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HEALTH CARE DELIVERY SYSTEMS

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

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SECOND SESSION

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COMMUNICATIONS

HEALTH CARE DELIVERY SYSTEMS

TUESDAY, MARCH 1, 1994

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:05 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Daniel Patrick Moynihan (chairman of the committee) presiding.

Also present: Senators Rockefeller, Daschle, Breaux, Conrad, Packwood, Dole, Chafee, Durenberger, Grassley, and Wallop.

[The press release announcing the hearing follows:]

[Press Release No. H–11, February 25, 1994]

FINANCE COMMITTEE SETS HEARING ON HEALTH DELIVERY SYSTEMS

WASHINGTON, DC.—Senator Daniel Patrick Moynihan (D-NY), Chairman of the Senate Committee on Finance, announced today that the Committee will continue its examination of health care issues with a hearing on health care delivery systems.

The hearing will begin at *10:00 a.m. on Tuesday, March 1, 1994* in room SD–215 of the Dirksen Senate Office Building.

"Many analysts believe that health care reform proposals before Congress would accelerate the rate of change in our health delivery systems," Senator Moynihan said in announcing the hearing. "It is vital that the Committee gain a clear understanding of current delivery systems and the impact that health reform will have on their evolution."

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. A very good morning to you all and to our distinguished panel, and to Dr. Ellwood, venerable before his time. I will have no opening statement. Senator Packwood does. I turn to Senator Packwood.

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON

Senator PACKWOOD. This does not apply to Dr. Ellwood, but I thought it was a good witticism. A number of years ago at a political banquet that was honoring a fellow that was particularly impressed with his own achievements and the MC said a legend in his own mind. [Laughter.]

Mr. Chairman, we have an opportunity today—in fact, I was surprised there was not a line three times around this building. I think this is one of the most important hearings that we are going to have.

The Chairman and I gauge how much money is involved by the length of the lines. Whenever we have hearings on welfare reform or children or something like that, there are two or three reporters and maybe ten people in the room.

The CHAIRMAN. Half of which have got here by mistake. They get up and leave as soon as they find out the subject matter. [Laughter.]

Senator PACKWOOD. But the health delivery system, and whether or not the Federal Government can manage it better and produce better results than a private delivery system is a critical question. That is what we are going to hear examined today and we could not have three better witnesses.

I just wanted to say that we have got to do better than what Dr. Reischauer told us. I do not mean this to be critical. But when he said, if the President's plan is adopted—and I sensed he had a certain warmth for it; he did not really endorse it, but warmth—he says, we will reduce our medical costs in this country from a projected 20 percent of GNP to 19 percent of gross national product, when today it is 14 percent. That does not seem like the right direction to me to say victory is getting 19 percent instead of 20 percent.

So I am very encouraged to have you here. And Oregon and Minnesota are two States where the private sector has done a very good job. The Oregon Association of Hospitals in 1992 finished a study matching Oregon's hospitals with others. And if other hospitals simply equalled Oregon's practices, there would be 5.5 million fewer admissions, 64 million fewer hospital days, and an estimated saving of about $50 billion in medical expenses a year in the United States. This is being done by the private sector—private nonprofit hospitals, the private sector—in Oregon now.

I think that is impressive and I am looking forward, Mr. Chairman, very much to the comments these three gentlemen have to give us.

The CHAIRMAN. Most assuredly. Just to be specific about your projection, the CBO study shows us in our present base line—that term which says you go on at a rate of increase with the past—we would be at $2.220 trillion in outlays by the year 2004, a decade out. With the changes in base line proposed by the administration, that drops to $2.070 trillion. A difference, but as Senator Durenberger was making the point the other day, not overwhelming, almost at some point marginal.

Senator Durenberger?

OPENING STATEMENT OF DAVE DURENBERGER, A U.S. SENATOR FROM MINNESOTA

Senator DURENBERGER. Mr. Chairman, thank you very much. I thank you both for your comments. I appreciate the opportunity that I have been given to help you all take a couple of hours and try to begin to understand the problems in the delivery system.

I find that one of the main things that divided us in this battle of the health plans is trying to understand what is the problem out there. And because we all individually like our doctors or we like the care we get, we admire the medical miracles and so forth, we have a tendency to think it must be the paperwork that is the

problem or it must be the insurance companies that are the problem, or it must be the drug companies that are the problem.

We do not understand that we are all part of the problem in one way or another. We have grown up with it and that is one of the reasons why we have some difficulty understanding it.

Some of the people that I have become acquainted with over the 16 years that I have been working on the issue of health care reform in this committee, pricing medical products—which is something that a lot of people insist we cannot do because it is a social good. We insist on doing it here through Medicare with DRG's and then with RBRVS and then with a lot of other approaches—it is part of restoring the sense of a market in medicine.

What is absent today in the medical marketplace, of course, are the consumers. Because consumers do not have any information, consumers cannot be wise buyers. They do not know what they are buying. They do not know what they are getting. They do not know what they are paying for it. That is a problem.

On the provider side, the problem is that there are all kinds of restrictions on entry into the marketplace. They are created either by antitrust laws. They are created by State benefit mandates They are created by the licensure system. They are created by the reimbursement system.

Over time, we have insisted on making the market for delivering health care services so difficult to organize is hard to recognize, you know, a good, high quality, high value provider of care.

The people, Mr. Chairman, that we will hear from today are people who have recognized this before I did—Paul and I first met in 1966. He was doing health care reform. Gordy and I have met, I think, probably—well, we met first before I was elected to the job.

The CHAIRMAN. For the record, we record that Gordy is Gordon Sprenger.

Senator DURENBERGER. Yes, right. And Tom Pyle and I have come to know each other and I have respected him a great deal as the head of the one really accountable health plan in Massachusetts, the Harvard Community Health Plan, and now contributing his talent at MetLife.

Then there is another panel that will follow them of equally knowledgeable persons. So, Mr. Chairman, I think this is only the beginning of exploring the most critical part of understanding health care reform and I appreciate your giving the time and attention to it that you are doing as Chairman.

The CHAIRMAN. No, sir. It is you who suggested this and produced these extraordinary panels. We are hardly for the first time, much in your debt.

Senator Dole, we welcome you once again, sir. We want to get to hear the panels.

Senator Wallop, good morning, sir.

Senator WALLOP. I have no opening statement. I am anxious to hear the panels, but want to welcome Dr. Ellwood, who is part and parcel of a little place in Wyoming calling Jackson Hole.

Dr. ELLWOOD. We call it the Teton Village Health Club. [Laughter.]

The CHAIRMAN. Well, on that very friendly neighborly note, we welcome you, sir. Dr. Ellwood, you are first on our list.

STATEMENT OF PAUL M. ELLWOOD, M.D., PRESIDENT, THE JACKSON HOLE GROUP, TETON VILLAGE, WY

Dr. ELLWOOD. Well, Mr. Chairman, I am especially satisfied and gratified to be here today because you have been, as you know, an inspiration and a mentor to my son, David, the welfare reform Ellwood. I hope you are more successful in moving forward the welfare reform process than I have the health care reform process. The rest of the committee consists of both friends and heroes of mine as we have fought to reform health care.

