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Does Managed Care Work?

Track: Health

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Summary: The backlash against managed care has lasted for several years. Many of the major carriers have significantly loosened their management of care, which has been a partial contributor to the higher cost trend in recent years. Given this environment, what can be expected from managed care?

Controlling this environment is hampered by a lack of visibility and understanding of performance at the provider level. These broader issues lead to problems commonly dealt with by health insurance actuaries that affect the cost and pricing of health care, inadequate development and use of practice standards practicing differently for patients covered by different insurers and the malpractice crisis.

MR. JOHN P. COOKSON: I'm with Milliman USA; I'm the outgoing chairman of the Health Section Council. Brian Klepper Ph.D. is a founder and executive director of the Center for Practical Health Care Reform. They're a nonpartisan, multiconstituent effort to improve the American health care system. They've got a lot of things going on, a lot of activities. Brian is often quoted in *The Wall Street Journal,* on CBS News and in *The New England Journal of Medicine.* He's been the chairperson for the last few years of the U.S. Employer Summit on Health Care. At the San Francisco Spring Meeting two years ago Brian was our Health Section speaker at the luncheon and stimulated a lot of activity and thought-provoking issues within the Health Section. Two initiatives have come out of that. One, you may have seen, is a literature search on the Health Care System in Crisis. Those data are all available on the Health Section Web site. There's also a group within the Society working on the

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topic of the Health Care System in Crisis. I think a lot of that came from the instigation of Brian at our meeting in San Francisco.

I will talk from an actuarial perspective, but our intent is to be fairly open. The structure is to stimulate discussion and get the juices flowing. In terms of managed care, I think we're talking about it in the broad sense. What isn't somewhat managed these days? I think I can answer the question up front fairly quickly. Does managed care work? It has worked. It's probably not working now, not in the traditional sense or the way we traditionally think about managed care. But I think we're in need of a major paradigm shift, based on information. We really need more and better information and not just data. We need to extract the juice out of the data floating around out there and see what that's telling us. I want to share a couple of examples of things we're doing that I think do that, but I think they need to go even further.

I've seen estimates: although these things aren't really hard numbers, over 50 percent of health care costs result from poor quality or inefficiency or are not efficacious. These all result from the variability of health care, poor care and overmedication, other quality issues and the lack of following evidence-based practice. I think these are the areas that are going to be important in the future. This profession really needs to get involved in terms of interpreting this information and getting it out there and seeing how we can influence the direction of health care in the future.

By way of historical background: managed care went too far and used the wrong approach, rigid controls, restriction of choice, expensive administration, all resulting in the backlash. As I mentioned, the evolution will be technology. We really need to get the information out of the data. We have to evaluate providers in an integrative way for quality, cost and efficiency. You all have seen studies and articles about small area variability in health care costs and practice patterns, but we need to go beyond small area variations. These differences are provider specific, so that’s where we need to start looking at this information.

You have supply-induced demand issues that are also totally entwined with this variability of practice patterns. You also have the whole issue of not following evidence-based practice. In fact, there's not a lot of evidence to follow, so there is a lot of "Well, let's try this, let's try that." My thesis is that we have to use information to improve the performance of the system. I'm going to go through some examples of the kinds of changes and issues that need to be dealt with.

For example, gastric reduction surgery has reached very high volumes and has had rapid increases. It has been a very expensive procedure over the last couple of years. What are the appropriateness criteria? What are the complication issues, and how much is that costing in terms of the care that's being rendered? What are the long-term savings, and what's the resulting health improvement?

As another example, consider the dramatic increases in hospital charges and the reimbursements in the inpatient outlier provisions, and what are they doing to costs? For outpatient reimbursement, it is the same thing. There are dramatic charge increases in terms of the types of services being covered and the cost of those services. Then you have these full-body scans that you hear on the radio ads all the time. Are these scams? Are they valuable? We need to be getting involved and reacting to these things and identifying whether these things are good, bad or indifferent.

