriented, specialist-dense system are potentially no greater than the dangers and problems inherent in a risk-assumed capitated system where, in the short term, dollars are to be made by doing less. I hope you'll ask me some questions on that.

MR. LEE: Dr. Brant Mittler is an honors graduate of Harvard College. Dr. Mittler received his MD degree from Duke University School of Medicine. He has practiced internal medicine and cardiology in San Antonio since 1976. Dr. Mittler has been an active spokesman for the preservation of the patient/physician relationship during this time of dramatic change in our nation's health care industry.

In 1985, Dr. Mittler cofounded Physicians Who Care, a national medical consumer advocacy group. He has appeared in the local, regional, and national print and broadcast media. His appearances include ABC TV's "World News Tonight," "Good Morning America," the "Home Show," "NBC Nightly News," and the "MacNeil Lehrer News Hour," as well as radio and television talk shows throughout the United States. He provides weekly medical reports and commentary for KENS TV, the CBS affiliate in San Antonio. Additionally, his commentaries on social and economic issues and medicine have appeared in *The Wall Street Journal, The New York Times, The Los Angeles Times, Best's Review,* and numerous other publications. Dr. Mittler serves as chief of cardiology at the Southwest Texas Methodist Hospital in San Antonio.

DR. BRANT S. MITTLER: I think some of what we're going to talk about has to do with trying to formulate programs that deal with the average patient, when in fact, we as providers—whether we're hospital administrators, CEOs, or physicians—are concerned with the problems of having to deal with the individual patient and associated family members. Very often what applies to the average patient doesn't apply to the individual patient.

I want to address some issues that deal with the medical profession. Some of them have to do with the sort of training physicians have in business and managed-care principles. We have virtually none. The physicians don't get much business training

these days. At the medical school in San Antonio, the ET Health Science Center, when Steve Cohen, who is the other founder of Physicians Who Care, and I wanted to speak to the students about issues in health care reform, capitation, and managed care, we were told that there is no time in the curriculum during the four-year period to talk about these issues, at least, perhaps, not by people with our specific bias.

In terms of the business practices of medicine, very little is presented in the medical school curriculum. Physicians today are overwhelmed with the changes that are occurring. I'm sure you've all read the headlines that hospital systems in every community in this country, certainly in every major metropolitan area, are involved in what's called "merger mania." The large hospital systems, such as Columbia and others, are seeking to make deals with hospitals, and that does involve professional staffs of hospitals. Physicians are having to make decisions about becoming investors, about which system to affiliate with, about which managed-care contracts to sign, about which physician hospital organization or physician organization to become associated with, and these are things that we were not taught in medical school. We were not taught these things in fellowship training programs, and I dare say that neither practicing physicians nor the faculty at most medical schools are prepared to deal with these issues.

These are complicated issues, issues that I believe to some extent have no right answers. But it is causing enormous turmoil in the medical profession at this time. I think that this sort of turmoil is also contributing to what we might say is some type of denigration of patient care. Physicians are spending enormous amounts of time worrying about these issues. That, I think at some level, has to detract from patient care.

Well, I want to deal with some of the issues about how physicians make decisions. And what is the appropriate role for third-party payers in decisions? I also want to address some questions about what market-based or legislated health care reform might have for patients and physicians.

My particular area of interest during the past 25 years since I've been in medical school has been in observational databases. I'm proud to say I was one of the founders in a small way of the Duke cardiovascular database. I maintain the faculty appointment at Duke to this day, and last week we actually celebrated the 25th anniversary of the Duke cardiovascular database. I believe it is the largest database of cardiovascular disease in the world. I think that my experience with this cardiovascular database has certainly colored all of the ways I've thought about the clinical practice of medicine.

I had initial training in health services research way back when with the Johnson Foundation at Duke and Hopkins, and I'm one of the few who ultimately went into private practice as opposed to public practice. I think that the experience of being in the daily private practice of medicine has given me an interesting and different perspective on what should be done with health care reform.

Let me just make a few statements at the outset, in terms of the chronic diseases that we see in health care that contribute so much to the cost of medical care. Coronary artery disease, strokes, osteoarthritis, and diabetes mellitus consume

perhaps 14% of the health care budget, as some recent studies demonstrate. The clinical course of these chronic diseases is largely unknown. Now I know that may shock you, but it is very difficult for cardiologists, for example, to predict the exact clinical course of a patient with coronary artery disease.

In spite of all the high technology, we do not have a test that can predict the two things that patients and doctors want to know: sudden death and heart attack. These events occur and they are not predictable. Now we certainly have some idea about outcomes and the distribution of outcomes in patient populations. But it's very difficult to predict these events. And of course, these are the things that you're interested in, that the payers are interested in, because they want to get some idea of the risk of the population in which they're insuring, or managing, I should say. I should say managing, because as one insurer states it is not in the health insurance business anymore, it is in the managed-care business. I kind of wonder, if it couldn't figure out how to insure people and how to estimate risk, why should we trust it with managing care? It certainly is prepared to do that. And yet, it claimed at one point to be an insurance company.