This hearing is the first in the health care reform debate where a powerful policy making body has sought to look at the health delivery system, a system of health services that all Americans are going to be dependent upon, and where we expect that competition over price and quality will set the stage for a better health system.

Most of the organizations that we expect to emerge from this process most closely resemble what we have called health maintenance organizations, or accountable health plans. I thought I would briefly define for you what we mean by that.

First of all, we expect that the dominant health delivery organizations will be those that combine health insurance with the actual delivery of health care. That is a very important objective because it means the organizations that pay for medical care actually have to make sure that it is there. And the most aggressive recruiters of physicians, particularly primary physicians that we see, particularly in smaller communities, are these health maintenance organizations, which actually have to have the care there, rather than just simply paying for it.

An example of this is the Mayo Clinic, which has now decided to become an accountable health plan. It is establishing grants just now in a 120 mile radius around the clinic. You will be able to go to a primary care physician within 30 minutes who will be working with the Mayo Clinic in that huge geographic area. We would expect other organizations to behave in the same way.

The second characteristic for these organizations is they are paid on an annual per capita basis, which is calculated in advance. So they are in a position in which they have to deliver medical care efficiently and make it easy for people to get into the health system early so that they do not become unduly ill and cost more money.

Third, these organizations enroll consumers, they commit consumers to obtaining their medical care from them, for a period of a year. Now, the usual medical transaction is the length of a hospital stay or for a doctor visit.

But with these arrangements, these organizations are in a position in which they have to coordinate care and have to be responsive to people and are in a position to follow the impact of medical care over a much longer period of time. This puts them in a position in which they are more likely to emphasize prevention.

In emphasizing prevention, it is important that these organizations, of course, retain their enrollees for more than a year because so many of the prevention activities that we engage in really take more time than that.

The fourth characteristic that they have is, they provide uniform and rather comprehensive benefits. Their benefit package, I suspect, is one that you should consider as a prototype for universal

coverage, because we know how much it costs, we know how well it works. It is already in law; 35 million people of all ages are receiving this particular set of benefits.

The final characteristic of these organizations is that they have already engaged in insurance reform—they community rate for individuals and small groups. They have to provide some continuity of coverage. They have to accept all comers to their organization.

One of the rather historic ironies of this hearing is that in 1970 Presidential Assistant Daniel Patrick Moynihan's Deputy, a fellow by the name of Chester Finn, was one of the original devisers, if you will, of the plan to use Medicare to reshape the health delivery system; to have Medicare, the largest buyer of medical care at the time, use HMO's to reshape the private health system.

This particular committee was testified before in June of 1970 by then-Secretary of HEW, Elliot Richardson, advocating that idea. The idea died in this committee and it was not until 1985 that Medicare chose to offer risk contracts to people—15 years later.

Now this is not too atypical. In virtually every country where I have had an opportunity to work and where they have single payer health systems, the government finds itself in a position where it is very difficult, and they are reluctant to attempt to use their massive purchasing power to reshape the health delivery system.

President Clinton's plan falls into the same trap. Medicare is treated as an exception to the prevailing form of health reform that is expected in the private sector and Medicare presumably continues to be paid on a fee-for-service basis and relying on DRG's.

Mr. Tull and Gordy Sprenger will comment on the implications of the distorting affect of this legislation.

Another thing that I would like to point to historically is that we have the tendency to underestimate how long it will take to restructure this massive health delivery system.

In 1971 in HEW there was a debate between, you know, management experts as to just how many HMO's we would have when. There was one group, the conservative group, that felt we would have 1300 HMO's serving 65 million people in 5 years. Now they were debating with another group that felt we would have 5,000 to 10,000 HMO's serving virtually the entire population in 10 years. Both lost.

What we have at the present time is 540 HMO's in the United States serving about 42 million people; and the sluggish HMO risk program, which has now been in place for 9 years, I guess, is serving 2 million out of 35 million seniors.

HMO's are growing. You can see in this first graph that you have at your desk that they are growing much more rapidly. We expect them to be the dominant——

The CHAIRMAN. You project that they are growing rapidly? The last 4 years have been slow.

Dr. ELLWOOD. Yes. Right.

The present number, at least as of July, is the number that is contained in my testimony—42.3 million and some odd thousand people.

HMO's do enjoy a cost advantage over other forms of health delivery. In your second graph there, you can see the premium increase rate for HMO's in the last 3 years, with again the 1994 pre-

mium being just newly collected. That is still not a satisfactory number. It is still considerably higher than the consumer price index, but is the lowest rate of cost increase in health care since the time that the Nixon Administration slapped price controls on the health system.

As a consequence of HMO's ability to contain costs more readily than the other forms of health care, we have this phenomena that you see on graph number three there, with HMO premiums steadily declining relative to the other premiums, those of the PPO's which are one of the HMO's rather timid offspring, and indemnity coverage which is relatively flat. So the gap between the premiums, between HMO's and the other forms of health insurance, keep broadening.

The last graph is this one, graph number four. It is called "Survey of Percentage of Employees Enrolled by Type of Coverage in 1992." I find it particularly interesting to look at the West Coast market, where we have the most intense competition. You will notice there that indemnity coverage is dying and is down to less than 20 percent.

PPO's are larger than HMO's, but those are a very unusual form of PPO out there. What a PPO is, is simply a health care organization that generally approaches employers and offers them discounts on doctor visits and hospital days, but does not put providers at risk the way an HMO would.

What is happening in the west is that the PPO's are gradually moving to put their providers at risk and they are more and more closely resembling HMO's. I think that the same pattern can be expected for the rest of the industry.

Now while indemnity insurance is in the grave yard, HMO's have some fairly serious defects as well. I would like to identify those.

HMO's need to improve considerably, both in clinical effectiveness and consumer quality accountability if they are to carry the burden of health delivery reform into the 21st Century. That is why we have changed the name of them to Accountant Health Plans.

HMO's have saved money by reducing hospitalization and by purchasing health care from doctors and hospitals at lower prices and by matching the number and types of doctors that they have to the number and types of people that they are responsible for.

Now as a consequence of that, the number of doctors that HMO's need is about half as many doctors as we have—120 doctors per 100,000 people, compared to something in excess of 210 per 100,000 practicing now. And in the pipeline we get up to 300 doctors per 100,000 people.

So that if we were to have wall-to-wall HMO's, we would have a doctor surplus in the neighborhood of 50 percent; and a hospital surplus in excess of that.

Now most consumers who have not participated in health plans, and many who do, have exhibited a concern that if you cut the cost of health care you are cutting the quality of health care. Cost cutting in health care is synonymous with cutting quality.