We have an issue of perception of cost. All the different players have different perceptions about what's going on. The insurers feel constrained. They're concerned about denial of care issues, they're getting sued and so on. The employers clearly think the costs are too high. The employees and the insured have been shielded from prices to a large extent because of relatively low copayments, but there's more transfer going on these days, and the costs are getting shifted back. Who gets the blame? It's usually the insurers. From the provider perspective, payments aren't enough. There are denial of care issues. There is too much paperwork. Everybody's got their own set of gripes and a different perspective of what's going on. I think Brian really has a good way of trying to bring all the players together. That's one of the things that really needs to be done.

Clearly malpractice influences providers' costs. There are dramatic geographic variations in malpractice costs. It changes practice patterns. New doctors can't afford the premium in some areas. I've heard that in the Philadelphia area you can't find an orthopedic surgeon who's under 55 now because the new guys coming in cannot afford the malpractice premiums. This ties in with the quality issues as well; lawsuits aren't always about quality issues. They are often about undesired outcomes. You don't like what happened as a result, but there's a probability that any treatment is not going to result in the desired outcome. We need to improve the quality of the information. One other point is that the lawsuits tend to discourage information because providers are reluctant to make quality issues known if they think there's a risk that they're going to get sued. These all are issues that have to be dealt with, and they're sort of part of a very broad spectrum of issues.

I think from an actuarial perspective we need to change the focus of our pricing tools. As I mentioned, area cost factors are not precise enough. We must distinguish between providers. It must be on an apples-to-apples basis, both within networks and out of networks. The tools must be readily applicable in the actuarial financial cost-estimating process.

I want to give some examples of real actual data that we've been working with. For comparing hospitals, I charted inpatient and outpatient. These are large hospitals in one metropolitan area. I've got a number of categories that I'll go through trying to integrate what's going on in the data. The information on quality results from the application of the Agency for Health Care Research and Quality software. The

federal government has commissioned Stanford University and the University of California at San Francisco to develop software to use administrative data to measure hospital inpatient quality, and hospital quality in general. We aggregated the inpatient-related quality issues into four broad categories, and then we looked at the distribution of the measures.

We've identified high or low quality as being in the lower 15 percent or the higher 15 percent, and very high and low quality in the lower or higher fifth percentile. Of those four measures in quality, Hospital A was in the low-quality area in three of the four. Hospital B was in the low-quality area for two of the four, and so on. Hospital K was average on all four measures, so it was in the middle range. Hospital L had had one high-quality measure, and the other three were average. I did this just to set the perspective, so that you're making your reimbursement decisions based on the quality information that's available.

You can get the software directly off of the Internet. It's very resource intensive, but you can get it, though you need lots of data. Basically we run it on public data sources. Your own data within your own system probably aren't sufficient. They suggest running it on the entire hospital data set. There are only about 20 states where you can get that. I run it on the Medicare data set, which is much more consistent quality data and basically covers all your hospitals across the country.

You're not statistically different. We just made some arbitrary breaks to see who's in the middle. You can run statistical confidence levels, which I think ultimately needs to be done. I think it's the outliers that you need to be concerned about. You can look at confidence levels and make a determination.

Next I considered the relative charge level. I based it on a very detailed relative value per diem charge level that looks at case mix and severity. There are over 1,400 categories, 1,400 values in a relative value scale that's used to benchmark these prices. The geographic differences are taken out. Of course, these data all relate to the same geographic area, but nationally the geographic differences are taken out. These are relative to the national average hospital area; for example, Hospital A is 324 percent of the average charges for their case mix in severity compared to the national average.

Hospital L is 117 percent. Its particular metropolitan area is a relatively high-charge area. The discounts are disguised actual discounts of the carrier. They're rounded, and the actual discounts are actually a little higher than my example. Hospital A's discounts, the discounts off their charges, are probably somewhat greater than 80 percent, probably between 80 and 85 percent. So then, by applying the discounts to the relative charges, we come up with relative reimbursements; we've indexed the relative reimbursement. We just arbitrarily picked Hospital K and indexed everyone to Hospital K. With this scale some are being reimbursed as much as 50 percent above Hospital K for the similar mix of services. A few others are actually below Hospital A.