Well, for these chronic diseases, I think an important concept for you to understand is that the expensive procedures or interventions occur in a continuum. With all of these very high-tech, fancy procedures—atherectomies, laser angioplasty, bypass surgery—people very often think that an intervention is done at one point in time, that the patient goes home and lives happily ever after. But in fact, patients with coronary disease aren't cured of the disease.

Now most of my patients with coronary disease are shocked when I tell them that we can do this intervention, but they won't be cured of the disease. They say, "What? I thought I was cured." I tell them, "No, you still have coronary disease. If you don't stop smoking and stop eating all those Big Macs and fatty foods and try to decrease the stress in your life, these problems may come back. And in fact, even if you do all of these things, there may be progression of the disease. And even if we intervene at one point in your artery, you may have further disease downstream from the site of the bypass." Now these are shocking statements to most of the public. These are statements that I'm not sure that those estimating risk understand, but they should understand them.

For example, performing the bypass surgery is not the end of taking care of a patient with coronary artery disease. But how often do we see these decisions characterized as bypass surgery versus medical surgery or bypass surgery versus angioplasty? That's a decision at one point in time. Two weeks ago I sent a patient home from the hospital. She had had an acute heart attack and underwent thrombolytic therapy, which is blood-clot-dissolving therapy. We had done an isotope stress test and she appeared stable at that time. She went home and continued smoking, in spite of our best educational efforts and in spite of the intervention of cardiac rehabilitation—nurses, dieticians, the whole teaching team—which is very expensive. Two weeks later she was back with more chest pain. This time she underwent angioplasty. I sent her home. If she resumes smoking, she may be back next week. Next week it may be bypass surgery. These are all expensive interventions. But what am I supposed to do?

Do we want to become like England? In one part of England, the surgeons have said, "If you keep smoking, we will not perform bypass surgery." I just came back from a conference in England, and on the plane I met a 65-year-old fellow who was on his way to Oklahoma City, where his daughter is a nurse working for a cardiologist. He had just been diagnosed with severe, life-threatening coronary artery disease. He showed me his cardiac catheterization report. The consultant had recommended immediate bypass surgery. He was placed on a waiting list. And that waiting list, he was told, would be two years.

But in any case, we have to deal with the American public now. When they have these problems, we deal with them because they are patients in need, and if we don't deal with them, we'll see their lawyers and families in the courthouse. So I want you to have some appreciation of the clinical course of chronic disease. In some sense, we're muddling around. There are very few right answers in medicine. Doctors do the best they can.

Tim asked me how physicians make medical decisions. If you read the popular press or you watch television, you think doctors make decisions with only one motive—to make money. I would say that is not what motivates most physicians. Very few physicians make decisions based on how much money the procedure generates. They make decisions based on what they think the best procedure for the patient is at that point in time. But clinical decision making is an interesting process and is very often flawed. That's where we need to put a lot of effort in this country.

Now most of you are probably aware of the Rand studies. You've all heard the statistics, that perhaps half of all bypass surgeries are unnecessary. That number came from a series of studies done by the Rand Corporation several years ago. Various parts of these studies have been published in *The New England Journal of Medicine*, *The Journal of the American Medical Association*, and then primarily in monographs published by The Rand Corporation. These kinds of statistics, which say half of all bypass surgeries or half of all hysterectomies are unnecessary, have led many of those advocating reform to say there's a lot of waste and inefficiency in the system. They say if we just cleaned out all those inappropriate procedures, there would be plenty of money left to go around.

Well, let me make a couple of comments on that. This country spends about $8 billion on bypass surgery. We spend $9 billion on pet food. And when you throw in the money we spend on fancy sweaters and collars for dogs and cats and all the rest, that comes to about $11.5 billion. We spend about $11 billion just on designer sunglasses. We spend $40 billion on gambling. We spend $20 billion on lawn care, $30 billion on golf. It goes on and on and on. If we didn't do one more bypass operation, we'd hardly make a dent in the amount of money we spend on health care. So I think that the whole issue of bypass surgery is blown out of proportion.

Let me make some other comments about this whole process of defining what's appropriate and inappropriate. I think that's a key issue that Tim wanted me to address. I believe that the entire Rand methodology has not been critically examined; the Rand methodology is fundamentally flawed. It's commonly referred to as outcomes research, yet most of the Rand studies that have to do with these expensive procedures have not looked at outcomes at all. They've taken a group of

experts—a handpicked, small group of experts—and they've had them read summaries and records and make decisions—Monday quarterbacking so to speak—about whether a particular procedure was highly appropriate, highly inappropriate, or equivocal.