They are fearful, too, that they are not going to have the opportunity to find a suitable physician in one of these organizations. I have already told you, they use less doctors and want to use less

doctors than the rest of the system. I think some of these fears are justified, but both problems are correctable.

The government, I believe, needs to establish, in collaboration with providers and consumers, a uniform system of public accountability for these organizations. I do not mean a system that tells you simply how long you have to wait to see a doctor or that kind of thing. I feel that these organizations should report to the public on the impact they are having on people's health. That is what we want from the health system. We want better health.

It is possible now to measure after adjusting for the severity of the patients they are taking care of, the impact of health care organizations on function and well being. This particular system offers us the opportunity to do that because they have responsibility for people over time. They are not just providing doctor visits and hospital days. They have a population that is theirs for an extended period to follow, treat, keep well, provide ideal health care to. That is why we call them accountable health plans.

The same system can be used to improve physician decision making. I was reviewing recently the number of statistics on HMO's and I was struck by the fact that even though they have been more economical and more efficient, they still show the wide variation in the frequency with which they do gall bladder operations or take out uteruses that the rest of the system does.

They have not, up to this point, taken advantage of the fact that they have better potential information on their consumers and could use that information to improve their decision making.

Finally, on the matter of consumer choice, you will notice on this graph, the last one I showed you, there is a little thing called POS. That stands for point of service. More and more HMO's have decided to offer their enrollees an opportunity to go out of plan. If they want to see any doctor of any hospital of their choice, they are permitted to do so and are charged some extra premium for doing so.

I feel that in every place in the country where we have health plans, at least one of them should offer a point of service choice. I do not know that we need to force everyone to do it, because putting in a point of service choice means that you are operating an indemnity insurance company at the same time that you are offering an HMO insurance company, and it kicks up your reserve requirements and makes it much more costly.

I think it is a very, very hollow promise to say to people, we are going to have a fee-for-service plan out there and an indemnity plan in every community. You can see by these statistics no one can afford to operate an indemnity plan in the future if we have a truly competitive health system.

I very much appreciate the opportunity to appear before you, Mr. Chairman, and your distinguished committee. Thank you very much.

[The prepared statement of Dr. Ellwood appears in the appendix.]

The CHAIRMAN. We thank you, Dr. Ellwood. Those were luminously clarifying thoughts and we will get to the whole panel in a moment.

I believe Mr. Pyle, who is the executive officer of MetLife Healthcare, you are next, sir.

STATEMENT OF THOMAS O. PYLE, CHIEF EXECUTIVE OFFICER, METLIFE HEALTHCARE MANAGEMENT CORPORATION, WESTPORT, CT

Mr. PYLE. Thank you, Mr. Chairman and members of the committee. I am very pleased to be here. I have been involved in building and managing health plans. When I started, the HMO name had not been invented by Paul yet. But I have been doing this since 1972, first at the Harvard Community Health Plan for 20 years, and then after a couple years working with Dr. Ellwood, now at MetLife.

I am especially pleased that you have decided to focus on the delivery system today because that is where the care is; and as Willie Sutton said, that is where the money is. You can talk about administrative savings. You can talk about a lot of things. But the preponderance of what we deal with in health care are the people who deliver the care and the facilities that deliver the care. So that is where the quality comes from and that is where the money goes.

The accountable health partnerships have really received too little emphasis. All of the press has been about purchasing cooperatives of alliances, as though they delivered care or as though they could affect value.

Allen Entovin's original concept was that they would be like a grocery store shelf on which products would be displayed by manufacturers, and I put that word in quotes, and people could choose. They would not be regulatory entities.

The game of health care value is in controlling costs, improving quality, improving access. That game is going to be played and won by accountable health partnerships, not by some other intermediary entity. It is sort of like the plug that hooks your telephone to the telephone system, but it is just a plug.

The CHAIRMAN. Mr. Pyle, would you mind if I just interject to say we have had a lot of trouble getting a sort of lexicon up here identifying what different words mean. What was HMO is now AHP?

Dr. ELLWOOD. Well, if you have the accountability aspect of it that I mentioned, we would call it an Accountable Health Plan. But at this point they are not accountable and we still call them HMO's. So let us stick to HMO's for the moment.

The CHAIRMAN. All right.

Dr. ELLWOOD. It makes it easier perhaps.

The CHAIRMAN. And will you stick to HMO's?

Mr. PYLE. Sure. I would be happy to, wherever we are going. [Laughter.]

Coming from the HMO industry, it is easier for me to stick to it than it might be for some others who are here.

Using the word HMO or Health Maintenance Organization, but saying as I deeply believe as a manager that it must be accountable, whatever it is called, I would just comment to the committee that accountability is a novel concept in health care and most people do not realize that.

But until recently—and I am talking recently in the scheme of things, perhaps the last 10 years—court decisions had not held hos-

pital trustees accountable for the physicians' activities on their staff. It was hard to get professional testimony in malpractice cases if you were a plaintiff. Disciplinary actions were kept secret in the medical field.

There was no information published about the performance of organizations and old style insurers were passive players. They did not take responsibility for the care that was delivered. So this idea of publishing information, of getting it out to consumers is a very new concept and should not be——

The CHAIRMAN. An HMO can do this?

Mr. PYLE. An HMO can do this, but an HMO would do it with great concern if it was the only player in the industry that was doing it. Because if you look at a death rate of——

The CHAIRMAN. That is called innovator costs.

Mr. PYLE [continuing]. One percent for something, and you do not know that normal is 3 percent, you can say, well, they are killing 1 percent of the people, to use a very crass example. So this idea of accountability is a new one.

Similarly, on the non-qualitative side, costs have been shifted, misallocated, disguised, subsidized. This has fostered entitlement and irresponsibility in the population of this country and some of the current debate has not helped it very much.

So we have taken in recent times our first tentative awkward steps into a new era. Where is the data going to come from? Well, we are getting it not from malpractice, which is not very useful. As you probably know, in New York State that wonderful study that was done by people from Harvard showed that for every malpractice case that was brought there were 10 incidents that were not looked at at all. So that is not a system.

We need, as Dr. Ellwood has suggested, outcomes information. We need immunization data. We need waiting times. We need member satisfaction. We can report these things. We can achieve ever increasing clarity about them and relevance as we develop benchmark data in the years ahead.

The first year's standards will be weak, but they will improve as people are forced to look at their own performance. Costs can be clarified to consumers and the changes that have been proposed in the tax area could help this a great deal so that people know what they are paying for and know when they are buying a more expensive plan.

The integration of finance and delivery elements into a single organization permits management. That is the only kind of organization I have ever managed in the health care field, where I had control of both, and could make substitutions of one thing for another because I did not have to go to some third party to get approval to see if it was covered to put a woman who was pregnant and having problems in a hotel instead of either sending her home or putting her in the hospital, for example.

These organizations can compete to improve based on the reported information that they put out. They can engage in total quality management. Most important, and one of the reasons that I feel so strongly about not having an overly regulatory intermediary, is they can experiment. And the ability to experi-

ment is the ability to improve. And the inability to experiment is the inability to improve.