The next item we've taken is the efficiency of how they managed their length of stay. These data are an estimate of our models of the days avoidable on length of stay ranging from 41 percent avoidable in Hospital B down to 27 percent, I think, in Hospital H. These are medical/surgery-only–type cases and measures. So we can then incorporate the avoidable days due to length of stay into the reimbursement calculation, and then rebenchmark to Hospital K. On this basis, relative to Hospital K, Hospitals A and B are getting almost 165–70, percent which is 65–70 percent higher reimbursement, but also subject to their lower-quality measures on average.

On the outpatient side we also looked at a similar type of analysis of the relative charges, relative discounts and relative reimbursement. We have a relative intense measure of ancillaries, which we've extracted from the inpatient data. There's no way from the outpatient data, at this point, to measure the intensity and usage levels. But the way I'm looking at it is the way that the physicians practice within the hospital on an inpatient basis in terms of how they use services and ancillaries. You could use a different assumption here.

We looked at adjusting the reimbursement for relative intensity. The relative reimbursement intensity was adjusted so that, again, it was benchmarked to Hospital K set at 100 percent. Hospital A is three times the reimbursement level, Hospital B about two times, etc.

We need to go beyond this little analysis, but these are the kinds of things that we, as a profession, need to be digging into and getting into this information. We need to understand what's going on. We need to get that information out there.

One other issue is that you can actually track efficiency performance improvement. A hospital hired a consultant beginning in late 1997, a physician consultant to improve efficiency using protocols. What we've done is tracked their medical/surgical efficiency based on the days avoidable due to length of stay. I'll also note that this hospital has higher-than-average quality. The year 1996 was the baseline. The hospital had 32 percent of their days avoidable based on length of stay compared to our benchmark. The U.S. average was 36.2 percent. This hospital's advantage was 3.9 percent.

Toward the end of 1997 is when this improvement program started. During that period of time they dropped to 27.9 percent. The U.S. average dropped to 33.5. So their advantage increased slightly to 5.6 percent. But I think you really see the change over the next few years, in 1998–2001. The hospital dropped fairly significantly over that time period to 12.4 percent days avoidable in 2001. The U.S. average had dropped to only 29.8 percent. Their advantage had increased to about 17.5 percent during 2000 and 2001. You can actually measure these things. You can see the impact of performance, and there is the ability to do that. There are a lot of hospitals that are making these improvements, but the vast majority is not.

One other aspect of having this information is when you come to an impasse in negotiations, the carriers always lose because they don't make information like this available. The hospitals will plead they're trying to hurt women and children. You lose that PR battle. But you need to get out there and show your information such as this is what the hospital charging, it is three times the national average, and you want a 30 percent increase. You can show that their quality is this level and their efficiency is this level. You have to have information that you can get out there. Maybe you can start to have some impact in some of these battles.

This analysis is all case mix severity adjusted. There are four levels of severity. Even within that we look at the diagnosis, the procedures, the source of admission and the discharge source. They're all taken into account.

We need to use these analyses to classify the providers in terms of what are we going to do with benefit design, contract negotiation issues, network selection and employee education in terms of whom they are choosing. In terms of the quality measures, I just did a simple analysis, but how do you really want to use the quality? Do you want to statistically determine who's average, who's statistically better and who's statistically poorer? Do you want to look at quartiles, quintiles? There are two other types of quality indicators that I didn't even include with my major subcategories. You really want to try and bring all of that into the process, so I encourage you to get familiar with this kind of information.