Now the interesting thing about the Rand studies—and if you haven't, you ought to look at the original data—is that there was an enormous amount of disagreement among the experts. If you go back and look at the primary data, you will find that for most of the procedures looked at, the experts disagreed among themselves about half the time; and very often more than half the time. They got a little bit more consensus by the delphi methodology; after their independent reviews, they got the experts in a room together to talk about them. Then they got a little bit more agreement. Now I think the thing to understand here is that the methodology is suspect. Also, the people they brought together were internationally renowned experts. And among the experts there was an enormous amount of disagreement.

Perhaps the best comments on the Rand methodology were made by John Winberg, who's the father of small-area variation research. Tim asked me to talk about the fact that there can be enormous differences in the rate of procedures done from one county to another, or from one state to another; procedures such as radical proctectomies, bypass surgeries or hip replacement. Winberg is quite famous for showing the big differences in major procedures, differences between New Haven and Boston, both great bastions of academic medicine. And what Winberg said in an editorial in the *Journal of the American Medical Association* in 1987 was that it should not be assumed that shunning inappropriately used procedures will substantially reduce the number of procedures physicians performed and therefore reduce costs. He said it is time to recognize that the major clinical decision problem responsible for costly variations and practice styles derives not from bad quality but underevaluated theory. He went on to state in another editorial in the *Journal of the American Medical Association* in 1991 that the questions about the probabilities for outcomes and the preferences of patients cannot be settled by occasional committees of experts who are hired by private managed-care firms to define the appropriateness of care. He makes a strong case for doctors and patients deciding together about which procedure should be done at one point in time.

I think the important concept to understand is that these definitions of appropriate and inappropriate are not really written in stone. There are questions about the methodology. There are questions about whether these figures even hold up. More recent Rand studies were just published last year. They looked at the rate of appropriateness of bypass graft surgery, angioplasty and angiography, and in New York State, they found that the rate of inappropriate care was in the order of 2-4%.

A recent report out of Sweden looking at bypass graft surgery found the same rates, about 2%. So I think that if the health care reformers are looking to save a lot of money by cutting out all of these so-called unnecessary procedures, they may be barking up the wrong tree. My favorite definition of necessary versus unnecessary care is that the necessary care is that which you and your family get when you're sick. Unnecessary care is that which applies to the other person. It's all relative.

Now I'd just like to make some comments here about managed care and HMOs. In the popular press, Physicians Who Care is always characterized as being an anti-HMO organization. I'd like to second what David Page said. I believe that the gains to be made from managed care, and specifically health maintenance organizations, are small. In fact, I think there will be many negative consequences that have not been widely appreciated. One of the reasons is that the media, the national media to be specific, have largely adopted a see-no-evil, report-no-evil posture toward HMOs. Only recently have some of the negative stories begun to come out.

Doctors have not particularly been a good source of information in recent years, because some have reportedly been asked to sign gag clauses. One of the largest HMOs in Cincinnati had doctors sign a gag clause. It said if they in any way produced stories or made comments that impacted negatively on the health maintenance organization, they would be fired. And I think some 96% of the physicians signed, which certainly isn't a very good commentary on the motivation of physicians these days to protect their patients. Health maintenance organizations have fundamentally changed the doctor/patient relationship. Instead of physicians working for patients, physicians are now working for third parties, who often are corporations headquartered thousands of miles away.

Already there is evidence accumulating that health maintenance organizations may, in fact, have an adverse impact on patients. This is because of the perverse incentives that they use. Doctors are paid more for doing less, or they're sharply penalized for doing more for patients. I brought along some clippings from my files that I've gotten in recent weeks. This article, from the April 20, 1994 issue of the *Journal of the American Medical Association* is on treatment differences and other prognostic factors related to breast cancer survival. This article was reported in the mainstream media, in the national press. Only in *The Wall Street Journal* was there one sentence about what I think is a bombshell—survival rates vary by hospital type for patients with localized disease, with significantly better rates at larger community hospitals and significantly worse rates at HMO hospitals.

The article was reported as being evidence for the use of lumpectomies, in the wake of the fraud allegations with one of the major studies that had to do with lumpectomies in women with breast cancer. But this study really wasn't set up specifically to look at lumpectomies. It was set up to look at survival rates in various treatment settings. And one of the shocking conclusions was that women in HMOs fared significantly worse.

Much other disturbing data have come out about HMOs. One study last year looked at patient satisfaction among 17,000 enrollees in a health maintenance organization and found, by a wide margin, patients prefer fee-for-service medicine and have negative feelings about both health maintenance organizations and large group practices, in terms of their ability to get to the doctor, the waits involved, and their ability to get specialty care. Another report from the Medical Outcomes Study looked at patients with serious depression and found that they fared much better in fee-for-service settings than in HMO settings.