Competition is one of our most powerful motivators. Any of you who had the opportunity to watch our athletes and other athletes at Lillehammer could see the power of competing against other athletes to excel. It is much, much stronger than trying to meet a standard that has been set by some official to do something.

We need to have that in the health care field so that we can bring our costs down and improve our quality the way the electronics industry has done it, the way the airline industry has done it.

In Massachusetts, where we now surprisingly have 42 percent of the people enrolled in real HMO's, the highest in the nation, we see very strong health plans that were stimulated by the Harvard Plan—plans like Fallon, Tuffs and Pilgrim that have grown to compete in that market. Now markets are inherently self-interested. And, therefore, they must be guided to prevent anti-social behavior.

While we need to have a market to bring costs down and improve quality, we need to have some guidelines to provide access, portability and reasonable pricing that is not discriminatory.

In this kind of environment, I think we can have flourishing accountable health plans. The plan sponsors will have to have skill. They will have to have financial resources to protect the consumer, not themselves. They will have to have a standard benefit package or competition will be difficult for consumers to understand. Pricing will have to be on a reasonable basis that does not discriminate against the ill. Consumers need to have guaranteed; and, finally, to go back to my starting point, accountability.

In this kind of a market I think we will see all types of sponsors—current HMO's; group practices, such as Leahy or Mayo; employers, such as John Deere; hospitals; insurance companies, although they will be less important than they are now. Some of each of these will succeed; some will fail. And that is the market that will produce the kind of health care system that I think we aspire to.

[The prepared statement of Mr. Pyle appears in the appendix.]

The CHAIRMAN. We thank you very much, Mr. Pyle. I want to note for all present that we have spoken of costs coming down, which we will get to. We have not heard that proposition before. We have been talking about holding down the rate of increase.

And now appearing for the American Hospital Association, Gordon Sprenger, who is the Executive Officer of HealthSpan Health Systems Corporation of Minneapolis. Mr. Sprenger, we welcome you, sir.

STATEMENT OF GORDON M. SPRENGER, EXECUTIVE OFFICER, HEALTHSPAN HEALTH SYSTEMS CORPORATION, MINNEAPOLIS, MN, ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. SPRENGER. Thank you very much, Mr. Chairman. I am pleased to be with you and be able to represent my colleagues at the American Hospital Association.

Back home I am involved with a system of hospitals, both rural, as well as urban, specialized hospitals. We have physician groups

that are part of our organization, home health care plans, ambulance services, the full continuum of services. That is my frame of reference as I give my comments to you today.

The health care reform debate, we believe, has truly become focused on financing broader health care coverage, but it is vital that we not lose sight of what we will do with that broader coverage. That is what I would like to speak about today.

Given the stakes involved, Congress is facing a formidable task. We commend you and the administration for engaging it and we pledge our assistance in working through the many complexities it represents.

First of all, what is wrong with the current system? From our perspective, in one word, I would say it is incentives. The incentives in health care are skewed at almost every level. The incentive for insurers is to avoid risk. Provider payment methods, creating conflict between hospitals and physicians for the DRG system, for Medicare patients, the per diem payment mechanisms, discounts off of charges, have all pulled some costs out of the system. That is absolutely right. We have pulled some costs out of the system with some of those vehicles.

In Minnesota, independent studies indicate that our costs are 20 percent below the national average. While that is still very good, it is not good enough. The system truly needs to be overhauled if we are going to take additional costs out of the system without affecting quality and maintaining reasonable access.

The purchasers in Minnesota, as I indicated, are not satisfied. The pressure is as great on us as it is in any other part of the country. How did we get to that point of being 20 percent under the national average? Our market has evolved. It is not like a light switch. It did not suddenly happen. It is not necessarily driven by government reform. Although certainly, our State Legislature has nudged us some, our managed care market has matured through competition and quality has been maintained.

Studies, the same studies I referred to on the cost savings, indicate that the health status of Minnesotans is at the top of the list of this country. Learning from experience, we know that the next generation of managed care services is the development of these integrated care systems that we are talking about, with the focus on the clinical management of health care, with emphasis placed on improving the process, not the administration of health care—providing the care to ensure efficiency and good outcomes.

This, in our community, has resulted in the coming together of providers and health plans to form integrated care systems. That is why my own particular provider organization, HealthSpan, is merging with Medica, a major HMO in our community. Similar organizations are forming elsewhere in the country. This is a natural marketplace evolution.

We cannot take the next step, though, to meet our market pressure, without moving into this integrated delivery system model. However, this development needs to be balanced with the setting of industry standards by government. Rules need to be established to prevent such systems or accountable health plans, HMO's—whatever, Senator Moynihan, we want to refer to them as—from enrolling only healthy people, to establish a standard set of appro-

priate benefits, to ensure public accountability for results, as my colleagues have been talking about.

Government need not regulate the form of these health systems or their process of management, but they should require accountability, so that the public can buy health care on the basis of price, service and quality and do so in an informed manner.

The Minnesota experience does encourage us that market-driven competition balanced by appropriate government reforms can result in high quality care being efficiently provided. Most of us providers have little incentive to prevent illness. We have a sickness system, not a health system.

Not only are financial incentives not there, but the short term contracts that health plans have with employees or employers that go year-by-year do not motivate any provider or any health plan to invest in preventive care. Why should you? You may not be around to gain the benefits of that early investment.

So the most important message that I want to leave with you is that we must fundamentally restructure the health care delivery system. How do we restructure? Again, develop these community-based delivery systems that link providers together into what AHA calls community care networks. In Minnesota we call them integrated service networks. They are the same thing. They just have different names.

The CHAIRMAN. Are they HMO's?

Mr. SPRENGER. They could be, except I am talking about—the HMO from my perspective, unless they are staff model HMO, have salaried employees. I am talking about bringing all of the providers together into a network.

The CHAIRMAN. You are close. You all three are talking about essentially the same idea here, are you not?

Mr. SPRENGER. We are close, except I am talking about integrating the providers much more into the network than what the typical HMO would have.

The fragmentation of the current health care system has created, I believe, a nonsystem that is difficult for patients to comprehend. This causes duplication, non-coordinated care, no single accountability that an individual purchaser can look to.

Our market in Minnesota is demanding accountability, from small employers that are coming together, to large employers banding together into purchasing groups. Our fairly sophisticated purchasers understand that discounts off of services and lack of potential risk-reward incentive plans do not encourage you to ask the appropriate questions.

We need to establish mechanisms that coordinate care and paperwork across provider settings. And over time, I believe there should be common patient registrations, unified medical records. My hope is that this would become common shared information across competing health plans and community networks.

We are finally maturing enough in Minnesota, I believe, to realize that competition is not overpracticed protocols or guidelines or basic information. Everyone in the community should have the right to have access to the best way of doing something.