In terms of price efficiency levels, I was looking at results in aggregate, but these are also case mix severity adjusted. You need to get at relative reimbursement. I think you need to look at tertiary care, clearly, separately, acute medical/surgery and other specialty care. You really want to efficiency-adjust the inpatient because, clearly, for somebody who's using longer lengths of stay, that needs to be taken into account. The decisions for the payers are the break points for classifying providers. They can decide how narrow and how broad they should be, and how to structure these things. They also need to decide the interactions of the price, efficiency and quality and how to integrate them.

Additional issues that really need to be dealt with—and these are sort of some of the subissues of the broader scope of things that Brian will talk about—are out-of-network, out-of-pocket limits. If you have a very high-charging hospital that's not in your network, and you have 60 percent coinsurance based off of charges, but you have a $5,000 out-of-pocket limit out of network, what does that hospital care on a $100,000 charge what the patient pays. They can write off $5,000 of that and get essentially more than full reimbursement. If you're paying out of network on a charge basis because of your out-of-pocket limit, they're not losing anything. I think you really need to consider some kind of reasonable and customary limit for hospital services for out of network.

The next area that we really need to start looking at from an actuarial perspective is measuring efficiency and evidence-based practice. I think there needs to be some

kind of a consumer's union, like the one that rates cars, to rate treatments. What's efficacious, what's not efficacious? I think that's a big untapped area that really needs to be addressed.

All these things aren't going to happen overnight, but I think we must start now. I hope we're not too late because there's a lot of work that needs to be done, and we really are in crisis mode.

MR. BRIAN KLEPPER: The answer to our topic "Does Managed Care Work?" is we don't know. It's never been tried. I want to start with something else. A week ago Thursday I got a call from *Business Insurance,* and they wanted a comment on the fact that Leapfrog Group had put out a survey to 260-some-odd California hospitals. The amazing thing was that two-thirds of the hospitals responded to the survey, and the group published the data. What was remarkable about it was that the results of the survey were terrible. It showed that computerized prescription order entry rates were extremely low, that safety was terrible in these hospitals. The woman who called me from *Business Insurance* pounced on that, and she said, "Well, what do you think of these numbers? They're lousy, aren't they?" I said, "Who cares? The important thing was that the hospitals published the data."

The reason that we are in a crisis is because of the invisibility of the results of health care processes. If you want to narrow it down to one single problem, that's the sucker right there. We don't know squat about what's going on. The kind of analysis that you just heard is so revealing not because the results are terrible, and the results are terrible, but because we've never looked at these numbers. Nobody ever does anything about it. That's why we have the problem that we have.

We have no transparency, and because we have no transparency, we have no management capability. We don't. We don't have compatible information technology. Hospitals can't talk to hospitals; they can't talk to health plans; doctors can't talk to each other. Nobody can talk to anybody because we haven't identified standardized metrics that go into the information systems. There are a lot of issues there. We don't have standards of care; we don't use evidence-based best practice. Most doctors have no idea what they are. We haven't used the technology to bring them into the exam room. We don't have any accountability. We don't have any way to identify issues.

If you want to order a pizza, you can identify who's going to get it to your house the fastest. If you need to have your daughter operated on and have her heart cut open, and you're looking for the guy who has the best shot of getting her off the table alive, there's nowhere to get that information. Not only that, but the American Medical Association (AMA) will fight you tooth and nail because they don't want that information known.

We have to figure out an answer. We have had, in American health care, panel after panel, mostly of people who are academics and experts, about things they've never

actually touched. The panel comes together and says, "Here's what we need to do to fix American health care." You know what the answers are, knowing what to do to fix the system: that's not hard. Fixing the system, that's hard. Why? Because there's a trillion and a half dollars at stake, and everybody has their piece of it, and they don't want to let anything go. The question is, How do we make changes?