I could go on with other examples. On the front page of *The Medical Tribune,* June 2, 1994, is a comment by Michael Weber, a professor of medicine at the

University of California Irvine. He is one of the international experts on hypertension and raises his concerns about HMOs discouraging referrals. I think that not only should we consider these perverse incentives impacting the quality of care, but I think that we have to think of them also in terms of the specialists-generalists mix, which is so popular to talk about these days; that allegedly we need more generalists and fewer specialists.

I'll just make one comment about that. I work with many family physicians. When family physicians and general practitioners (GPs) get sick, they look for the best specialist they can find. They don't go to GPs. They go to specialists. And while we're on the subject of HMOs, I think it's important to ask your physician and other physicians how many of them enrolled themselves and their families in HMOs. The answer is not many.

These were some random comments about some of the questions that Tim asked me to bring up. I have substantial questions about the methodology used to generate a lot of the statistics and about appropriate and inappropriate care. I believe that there are substantial issues that should be raised about the generalists-specialists mix. More questions should be raised by the leaders of academic medicine and by the mainstream media, about the quality of care in HMOs and whether, in fact, managed care may be harmful to your health. And I believe that all these questions are going to be asked more and more as the health reform debate intensifies. Frankly, I was happy to read the editorial comment in *The Wall Street Journal* today: "Earth to the White House. It's over."

MR. LEE: We're going to take questions. What's the general feeling within the hospital management industry about what's likely to happen in the near and short-term future?

MR. PAGE: They don't think it's OK, and they don't think it's all going to go away at the end of the day. Dr. Mittler's comment about the merger mania and the consolidation of the health care system is mostly driven by the senior management of health-care institutions looking at numbers and utilization rates in the highly managed-care area. In highly managed markets in Minneapolis and on the West Coast, they are saying, "My occupancy rate is now 62%, my days per thousand are thus, so I can look forward to that dropping by 40% or more. What am I going to do with all these beds? I must merge. I must find some partners. And if I have many allies around me, I might be able to present myself in the marketplace as a more credible system and get more patients." But the institutional providers do not think it's going away. And they are scared out of their wits.

MS. LEEANNA M. PARROTT: Could I get your comments on the National Committee for Quality Assurance (NCQA) efforts and employer efforts for measuring the quality of HMOs?

DR. MITTLER: The question has to do with the NCQA to measure quality in HMOs. Well, I think the press needs to identify that group as being initially started by HMOs. It's not an independent organization. So it was founded by HMO dollars, and I'm rather skeptical of HMOs monitoring themselves. I think one of the issues has to do with underuse. How do you monitor underuse? How do you monitor not sending

someone to a cardiologist? How do you monitor not providing a particular drug? And I don't think that there are any systems in place that are doing that adequately. In terms of databases, we have very rudimentary databases in chronic disease management. Most of these HMOs have very crude data systems. They talk a big game, but I think they have a lot less fire power.

And let me make some other comments about that. I'm sure you are aware of the issues of low-power, medium-power, and high-power databases. For the most part, administrative databases are low power to intermediate power. I'm not aware of any of these systems having sophisticated database systems that could really be used to look at the kind of quality issues that I think ought to be looked at.

MS. PARROTT: Are those worthwhile efforts though? Are you familiar with the Healthplan Employer Data and Information Set (HEDIS) dataset?

DR. MITTLER: No, I'm not.

MS. PARROTT: Could I get your comments on some of the provider profiling methodologies that are out in the marketplace now? Are they good? Bad?

DR. MITTLER: Last year I headed what we call the third-party issues committee here at the Bexar County medical society. Many years ago we set up a third-party issues committee, which has been copied, I think taken statewide, by the Texas Medical Association. It started in San Antonio, and we asked doctors and patients to send in the problems they were having with insurance companies and HMOs.

Well, the CEO of Blue Cross/Blue Shield and one of his vice presidents came to our committee meeting last fall. We asked him to discuss with us the instrument they were using whereby they had kicked an internist out of their HMO. It turned out they had invited this internist in, supposedly based on his past performance, and once they got him in and his patients signed up, they then claimed they went back and looked at his data, and they said he was generating something like $337.13 per patient. We asked these Blue Cross/Blue Shield officials to please explain to us how much risk stratification they did. Did this doctor have sick patients? What kind of patient population was it? They said they couldn't do that, but that this sort of methodology, while it was crude, was a proxy for quality.

I think those sorts of profiling methods are extremely crude, and there's absolutely no scientific basis to them. Not that there should be science in any of this, but I'm very skeptical about how companies are profiling physicians. They're using cost as a proxy of quality, and I don't think they're looking at stratification of risk.

FROM THE FLOOR: This is along similar lines—provider hospital profiling. I'll direct it toward David Page. You mentioned that price shouldn't be the focus. I guess the implication is that quality should be. If that's the case, why hasn't the provider community done more to emphasize or compete on the basis of quality? Instead, it seems to me that community hospitals, in particular, are competing on the basis of maternity wards and that of type thing.