The real competition is over the execution of the guideline. What is the outcome of your implementation plan or of your prevention

plan? That is the key. In the formation of these community care networks, we need to remove legal and regulatory barriers, including antitrust, anti-kick back laws, physician referral prohibitions and corporate practice of medicine laws.

Let me give you a personal example. I have been through five mergers in the last 12 years—all to reduce capacity, all to maintain access, all to reshape our delivery system in our community from the hospital's perspective, most recently the merger with the health plan.

When I tell antitrust lawyers that I am trying to find a way not to have three CAT scanners in Minneapolis-St. Paul if we need one at all, I get the glassy-eyed look, because they are coming from the perspective in the commercial context that more is better. You should have a Wendys, and a McDonalds, and a Hardees all on the same street corner; and three CAT scanners is what will bring competition into the community.

We know that is not what is needed in health care. If we are going to provide a full continuum of services, then there may be fewer competitive players in a given community. There seems to be a preoccupation with the idea that we have to have many competitors in order to truly compete. What we really need is well-developed, well-integrated, well-financed, well-measured plans. We need help to do that.

The old model of purchasers going through a third party in order to receive services from providers, where the third party in essence manages the care process—and I will explain that in a minute—has got to change to a new model where the purchasers come directly to the providers in a comprehensive network, with the right risk reward incentives in place, where the administrative process supports the management of the scarce resources of providing those services, not directs it.

The old model had a structure that gave you as a provider a 1-800 number in order to get permission to give service to a client or a patient or indicated that if you had a coronary bypass, you came in on Monday and you had better be out on Thursday or Friday; or if you are a maternity patient, if you are in before midnight today you had better be out before midnight tomorrow.

That is what I refer to as the old model, the old administrative model. That was appropriate while those administrative organizations held all the risk. The question that is not being asked is, first of all on the coronary bypass, should it be done at all, and what is to give the incentive under the current system to ask that question?

There is no administrative structure, no 1-800 number that can ask that kind of question. The care giver must be in the position to make those decisions along with the patients. We need your permission to come together, remove some of the boulders that are there, to allow these community care networks to come together so that we can put the right incentive plans of risk and rewards in place as we shift from the paradigm where service was revenue to where service is cost and the real tests are outcomes in maintaining a population health status.

On that basis, our business will succeed because one of the major issues is to encourage capitation of payment arrangements for net-

works. I recognize the concern of the American public, which is absolutely appropriate. Why should they risk giving someone $300 a month to maintain their health status if all the reward comes through doing less for them? That is why the measurement systems are absolutely essential in order to counterbalance any temptation to do less.

It is no different than any other business. If you do not have good outcomes and you do not have good success rates, do not expect people to choose your plan the next time they sign up. It is important with health care reform now, Senators, as hospitals we recognize that the system is broken due to all the reasons I have stated. We urge you not to take the approach of tinkering around the edges of the problem, but to focus on the core issues and correct them at this time.

Help us remove the boulders that are in the way. They are not little rocks; they are boulders. Given the right tools, we as hospitals believe——

The CHAIRMAN. We will not have any aspersions made on the capital of Arkansas.

Mr. SPRENGER. All right, sir. We appreciate that.

The CHAIRMAN. They are not swamps.

Mr. SPRENGER. All right, very fine.

Given the right tools, we as hospitals believe we can collaborate with physicians, other health care providers, insurance companies, HMO's, to put in place these community care networks which will have the right incentive to do what is appropriate.

We are willing to be held accountable in a way we have never experienced in our industry before or in our fragmented system before and to deliver value-driven high quality service to our citizens. Congress needs to establish the broad rules—and I underline the word, broad rules—under which health care will be organized and delivered in this country. But they also need to leave plenty of room for the communities to develop their accountable health plans and to give flexibility in determining the ways in which these plans will be held accountable.

In other words, we need the parameters of the sand box established, which I hope that my written testimony and my comments today will help focus on. Given those broad principles, Senator, we as providers will respond to the challenges ahead.

Thank you very much for the opportunity of sharing this with you. I can give you many more examples but will wait until we get into the questioning period and discuss it further.

[The prepared statement of Mr. Sprenger appears in the appendix.]

The CHAIRMAN. Good. We thank you, sir. Could I just make a general point? I think someone mentioned paradigm shift here. The shifting to the measurement of outcomes is a point where mature discipline finally reaches—I mean, under Coleman in the 1960's we learned to measure and think of education in terms of outcome as against inputs and the whole input/output analysis preceded it as a theoretical idea. Clearly, I think we are at that point.

Senator WALLOP. Mr. Chairman, I would say that it has not been a spectacular success, measuring the outcome of education.

The CHAIRMAN. I would say, sir, it has, in fact, been just the contrary. It is a spectacular success and has told us how many things that we thought were so, were not so.

Senator WALLOP. Well, perhaps the measurement has been accurate, but what we have chosen to do with this——

The CHAIRMAN. We have not changed any outcome, is that what you mean?

Senator WALLOP. Well, one worries that the measurement may be enough to satisfy us and the outcome unchangeable when the government gets its hands on it.

The CHAIRMAN. Right. I can make the point and we will stop right here. We have heard about extraordinary events that go on in Minnesota, how well things do and how well things are done in Oregon.

About February a year ago, I was taking up this issue of education and demonstrated that the strongest correlation you could find between educational outcomes and individual school systems was the distance of the State Capital from the Canadian border. The correlation of 0.552, nothing else. So North Carolina roared in. Minnesota roared in. Oregon roared in. And the answer obviously is to move your State Capital closer to Canada and then you have solved all that problem. So what about that?

Senator Durenberger, this is——

Senator WALLOP. In this instance, I think not. Canada and health care are not appealing.

The CHAIRMAN. I do not want to arouse the atavistical concerns of the Senator from Wyoming. We will have another panel on that subject. This is Senator Durenberger's panel. Would you like to ask questions?

Senator DURENBERGER. Well, Mr. Chairman, I do have a series of questions. It was my thought to put some of these questions in the record because I know it is so difficult for some of our colleagues to get here.

I know one of the concerns—and I may leave it to my colleagues from South Dakota and North Dakota to explore this—I think they fall in your relationship to the Canadian border in one way or another. But clearly, as we have been struggling with the issue of redesign of the delivery system, we are also dealing with the realities that the system is already changing out there.

As medicine gets better, whatever that may mean, people are shifting their traditional relationships, both with doctors and with hospitals, out in our more rural parts of the country. We are all seeing such very interesting recombinations of delivery systems.

I talk a lot and hear about the Fargo Clinic and the Dakota Clinic and the Grand Forks Clinic, which are in Kent Conrad's State. But without them, we would not be improving access and quality of health care in this vast wheatlands, and sugar beet lands, and sunflower lands of northwestern Minnesota. One of the largest Congressional Districts in America geographically is in northwestern Minnesota, believe it or not.