I spoke to this group in San Francisco a couple of years ago, and it was great that some things came out of it, but let me challenge you. I'm going to make an argument that actuaries are the single most important professional group. The doctors are just self-interested. They're just run by their emotions, and they're all over the place. They're sure that they're smarter than you no matter who you are. The hospital representative and the pharmaceutical representatives have got their own deal. Actuaries sit in the middle and work with the data, and you identify the rules associated with risk. Health care, by definition, is about risk. It is all about risk. It's about financial risk and clinical risk. You are the intermediaries; you tend not to be interested in taking positions.

Let me try to urge you on. In normal times stability is the most underappreciated of characteristics. However, when instability comes it is the most fearsome of all characteristics because nothing works. Earlier this year a very large health plan called me. They said, "We just looked at our new enrollment numbers for January 1. Six percent of all of our enrollees disappeared in job-based coverage." It broke out into 2.5 and 3.5 percent groups. The 2.5 percent group was people who were in small companies. They had gotten 30–70 percent premium increases. They had also gotten huge premium increases in workers' compensation and professional liability associated with the reinsurance market after 9-11. Professional liability and workers' compensation are mandatory, group health is not. They dumped the group health. All their employees dropped out.

There's the larger market, the 3.5 percent market that are larger companies. In those companies they retained the coverage, but they increased the employees' cost share. Two things happened. Low-income employees dropped out, and, more excruciatingly, dependents at all levels dropped out because the employees just couldn't carry the weight. A 6 percent drop in job-based coverage is too much. A 6 percent drop in enrollment-based coverage in one year is a 24 percent increase in the uninsured in one year. It is also a 3 percent drop in total health care funding in one year because job-based coverage equates to 55 percent of total health care funding. So with this trend, and keep in mind that it's cumulative over the years, we're talking about a cost explosion that's running 6–8 times general inflation every single year.

The result of this trend is two things; first, in your community, the safety net hospital gets to take care of a fourth more people who show up with no payment than it did last year with no additional allocation. Grady Hospital in Atlanta, the largest safety net institution in the Southeast, is on the ropes. It will probably close its doors. All over the country major safety net institutions are collapsing.

The second one is, nobody cares about them, so let's just put them aside because we know we don't care. In Jacksonville, Florida, in 1982 the city cut a deal with the safety net hospital, which at the time was called University Medical Center. The deal was that the city would give them $18 million a year, and they'd take care of all the uninsured people. It was a reasonably good deal. It's now twenty years later, and the city's grown by 40 percent. The number of the uninsured, as the percentage of the population, has grown by 5 percent. There's been 350 percent medical inflation. Last year the city increased the allocation to $23.7 million. Meanwhile they spent $100 million a year for seven years on the football team. I mean, we don't have a money problem. We have a values problem. That's a separate thing. But the real point here is that the story is the same everywhere in the country that you go.

The real issue here is publicly traded companies. There are a couple of reasons that they're the real issue. Publicly traded companies run America. You don't think American Association of Retired Persons is behind the Medicare drug reform bills, do you? No, it's the Fortune 100. It's General Motors, who has a $58 billion retirement health care liability, and they want out from under it. They want to take their contractual obligation and put it off on the public bill. They're in cahoots with the pharmaceutical industry, which has deployed 700 lobbyists to Congress to make sure that in any bill that has language about Medicare drug reform, the phrase "no price regulation" is inserted into each bill. They have been successful with that. The net result of this will be that we will take on the contractual obligations that have been made over decades by the Fortune 100. The pharmaceutical companies will tell us exactly how much we need to pay on a per unit basis. It sounds fair to me; this is America.

If you want to make a change, you have to find the leverage point in corporate America. The leverage point is that the 6 percent drop in a single year in job-based enrollment translates to a 3 percent drop in total health care funding. That will happen this year and next year and the year afterwards until there comes a moment of genuine crisis, and the crisis is what matters here. If you want health care to work and you believe that it's worth making work, then there's a role for you to play that is more important than just about anybody else's role. The actuary's role is the infusion of transparency into the process with tools, tools like John mentioned or a bunch of other tools as well.