MR. PAGE: I understand your question. Why isn't the provider community being more aggressive in its competition on a qualitative basis? Part of that is that the health care field, for decades, either has been unable or has been unwilling to define in its own terms, at least from my perspective, what quality health care is. The basic assumption of many people who are buying the health care system is, if it's licensed either as a physician or a hospital, it's made a basic threshold of quality. Beyond that, there's nothing really relevant to pick and choose from; maybe beyond bedside manner and decor of the room and the politeness of the people in the admitting office.

I spoke to a group of the American Association of Retired Persons (AARP) in New Orleans three or four years ago, and we got into a heated discussion as to how they, as one of the higher-use groups of the health care system, would make decisions about going to a hospital. They had very little insight into outcome data. I don't know the reason why health care is not offered on a qualitative basis. The problem is that it's allowed on a price, price, price basis. And it's going to be incumbent on services, such as those that Dr. Mittler provides or in institutions that I run. If we think we have something that is distinctive and qualitative, it's incumbent on us to be able to demonstrate that in understandable terms to the public. Right now literally millions of dollars are being spent within the provider sector, trying to get that in a digestible fashion. I don't think it's ready yet.

DR. MITTLER: I'd just like to add one comment to that very good question. I think there are a couple of things. Look at the Health Care Finance Administration (HCFA) mortality data with hospitals. They finally threw those data out and they're not going to publish them anymore. But there was an enormous amount of effort spent on publishing hospital mortality data, and in spite of all that effort, they found that they really didn't mean anything. Well, it's very, very difficult to track, to come up with outcomes in chronic diseases. It's a complicated business. You're not just dealing with people with one disease; they have multiple, chronic diseases.

So one answer is, it's scientifically very difficult. Another answer is, it's very threatening to the provider community. And nobody knows exactly when, for example, the state may appropriate the data. In Houston, just a month ago, we had a discussion with major centers that are providing bypass surgery, about going along and participating in a state-funded cardiovascular database. A major consideration is, to what extent, if we participated in this in a scientifically viable way, the state would appropriate the data and use the data against the providers in an unscientific, political way.

FROM THE FLOOR: Well, if you say that it's too difficult, or not reasonable, or not in a provider's best interest to formulate these standards, then what other basis on which is there to compete than price?

DR. MITTLER: I didn't say that it was too difficult to do it. I'm just saying that it is very difficult. And we have many hypesters and hucksters out there telling the American people that they can do it, selling them a bill of goods, and I don't believe they can do it.

MR. PAGE: I have a follow-up to that. A series of three front-page articles about four years ago in *The Wall Street Journal* talked about three hospitals in Pennsylvania

within a 50-mile radius. There were significantly different outcomes for cardiovascular surgery in each of the three hospitals. And why was this? The series went through questions: Was it the more expensive one that had the better outcome or the one with the better doctors? No. Was it the one that had the better high-tech equipment, the one that had the better intensive care unit? No. The third article concluded with an extensive section by Mitch Rapkin, MD, CEO of Beth Israel Hospital in Boston. He said he could go into a hospital, and he did, and spend 45 minutes to an hour walking the hospital, talking to no one, and predict with a very high degree of accuracy what hospitals would have the best outcomes. And it wouldn't be based on the number of board-certified surgeons or doctors. It wouldn't be based on which has the high-tech equipment or the best medical records. The concluding piece of his three-part series was that he would absorb and feel the collaborative element of the practice within the hospitals; that is, how the cardiologists talk to the cardiovascular surgeons and how the nurses talk with the technicians. And he tested it out. The article concluded that he did that in a number of hospitals and that his prediction matched what the data showed as outcome. It's a very intangible thing—the collaborative nature of the institution. It's a very difficult issue.

MS. JOAN P. OGDEN: Many of my clients are providers, hospitals, groups of physicians. And I'm interested in the difference between their attitudes—maybe it's because they're using actuaries—and the attitudes that I'm hearing here. They are all looking at how to do a better job; in other words, working smarter rather than harder. And if they have a 62% occupancy rate, they're busy figuring out how they can move skilled-nursing facility care into the other 30% of the beds, so that they can effectively reduce cost and continue to provide the same level of services. So I wonder if there's maybe an approach difference here.

MR. PAGE: I certainly don't want to leave the impression that the people at Hermann Hospital are not trying to work smarter. In fact, because of our actuaries, we are aware of the fact we're selling a business that we can't back up with our cost. And we're not going to make it up on volume. So we are heavily invested in trying to work smarter and in trying to find out ways that we can reduce the cost of the hospitalization. My comments are not implying it's all bad. My view is that a panacea, a magic pill is needed to move to a capitated system that's going to answer all of our problems. I think the capitated system is going to make a major change in institutions. And if any hospital, certainly Hermann Hospital in Houston, is going to survive and come out the other end of this tumultuous change, we are going to have to examine what we do, how we do it, and come up with it being done better. So I left the wrong impression with the comments I made.