But it is being served by a changing delivery systems. There is now this large Fargo Clinic, for example, 200 and some doctors, is common ownership with St. Luke's hospital, which is the largest hospital and it is all owned by 78 churches, believe it or not, in

northwestern Minnesota and eastern North Dakota and doing a fantastic job of recruiting and providing health care.

So this has gone on despite the fact that we are working in a dysfunctional marketplace. There is a different situation in South Dakota where in Sioux Falls we have two very dominant hospitals that compete with each other all of the time. But in the nature of their competition is to extend services into Minnesota and into northwestern Iowa and out into rural South Dakota in order to, as Mr. Sprenger says, integrate the delivery of services.

But I raise that for two reasons—one to say, there is no one model of accountable health partnerships. There is demonstrated in America today, just by the change in the system, that there are a variety of ways of going about this.

The critical issue is the one of accountability, and that's what my question raises for those of you who have been the practitioners as well as the visionaries. There is a lot of concern outside our metropolitan areas, in the areas where the law of large numbers usually works against the access to high cost, low frequency services, for example, the concern about competition does not work in rural areas. What is the function of an accountable health plan or partnership in rural America and North Dakota and South Dakota and rural Minnesota?

And if any one of you would like to describe that or translate that a little bit for us—I know my colleagues are better than I on the subject, but perhaps that would be a good place to start.

The CHAIRMAN. Mr. Sprenger, you are from Minnesota.

Mr. SPRENGER. I would be happy to. In fact, it falls right in a meeting we had a week ago, Senator Durenberger, in which Fargo and seven other communities in rural Minnesota and ourselves all met in terms of how we could work to put together an integrated provider network that could become accountable for a given population base in their communities.

It is very much community based from the metro area with Metaca Insurance HMO plan, along with our church centers, but we would be able to provide certain services to them. They are willing to take certain risks. They are scared stiff of some of the actuarial risk that is involved in a total capitation payment, particularly where they are in communities where they might have enrollees of 10,000 or 20,000 people. But they are very comfortable taking risk around the management of a care process of a patient.

So I think it is a perfect example of what we are looking at, bringing multiple providers together, along with the appropriate insurance agent to put the right incentives in place, to give people the opportunity to really look at how can you manage a given population and maintain their health status in a way that we have never looked at before.

Senator DURENBERGER. But part of the question is, is the issue of choice—let us forget competition. But choice. One of the things that people are concerned about in the oligopoly or the monopsony that appears to be arising in Minneapolis, St. Paul or Minnesota is that even a big city like Sioux Falls may end up with one hospital, one medical clinic, conceivably if you believe those numbers. I mean, it could happen.

Does that mean then that people will have no choice in this system? Where does the choice come? That is part of the question. Maybe Dr. Ellwood.

Dr. ELLWOOD. I would like to try to take this one on. First of all, we use in referring to rural areas the expression managed cooperation, not managed competition. I think it is unrealistic to assume we are going to have two competing health plans in a lot of small towns. On the other hand, the organizational structure that Gordon, Tom, and I have described to you is quite appropriate for rural areas.

It is much better than what we have now, where doctors and nurse practitioners and others are part of some larger system where they can get help from centralized medical centers and so forth and get people to take the call for them and that sort of thing.

The second point I would like to make here is that we cannot think about these things as you have suggested, Senator Durenberger, along State lines. If you take the State of Wyoming and look at the way people use medical care there, if you are talking about the northeast corner of the State, Sherridan and Cody, those people get their specialized care in Billings and Rapid City.

In the southwest corner where I live, we go to Idaho Falls or to Salt Lake City. So we have to, I think, think of these delivery systems as crossing State lines and embracing centralized medical centers out-of-state, perhaps and primary care providers in-state, linked to those centralized providers.

Finally, on the matter of choice I think the notion of point of service that I mentioned earlier, allowing people the opportunity to go to other providers outside of their health plan if they care to is appropriate.

I met this last weekend with Robert Waller, the head of the Mayo Clinic. He says the Mayo Clinic now has contracts with 350 managed care organizations and that they have agreed to the same kinds of price schedules and so forth and so on that the health plans regularly follow. If you are in a health plan and you can go to the Mayo Clinic or to the University of Kansas or wherever to get your care, that is a very attractive feature which these organizations should not only be allowed to do, but should be encouraged to do.

The CHAIRMAN. Thank you, Dr. Ellwood.

Mr. PYLE. I just would like to add a word on that if I may?

The CHAIRMAN. Please respond.

Mr. PYLE. I grew up on a little island off the coast of Connecticut. It was curiously part of New York, although the only place you could get to from there, unless you owned your own airplane, was Connecticut.

The CHAIRMAN. Rogers Island?

Mr. PYLE. Fishers Island.

The CHAIRMAN. Fishers Island.

Mr. PYLE. It had 300 year round residents and it was a medical problem. I went through the death of my father there. I went through the death of my half-sister there, trying to manage their care with oncology at Yale New Haven Hospital with getting care from people with discharges being determined on which day there was a noon boat.

I can assure you, we did not have any choice other than to leave the island. That was the choice that we had. Had there been a system there that was designed properly and noncompetitive—I do not mean on Fishers Island, but over in Connecticut where there were quite good people who were willing to reach out—I think we have to find a way in places where competition cannot possibly work to have some kind of a citizens council that can contract with the system where there is only one system, but it has to be responsive to some group.

The CHAIRMAN. A fair point.

Now, Senator Packwood.

Senator PACKWOOD. Let me start with Dr. Ellwood. I have heard you say and mention to me when we happened to be seat mates on the plane 1 day that it is imperative that everybody be inside the system. Am I accurate in that?

Dr. ELLWOOD. Yes.

Senator PACKWOOD. And at one time—and we have had witness, after witness, after witness here say you cannot guarantee everybody inside the system without mandates. That if you tried to do it with just tax incentives or prayer or anything else, you will not get the people in.

I am a little curious about the Jackson Hole Group's views about mandates. I cannot tell from the Wall Street Journal for today if you shifted or not or whether you are tracking the Chamber of Commerce or what on mandates.

Dr. ELLWOOD. It is not a question you can answer very quickly.

The CHAIRMAN. Take your time. That is what we are here for.

Dr. ELLWOOD. We still are very strongly in favor of universal coverage. I just do not see how you can have a health system that really works, that has free riders, whether you are talking about market based systems or single payer systems or any other system. Everyone needs to get covered.

The question, I think, is how you get there. The original Jackson Hole proposals which called for mandates were written in 1990. We have had 4 years of experience since then to evaluate what is going on. I have been struck by three things.

One is the softness of the estimates of what it will cost us to get there.

Senator PACKWOOD. When you say cost us, do you mean the government or cost employers or cost who?

Dr. ELLWOOD. Americans.

Senator PACKWOOD. All right.

Dr. ELLWOOD. The government. Everyone.

We have seen estimates from Mathematica, Lewin, CBO, all of them conflicting with each other. We had a special meeting just on this subject. It is apparent why these estimates are so hard to make. They are made on the basis of assumptions about how people are going to behave. We assume that an employer that has lower health care costs is going to be able to pay more taxes because they will keep it in the form of profits or that they will shift it to the form of wages. We do not know that.