The key here is that, as the crisis happens, there will be a free for all. The AMA, pharmaceuticals industry, American Hospital Association, the accountable health plans and all the health plans, they will all come as the money dwindles and the demand increases and say, "You know, all we really need to do to fix health care is for you to give me more money." That's reasonable. That's what everybody is going to say, and at that moment there will be tribal wars in Washington, and they will play out. But in that scenario the guy with the biggest muscles wins at all of our expense. The result is still not sustainable because we have not addressed the core problem.

The core problem here is the six to eight times inflation each year in the cost structure. So lately—and I'm sure some of you work with benefits consulting firms—you know, you go to an employer. Let's say the employer has a hundred thousand lives, and it's the benefits consultants, the CFO and the VP of benefits, and finally the CFO loses patience. They will walk.

I was at a meeting in Washington in March, where a man from American Healthways, a big disease management company, got up, and he had a single slide. The slide said, "Benefits or profits." I thought, that's succinct: benefits or profits. We're talking about the perpetuation of your industry here because we can't seem to get anything under control. We're really talking about the substrata of that cost explosion and what we need to do to stabilize it. We need to fortify the safety net. We need to have a compatible IT. We need to have accountability. We need to have standards and so on.

To get there, what we're going to have to do is be prepared to go after those new tools that will allow us to manage and infuse transparency into the system so we can have managed care. The moment to do it will be the moment when things begin to go into crisis and turmoil. One of the things that we're doing is calling the leaders of health care organizations and business all together to say, "Do we really want to go to war with each other? Why don't we talk about creating a coalition platform around a narrow set of ideas that everybody can stomach—not embrace—but stomach when push comes to shove?" These are things like transparency, accountability, standards and all the same business disciplines that exist in every other industry.

I would like to discuss some data that probably aren't exactly right, but they're close. They show that two years ago, between 2001 and 2002, the number of people in Florida who were in small groups dropped by 13.2 percent, and the number in large groups dropped by 6.1 percent. That's the best data they can provide at this time. I know that's the same as it is in a lot of places in the country.

They all think that the problem is a problem of the uninsured. Let's clarify something. We've had 16 percent of the American population uninsured for 40 years. I think it's safe to say that we think it's okay that when they need care they can go to the emergency room, and we don't want to hear about it. The problem now is not the uninsured. The problem is the collapse of our mainstream coverage vehicles, the flight of people out of group health job-based coverage, the collapse of Medicaid. We haven't talked about the collapse of Medicare yet, but that's coming.

The only way to deal with these problems is with the tools that give us transparency. We all know this stuff; you've seen all this before. But, you know, we're getting uncompensated ER care, bad debt. I've been speaking to CFOs at hospitals who have been telling me that their bad debt has increased between 50 and 100 percent over the last year. That's because people are showing up. They

can't make their deductibles. They can't make their copayments, and they've got health issues that are no longer covered that they need taken care of. There's a narrowing of benefits and an increasing of the out of pocket. The safety nets are closing. The total health care funding will drop. Publicly traded health care organizations are going to suffer. Then because health care is up to one dollar in seven in one job in every 11, it's going to start cascading throughout the economy at large. It's a very ugly and frightening picture. It's in the extreme like nothing the country has ever witnessed before.

If I could get on my knees and beg you, I would. The actuaries are very, very, very important in all this. You do the numbers, you get the implications. I recognize that it is not part of your professional ethic to take stands. Now is the time to take a stand to argue for transparency of information, to argue for accountability, to argue for standards, to argue for infrastructure, because at the deepest level that's the only thing that's going to get us out of this. There's absolutely nothing partisan or political about that. These are structural arguments that you ought to be able to buy into without any difficulty at all.

FROM THE FLOOR: (Inaudible.)