DR. MITTLER: I don't want to leave you with the impression I'm interested in something other than working smarter. For example, why would one set up an observational database in cardiology? To look at outcomes. To see what happens to patients, such as the next patient you're going to treat. To see how past experience can be applied to the next decision. That's what I call working smarter. I don't think signing a capitated contract with Prudential or Aetna, or whatever, is going to make anybody work smarter. It's going to make money for the executives of that managed-care entity and for a few doctors who get involved in the contract, but nobody is going to learn how to take better care of patients. None of these managed-care entities is engaged in the process of research of how to do a better job taking care of

bypass patients. They don't engage in research. They're out hawking a product, and more power to them. But I think that the danger is that physicians and hospitals are going to become even more diverted from the process of learning how to work smarter.

MR. RICK P. VEGH: Mr. Page, I'd like to appreciate your comments that you made regarding the insurance companies. I think everyone from an insurance company in the audience should take some ownership regarding your allusion to the health care problem and our contribution; we heard you. The question that I have, if you could help me with a little perspective, is you alluded to the gouging of the provider profits by the per diems that insurers are deeming appropriate and are putting on you. Could you just give us an idea of, with regard to a dollar of health care expenditure now, in an indemnity environment, what these insurers are asking you to take or accept on a per diem basis? And I'd like to follow up.

MR. PAGE: I don't think I can answer quite the way you're asking me to, because I just don't have that knowledge. I can give you my view of what's going on in the marketplace in which my institution exists. Having to do with the per diem rates that were agreed to, the institution, Hermann Hospital, was not smart enough to take a look at where that was going. We had the insurance company do the managed-care piece, do the utilization management of that, and we not so wisely signed per diem rates that were based on some expected length-of-stay data on our patient population for that insurance company. And of course, what happened during a very short period of time, about 20 months, was that the length of stay for that population dropped tremendously. The dollar differential from that change in the utilization, which drove my systems to work better, I hope with just as much quality, went to the insurance company. Now that's the limit of my understanding and being able to answer your question. I don't know if that sets your next question up. But that to me was the process by which the institution allowed itself to be victimized by an outside organization that said we will manage your process inside. And we weren't smart enough to say that it's going there anyway. We better manage it and write a cap or a diagnostic-related group (DRG)-type price as opposed to a per diem price.

MR. VEGH: Well, I guess what I was looking for is the fact that some people allude to the presence of 50 cents on the dollar being accepted by the provider, and if it's not good enough, then they will take that down the street. It's like the $5 hamburger and your Big Mac example; people are offering it for $2.50. Why $5 now if $2.50 is an appropriate price?

MR. PAGE: Well, that's a good question. From my standpoint, I'm not making the hamburger at a price that allows me to sell it at $2.50. The guy down the street is selling crystal burgers; they're about the size of a tennis ball and one sixteenth of an inch thick. This state, the state of Texas, is going to have risk contracts for the Medicaid business. Consider the city of Houston, with its empty beds. The volume of bed capacity that can bid on that business is incredible. The Medicaid business is largely an emergency room and obstetrical business. Don't assume your 120-bed hospital in the suburbs is going to offer the same level of care at the same price as a teaching center that has a level-three neonatal nursery in it; that's not the same "hamburger." What is bought on the front end, is, I want a hamburger. I've spent a lot of time flying, getting my miles flying to Austin, saying, "Don't buy it like that,

because you can't expect us to be there when you need the garnish on that hamburger. We can't sustain it without the full spectrum of business." But we're not yet able to sell the hamburger at $2.50. And I think if we're going to survive, we're going to have to do two things: Get close to it, and we are. And count on something other than the marketplace give and take to recognize that academic teaching centers are bringing something other than just the hamburger to the party.

MR. JEFFREY L. SMITH: At the outset I certainly appreciate your perspectives, from both the institutional and professional provider side. It's only by working through these issues cooperatively that we really are going to solve the problem that we have. But just so that Mr. Page won't think we're wimps, I do want to go back to your comment about the current fee-for-service indemnity, specialists-concentrated system being no worse than a capitated system, where in the short run there is money to be made by doing less. Was that your point?

MR. PAGE: No. The point is, that is the potential danger. I think we're talking about the swing of a pendulum or a situation in which you set up solutions to solve a set of problems, but inevitably they're going to create a new set of problems. I think that's what I was referring to. It is impossible for me to imagine how we play through the fact that Texaco would come to an HMO, and say, "We want this type of policy." They get to pick and choose. Do they want the push-button windows, or do they want organ transplants and all those things? They say they don't. And then one of their middle managers needs a liver transplant. The patient comes to the emergency room, he sees the doctor with the family, and now has all the issues that we all get concerned about. But a decision was made, in a conscious, perspective fashion, what that company was going to give to its employees. Now downstream we have a name for the guy. Bob Randall. And he has two teenage kids, his wife's a teacher in the school, he needs a liver transplant quickly, and the company didn't buy it for him. That's a managed-care context. The group experience rate process isn't going to account for that. And that's a catastrophic problem, and it's going to occur again and again.