We heard this last weekend from an individual from California who set up a—I hate to get into the terminology here—a HPPC-like organization there. They found that a relatively large number

of small employers who did not previously have health insurance for their employees bought it.

But he was not sure about his numbers. He said that 22 percent of their people were new customers, but he did not know how many of those were new businesses and so forth. So we are dealing with a very, very soft set of numbers.

I simply defy you to come up with point estimates 5 years out on which we should base this system. We cannot do it. So that has made me more conservative about how we should approach universal coverage. The second thing is the success of the private sector.

I showed some numbers here about 5.4 percent for some they told us. But we are actually seeing negative numbers now in California in CalPERS and in this same Mr. Mibbs, this voluntary HPPC that is out there. They are actually getting premium declines.

My contention would be that if we get better and better at making medical decisions we are going to see more of that sort of thing. Incidentally, if you are going to plan on paying for health insurance on the basis of CBO projections of future costs, and those projections keep coming down, that amount of money that you have got to spend keeps getting less and less because the future is not as bleak as they projected it to be originally. So I think we can take something from the private sector's success.

Then finally, I am concerned about the divisiveness of the political process that is being used to come up with these things. It looks as if the House of Representatives is going to go in one direction and you are going to go in another. I do not think a thing as intricate as health care, particularly if you are going to project it out four or 5 years, lends itself to that kind of decision making.

So what we are for now is this. That we start out in year one focusing on those at 100 percent of the poverty level; that you take a couple of years to get that group covered. That represents, according to the lousy numbers that we have, 28 percent of those who are uninsured.

Build a better information system so that we can immediately find out what fraction of that population actually manages to get health insurance by virtue of this more extensive coverage. Then move on in two or 3 years to the 200 percent of poverty range, perhaps with a sliding scale subsidy. That represents 32 percent of those who are uninsured.

Senator PACKWOOD. Thirty-two percent more?

Dr. ELLWOOD. Thirty-two percent more.

The CHAIRMAN. So now you have half?

Dr. ELLWOOD. Now you have 60 percent. Now, at the same time I would like to see you put in place competing and at the beginning voluntary HPPC's, so that small employers who have not been covering their employees, who may be paying wages in excess of 200 percent of poverty, have a chance to buy coverage. Let us see how many of them come in.

Then at that point the decision as to what form of compulsion we should use, I think, should be made. Our group at present happens to prefer a combination of an individual mandate and an employer mandate. An employer mandate for those of over 100, because I think they have been the drivers in reforming the health system

up to this point; and I would like to see them continue to function as group buyers.

For small employers, I think it is most realistic to go to an individual mandate. But what we are suggesting is, get these structural changes in place, cover those most in need, keep track of what is going on, and then you make your big decisions in let us say the year 2000 or so.

You can commit yourself in advance, of course. But to say that one or another system of compulsion and mandate—employers, individuals or whatever—is the most appropriate way to go now is just beyond what we know about the way people behave and the way the health system is currently structured and paid for.

We are not backing off of the notion that everybody has to be covered. But we just do not like what we know on which to base decisions.

The CHAIRMAN. Thank you, Senator Packwood and Dr. Ellwood.

Senator Wallop?

Senator WALLOP. Thank you, Mr. Chairman.

Dr. Ellwood, I mostly liked your answer. But I think that you would have to agree when you say everybody has to be inside the system, that you cannot have a system with free riders. A mandate is a mandate of free riders. Is it not true that any time those of us who are in good health are required to pay a premium that accommodates pre-existing conditions or bad health habits, we are accommodating free riders?

Dr. ELLWOOD. Well, yes. The whole system is just replete with cost shifts now where those who have health insurance are paying for those who do not.

Senator WALLOP. But it will always be that way, will it not?

Dr. ELLWOOD. Well, that is why I say I think that we maybe ought to look at this like full employment, that maybe 98 percent is really universal coverage and we devise some other means of dealing with that 2 percent rather than tossing the whole system up in the air at the outset to get at a mysterious set of people that we really do not understand.

Senator WALLOP. Do you support health alliances as mechanisms to pool small groups of employers and individuals to purchase health plans?

Dr. ELLWOOD. Absolutely. I cannot think of—we have to somehow allow small groups of individuals to be treated like large groups.

Senator WALLOP. Is there any reason why we could not have multiple alliances competing?

Dr. ELLWOOD. We can have multiple competing alliances and they can have a variety of sponsorship. They do have to be open to all comers though. We do not want them to act like insurance companies in excluding bad risks. There is no reason why a chamber, an NFIB, whatever, could not form an alliance in a community and have more than one.

It does create one little technical problem. We have to adjust for differences in the risk that various health care organizations attract. Because, you know, we are not talking about insurance companies competing here, we are talking about major medical centers

competing with each other. So some of them are going to attract bad risk.

If we go to multiple alliances, then the State will have to set up some mechanism to look at the distribute of risk in each health plan and adjust it for those health plans that are attracting the bad risk because they happen to be a very good place to get medical care.

Senator WALLOP. One of the things that—I have constituents—I am sure all of us do, and you quite ably characterized the health delivery system in Wyoming. I mean, for Denver, Salt Lake, Billings, Rapid City and Jasper are, in fact, major medical delivery centers and local hospitals are sort of primary care.

But what happens if you are in an alliance and you have an illness that is not covered by insurance in that region? I mean, as you said there are some contracts with Mayo. But what happens if it happens to be Sloane Kettering and you have your contract with Mayo? How do we get out of these systems into a system that mirrors at least what most Americans currently have?

Dr. ELLWOOD. Well, that is what I was suggesting, that at least one health plan in each region offer what we call a point of service option, an option to go to anybody you want and have your health plan pay for most of it.

Senator WALLOP. I love that, but politics will not. And the reason is for the same reason the President, Senator Rockefeller and others make it a felony to go outside of the system and purchase extra coverage.

Dr. ELLWOOD. Well, we have not done that yet.

Senator WALLOP. No, we have not. But I am saying that——

Dr. ELLWOOD. In the private sector,that is the way it is behaving. If you look at——

Senator WALLOP. It is. But what worries me is that we are now involving politics to an extent never before witnessed in the choice of delivery and of mandates. Politics has a way of saying my constituent has to have Mayo available or he has to have this, notwithstanding the POS.

Dr. ELLWOOD. Right. Well, you know, on the POS thing, if you look at the east in this diagram that I gave you, you will notice that POS is very large there and HMO is relatively small. That is because people in that part of the country are not necessarily satisfied with the HMO idea and they want assurance that they can go out of plan.

In California where it has been around a long time, you can see that POS is a much less significant factor.

Senator WALLOP. But it is nonexistent in an HMO in Wyoming today. Is there any reason to suppose that it would be more successful in the future than it has been? We have had a couple as you know and they have failed.