MR. KLEPPER: We had to figure out how to frame this National Health Care Reform effort. We have major health plans and major employers. I got Microsoft the other day. We're trying to get together physicians, consumer groups, unions, everybody and get them to agree to this stuff. We decided not to frame it in terms of "We need to have universal coverage." We do need to have universal coverage of basic care of some sort. We need to get that dealt with. We need to have better quality care. The real issue is stability and instability. Stability is the thing that people care about. If you become unstable and you get to the point of being unable to do anything, that's terrible. That's the way we framed it to do this.

There are three principles that we've come up with. The system is worth saving for a lot of reasons. The hard part is effecting change. Stabilize the patient so you can work on him or her. Make sure that there are dollars associated with every patient that presents him- or herself for care, because if we don't do that, we will lose hundreds of billions of dollars of infrastructure that we have invested in over decades. That's what happens if we lose Grady. Basically, if we lose Grady, it's a billion dollars down the drain to replace that infrastructure.

This is a Democratic and a Republican argument. The Democrats would argue, "We just need to have universal coverage. Don't pay any attention to the price." Well, if you don't pay any attention to the cost and the cost explosion, it doesn't matter how much we spend; the system will eat it all if it continues to grow at eight times inflation. This is a Republican argument as well. "Protect our assets": that's the way it's framed.

Infuse management capability into the system. That has four areas: universally compatible information technology, standards, accountability at every level in the system and establishing some sort of centralized basis for technology assessment before things go to market.

The last thing is health care malpractice liability. I would urge all of you who are interested in this issue to look at the work being done by Philip Howard in Washington with Common Good: www.cgood.org. He wrote a book called "The Death of Common Sense and the Collapse of the Common Good."

It's not only tort reform, it's quality reform as well. You can't have quality reform without transparency.

Those are the big ideas. The other part of it is getting it done. We've mobilized to do that, to be positioned for when the guys who currently hold power and have been obstructionists recognize that the crisis turned hospitals against their interests. They will run free, become receptive to change, and that's the moment to move. This needs to be dealt with on the congressional level. There are lots of interesting issues associated with this.

We are doing it state by state. I'm very active with Florida right now. I just got invited to Colorado. There's a very interesting meeting that's happening in Washington on January 26 and 27, held by a group called The World Health Care Congress. At that meeting we will have a special breakout session. Senior executives from Fortune 500 companies will be delegates to our meeting. We will take them through this process: here's what the crisis looks like, here are the ramifications, here are these ideas that a lot of people can buy into. We will ask them to sign a resolution and get consensus on this resolution that says, "Give these ideas expression through policy adjustment in health care nationally." We can try to stabilize the system. That resolution will be hand carried to Congress. It will be used to frame the presidential debates, and it will be covered by *The Wall Street Journal* and CNBC. In other words, leverage the media and galvanize different constituencies. There are a lot of other things that are like this going on.

MR. JOHN W. C. STARK: There are two things that are in the shadows, and one is the legal profession. We've met with all these people, providers and so on, and every other word was legal action, sued—you know, pick some term. They're in this mix as big as anybody, but they're just hidden.

The other thing is when you talk about for-profit companies and Wall Street, the upper management really does have to focus on Wall Street. It seems like what you're talking about would require a change of focus. The focus there is meeting Wall Street's expectations.

As far as for-profit companies, whose expectations do we meet? Wall Street's? Are they in line with the things that you've been talking about?

MR. KLEPPER: They'll be absolutely in line, because if you get a 6 percent drop in enrollment in a year and a 3 percent drop in total funding in the system, there will be an impact on the revenues available to any for-profit company. There is a chain: revenues, margin, stock price, market cap and credit. All of those drop when you have a reduction of available funds in the system. That's why the stars pull the line.

MR. STARK: I guess my fear is, though, they'll align later rather than sooner, because all of a sudden it will be the health care sector is soft, put your money someplace else. Not only health insurers, but other health care companies' needs will dry up at a point when it's really critical.