DR. MITTLER: From my perspective, a couple of words stood out that seemed contradictory: *worse* and *short run.* And I guess those really are two contradictory terms. People have made the statements, "Well, in the short run it really is worse, because it's more costly." And that's why changes have been occurring to move toward a capitated system. But just as in a previous seminar, where government intervention was listed as being necessary to provide an outside intervention mechanism to the insurance industry, I think reimbursement and risk changes have been that outside influence on the provider community. I would say that the individual must take control of his or her own life, in terms of their lifestyles, their quality, and their ability to sit down with a provider to talk about quality, outcomes, and price. It's only then that we will get to where we need to be. Under that scenario, I would say that whether it's a fee-for-service specialist system or a capitated system, the mechanism is irrelevant once we achieve that objective.

MR. PAGE: I agree with you. And I really don't want anyone to think I said that one was worse. The dangers and problems of an indemnity-insured, procedure-oriented specialist system are potentially no greater than the dangers and problems of a risk-assumed capitated system, in which the short-term dollars can be made by doing

less. And the problem is, as an organization provider going into the marketplace on a capitated basis, which I believe I must do, my own employees are the only group I'm really sure I can take a preventive medicine view with. Because I know I'm going to have them. But if I write a group and put a lot of money at the start in preventive health for the Houston Transit Authority, and it leaves me on a price basis the third year, my investment in its preventive health is going to be gained by whoever gets the contract next. So the short-term thing is a real problem for us.

MR. WILLIAM R. JONES: I guess I'd like to make two points and get your reaction. First, there seems to be a misunderstanding as to just what an insurance company is and how it operates. We are primarily, or at least we have been traditionally, a financial intermediary. And to the extent we're out there negotiating per capita or per diem rates with providers, the vast majority of savings, if not all of it, is passed directly on to our employer customers. There's very little opportunity for that money to somehow get diverted into our pockets, just by the way the financial arrangements work. I've been with the Aetna for about 12 years now. We were not anxious to get into the managed-care business. We were really dragged there, kicking and screaming by our customers who were perceiving very serious cost problems in the marketplace and who really had no way to measure quality.

I've been coming to these kinds of sessions for a long time now. And every time I come to a managed-care session, one of the first and probably most important points that's always made is that for managed care to be successful, it has to be cooperative arrangement between the providers and the insurers and the employers who are ultimately paying the bill. If it is presented as an adversarial kind of relationship it will probably fail. And I'm sure there are many examples out there. I just wonder what your perspective is of the need for that cooperative relationship and whether all parties do have something to bring to the table.

MR. PAGE: Before I moved last summer to Houston, I worked in a closed group practice clinic arrangement that had an HMO in the marketplace. It was the largest in the state of Louisiana, with about 104,000 lives. The physicians were at risk. They owned 70% of the HMO, and the institution owned the other 30% They performed all the high-end, technical operations: transplant organ systems including heart, livers, kidneys, pancreas, lungs. They did what was written up in *The Wall Street Journal* articles I referred to: they collaborated with each other. The Ochsner Medical Institutions produced the lowest-case discharge charges without acuity index adjustment of any hospital of comparable services in the state.

Now I just told you that a group practice, working collaboratively together, took risk and produced the lowest cost charges on a discharge basis for both the over-65 population on Blue Cross data and the under-65 population of any hospital system around. And that was a collaborative process between those physicians and the people they insured. So I do believe it will work. And I think you're right, when we sell successfully in the marketplace, we're going to sell ourselves as a partner, and we're going to go out and screen for hypertension, glaucoma, diabetes, and other things. And we'll be credible saying that we can do things that we learn now to your work force and make an impact on your cost in four years. So I agree with you completely.

DR. MITTLER: Well, I don't want to end on too conciliatory a note. I've been talking at these conferences since 1985, and I've heard 1,001 insurance company executives moan and groan they're not making any money. And I've always said, why don't you get out of the business if you're not making any money? I've never been persuaded that any of these managed-care companies know what they're dealing with. I have documented in *Best's Review* the substance of telephone calls from many managed-care experts who are poorly credentialed, or if they do have the credentials they have no business trying to interfere with the doctor/patient relationship. People try to tell me when to send patients with life-threatening diseases home from hospitals. "Send them home on Thursday when we can't get into an operating room, and bring them back Friday at 6 a.m." I asked the physician, the radiologist in the teaching hospital in Boston if he would treat his father that way. He said, of course not, but his father doesn't have this insurance policy.