MR. KLEPPER: That's one of the things that we're arguing for. That's a great point. I hadn't thought of that; it's interesting. One of the terrible problems that we have is the very high cost of information technology replacement. The problem is exacerbated by the fact that even though the cost per unit transaction has probably fallen by three or four magnitudes in recent years, the costs of the new systems are still being identified with the legacy systems because the traditional vendors don't want to cannibalize their stock price in favor of the new technologies. They've sort of blocked market entry for disruptive technologies.

One of the things that we've argued for is a national program that would be sort of analogous to the Hill-Burton Act of the 1920s and 1930s where we decided to put a lot of money into investing and building hospitals across the country, a new program for helping to finance new technology that would be standardized.

At the Health Technology Center in San Francisco, Dr. Molly Jo Coy is arguing for a similar program. Hers might be better; it's a national revolving loan program that's available to all providers. You have early adopters who are investing in this sort of thing because they can understand the ROI that will come, and they have available capital. But if the capital is withdrawn, that could be a problem.

FROM THE FLOOR: From being in health insurance, I used to deal with some of the Blue Cross plans with some of the executives, who knew who the best doctors were in the community and who the best hospitals were, the most efficient, the ones that they would trust their family members to and so forth. Many times it was just the opposite.

What I worry about is, let's say, in a large community area you had a program that dealt with only the best 50 percent of hospitals and doctors who would do a great job at a great price, and, at some point, your capacity would be fully used up. They couldn't take any more patients. Meanwhile you have all these other hospitals and doctors applying enormous political pressure. There would be such pressure for somebody to include in these programs doctors you really didn't want in there because of either their practice or competence, their honesty, all kinds of different reasons.

If you track beyond that, even if you got through the legal wrinkles that allow you to keep only the best people, the capacity gets used up unless you can retrain these other people. In the case of hospital administration, suddenly this bad hospital over here has to be managed by the good hospital's administrator. You really have to take away their administration ability. How you do that legally or practically, I don't know. We can't have 30–40 percent of all the practitioners doing a bad job and live with it because they want to get paid. They have to get paid. They just won't go away.

MR. KLEPPER: One of the really great things about transparency of information is that it encourages in the best, in the healthiest possible way people who haven't been performing well to perform well. Most doctors, when they figure out that their results are not as good as their peers, will immediately come on board and identify what they're not doing and will do better. It's the invisibility that's killing us.

Do we want to be ignorant so that we don't really call out the bad guys? I think if we shine the bright light of truth on it everything gets better. That's certainly the underlying assumption.

MR. COOKSON: I have a slightly different take on that though. If you buy the fact that there's provider-based induced demand, there is inefficient care, there is inefficacious care, a lot of errors creating additional needs for care, then you need a lot fewer resources than are really out there to begin with.

I can see the same thing with respect to the expressed nursing shortage. If you measure the hospital performance and efficiencies, I estimate that half of the inpatient base in this country is avoidable. You don't have a nursing shortage if you take care of that problem. There is another aspect to this. Maybe we don't need all that care.

MR. KLEPPER: That's really true. It's a great point.

MR. ROBERT M. SACKEL: To follow up the point of that transparency, earlier this year Newt Gingrich was giving a speech to congressional staffers about the Medicare bill and how it needs to be fixed. His arguments were quite compelling. Interestingly enough, he argued for a government-funded database.

The concept was in terms of the concern about biological terrorism and the need to be able to have instant communication with various sectors of what to do. The need would fuel, perhaps with Medicare, a database of people's results and history of medical care, so you can correlate that into best practices. If somebody is in New York and then they're in Arizona next week, you can get the same information. It seems to suggest the government's funding of an incredible database to help with some of this transparency.

MR. KLEPPER: Actually Mr. Gingrich has been in the forefront of arguing to use technology to fix the system, which is exactly what we need. The rest of the Republican Party isn't there, but he's been forthright on that point. The privacy and security concerns are always there. You've got to use whatever levers you have available to you. Right now the hot topic for this government is security. There are good survey data out there now to show that the American people believe that. They are four times as worried about losing their health insurance as they are about another terrorist attack.