Let's be fair here. Everybody is talking in platitudes about the great benign influence of these large insurance companies. These have fundamentally altered the doctor/patient relationship. There is a presumption that Aetna or Prudential or Met Life, or whatever, knows how to take care of patients better than you do over the phone, by black box protocols. None of that has been assessed. It's all a bunch of bunk as far as I'm concerned. I think the bottom line to you as actuaries is that what you should be worried about is not what you're doing working for these insurance companies. What you ought to be worried about as private citizens is what's going to happen to the health care of you and your family when these kinds of people are coercing your physicians to make decisions; decisions that are based not on what's best for you or your family but what's best for the bottom line of that company.

In the final analysis what we're talking about is setting limits and setting priorities. We're talking about rationing. Who's going to do it? Are you and your doctors going to do it together explicitly? Or are some unknown business managers and the physicians they hire going to do it based on some corporation's bottom line?

MR. ALAN N. FERGUSON: You talked very properly about the crude methods the Blues used and the visit that they made down here. But there are much more sophisticated tools available. You're talking about the difficulty of developing them. But they're there, and they severity adjust, and they age/sex adjust, so you're making many more valid comparisons. That's a process that is evolving and will get better, and it will enable us to do a better job. But you sort of brush aside some of the things that are really outrageous in the system. Why, for example, is it that the rates of cesarean sections vary so widely across the country? Why do tonsillectomy rates vary so much? Why do carpal tunnel treatments vary so much? You can't make any sense of the system. Something seems to be wrong.

DR. MITTLER: Well, I read some quotes from Winberg, and I'm sure you're familiar with that literature, and you can go back and read Winberg's editorials in detail. But what I'm trying to say is, there are valid differences of opinion among equally credentialed experts. It's not because someone is trying to make a buck. There's an enormous controversy going on right now about how and at what age to treat prostate cancer in men. Should there be radical prostatectomies versus watchful

waiting versus radiation implants? These things go on in the best academic medical centers. The answer is, life is difficult. Clinical medicine is difficult. The history of medicine is the history of conventional wisdom proved wrong. You're saying that life is difficult, so shouldn't we therefore have Aetna or Prudential manage the care? I say no. They're no better at it than the providers of care. I'd like the providers and the patients to be equal partners. Let's get as many of these hangers on and third parties out of the process and clear the desk.

MR. FERGUSON: We're trying to do that with employer coalitions. And I think as the last person said, the whole incentive behind this comes from employers that look at the 40% or whatever it is going out of their expenses, more than their profits. They are concerned about their viability. We need to work together to help do something about it.

DR. MITTLER: Well, let me just make a comment about that. And I've certainly advocated this—Pat Rooney was on the program before this, and you know he's been a strong advocate with Golden Rule Insurance of medical savings accounts. They published Phil Gramm's piece on medical savings accounts in the *New England Journal of Medicine* this week. And I think that brings to mind the whole issue of what these employer coalitions are doing. I believe that the employers should get out of the health care business and health insurance business. Let Chrysler worry about making better cars. Insurance would become true insurance. In other words, it would take care of catastrophic costs. Let the first $2,000 or $3,000 be the function of the individual and the doctor through the use of medical savings accounts. I think we could further rationalize the system, and I think many employers in this country would be much better off if they got out of the health care insurance business. Let insurance cover catastrophic costs the way it should.

MR. LEE: We'll wrap this up. Let's beat on people who are not here: the lawyers. Could I have a comment from each of you on the impact of malpractice, threats of malpractice law suits? How does this threat affect, on the day-to-day basis the way you practice medicine, Dr. Mittler, and the way your facility delivers care, David; and therefore, how does it affect the cost of health care?

MR. PAGE: I have no doubt but that tort reform would make a significant improvement in the health care system. I can't comment about how many times a procedure is ordered in a defensive mode. Certainly it gets blurred tremendously in a teaching institution, where the procedures are ordered and tests are ordered for the learning process.

DR. MITTLER: Well, I think doctors order tests extensively to avoid being sued. Bexar County is considered to have one of the most dangerous courthouses in the state of Texas. I don't know how it compares with Harris County. But Bexar County is certainly a dangerous place.

Doctors order many tests everyday and I do, too, to avoid being sued. If someone comes in to see me because of chest pain, as a cardiologist I can't pat him on the head and send him out. In a managed-care environment, perhaps I could do that. And as you know, given ERISA, for many of the companies not subject to the rules of the state department of insurance and not subject to being dragged into state

court, the employer insurance entity is not at risk. And the doctor ends up holding the bag. A lot has been written about that. And I think physicians are slowly beginning to understand that; in fact, under managed care there may be a lot more liability. I think the estimates of $20 billion spent on defensive medicine in the United States are underestimates. I would say that the number is much larger. Defensive medicine is a part of the everyday practice of medicine of every practicing physician that I know. And it affects the consumer, it affects you when you go to the doctor and register a complaint. It's going to affect the tests that get ordered; not because the doctor wants to make money, but because the doctor is afraid of being sued.