Dr. ELLWOOD. Well, I think so. I mean, I work on these things every place I live. We had Minnesota as a laboratory and a place to work on and now it is poor old Jackson Hole.

Senator WALLOP. Yes, but not everywhere in Wyoming is Jackson Hole.

Dr. ELLWOOD. No. But I mean we now have a group of citizens in Wyoming meeting together, working on the formation of both health plans and some sort of purchasing groups in Wyoming.

Senator WALLOP. Mr. Chairman, could I just have one minute?

The CHAIRMAN. Please, Senator.

Senator WALLOP. Our worry, and I think you will be able to agree that it is a problem, is that in a rural State like Wyoming, we have a hard time under Medicare preventing primary care providers from being drained away to urban areas. As managed competition increases, how do we deal with a problem that will only get worse?

Dr. ELLWOOD. Well, my feeling is—first of all, the number of primary physicians is changing. It is very interesting how much better the kids anticipate what is going to happen than the rest of us do. The nature of the specialty choice of young physicians has changed dramatically in the last year.

Family practice residencies are filling up, general internal medicine is. We are going to have more of the right kind of doctors. But, as I pointed out at the beginning of my testimony, if we have an HMO or an accountable health plan in Wyoming, its obligation will be to find and pay the doctors to serve there and they will have the money in advance. They will know that it is there.

If you are a doctor hanging up a shingle in Thermopolis, you do not know whether the patients in Thermopolis are going to come to you or not. But if on the other hand you have the people committed for a year as part of a larger system, you can calculate exactly what you need in the way of health resources in Thermopolis and have the money to recruit them, to put them there.

Wyoming is never going to be able to recruit against California if it does not have these things, I can tell you, because the value of primary physicians in California has shot up now. They are paying as much or more for a new family practitioner in California as you would pay for a new surgeon. That is just a complete change. But rural America cannot compete against that, unless it has this kind of restructure.

The CHAIRMAN. Thank you, Senator Wallop and Dr. Ellwood.

I would like to just record—now this is not proven fact—but I have heard that Senator Rockefeller, that provision where you can go to jail as a felony offense for picking the wrong doctor, he is going to make it a Capitol offense. That way it will go right through the United States Senate. [Laughter.]

Senator WALLOP. It will at last attract the conservatives. [Laughter.]

The CHAIRMAN. So you might as well be prepared for that. It was bound to occur to him eventually.

Senator Dole?

Senator DOLE. Well, I think it is obvious there is a lot of shifting going on in views of everybody on health care. I think we were way out on the left or wherever you might be. There is a lot of movement toward the middle and maybe beyond. I think you may yet come up with a pretty good health care plan if we are careful and cautious. I think that is what happened in the second meeting.

Did you get into price controls in your second meeting, Doctor?

Dr. ELLWOOD. Senator, we did not get into them in our first. [Laughter.]

Let me be serious about this. I do feel that it is an appropriate objective for health care costs to be growing no faster than the rest of the economy and that it is an appropriate objective that we hit GDP plus whatever increase in numbers and change in the health status, adjusted by whatever change in the composition of the population that we experience.

But I do not think it is an unrealistic objective to go for that. But my contention is that we can measure our ability to do that and that our chances of doing it are greater in a market driven health system than one in which the government sets targets and we will all just price up to the targets.

Senator DOLE. That is a view I think shared by a number of our colleagues, I hope.

I want to ask Mr. Sprenger, I live in the rural State of Kansas. You talked about antitrust. In all the rural States it is going to be critical that we have consolidation and coordination. Do you have any specific suggestions? Is this because of FTC or legislative road blocks?

Mr. SPRENGER. In my particular example, it more came from State than it did from federal. We fortunately, and our Legislature now this past year has provided us an opportunity to have some exemption, in which if we can demonstrate that for quality and cost and continuing to give good access, that the Commissioner of Health does have the authority in which to give some exemption.

I think that is a good example of a boulder I referred to that needs to be removed by government, so that those kinds of responsible decisions can be made to allow appropriate providers to come together, to merge, to consolidate.

In our community, you know, if I go back 15 years in health planning, we used to say we would probably need 400 or 500 beds per 100,000 population in a given community. We are planning by the end of this decade in our managed competition community one bed. We now have 5,000 staff to open beds in the metro area and we have 2.5 million people—I have 2,500 hospital beds in my system, so I told everybody else they could close down and I will take care of everybody.

But there is going to need to be more consolidation, even with all the consolidation we have in our community. And you have to help us do that. It is my experience, with all the mergers I have been through, that there are very strong feelings in a community for their community hospital. It is like schools; it is like anything else.

You have to give them an opportunity to be part of something that is going to continue on. And through these kinds of mergers you can close down some brick and mortar, but they can be a part of a broader community mission than just running a hospital.

Senator DOLE. Mr. Pyle, is it absolutely necessary we have a uniform benefit package? We have had some suggestions you have catastrophic coverage. I think many people would agree to such a suggestion. However many of the bills have no uniform benefit package.

Mr. PYLE. Well, you can do almost anything. But the use of the catastrophic package, while it will provide catastrophic care, will cause us to not have preventive care available and some people, therefore, will not seek it.

I think we will find cost shifting going on. I think we will also find that with a catastrophic package you will not be able to support the development of delivery systems. It will bring costs down. So the effect will be inflationary with that kind of package.

But finally, we have seen incredible talent in our medical field at up scaling procedures so that they fit into some bucket that they otherwise do not belong in. I think we would find a gross increase in catastrophes under that kind of system.

Senator DOLE. If I could just ask, if HMO's hold out the promise, as I assume they do, to hold down costs and provide high quality care, why are people reluctant to join? We have, 35 million Medicare beneficiaries only 1–2 million have joined. Dr. Ellwood?

Dr. ELLWOOD. I think one big factor is the tax code. We reward people for seeking out more costly sources of care. Employers do too. It is very common for an employer to have half a dozen benefit packages presented to them and to decide to pay the premiums of the highest cost package because it is tax deductible. They perhaps want it.

And unless we somehow find a way to motive people to seek out more cost effective care, cost effective health systems are not going to flourish.

Senator DOLE. Could I just take a moment?

The CHAIRMAN. Please.

Senator DOLE. You mentioned the Mathematica study I think that study indicates that Medicare costs for those in risk contracts are higher than they would have been under the traditional Medicare program. You mentioned a number.

Dr. ELLWOOD. I am familiar with that study. What it showed was that the premiums that Medicare was paying to HMO's were higher than the people who were joining the HMO's justified, even though the Medicare program discounts the premium of the HMO's by 5 percent.

Now the reason for that is, people who have any sort of pre-existing condition, any chronic illness, are very reluctant to change doctors or change their source of care. So those who are well or more healthy were attracted to the health plans because the health plans offered them a much broader array of benefits at lower costs.

They had this adverse selection going on. The Mathematica study pointed out that the HMO's, once people got in there, were actually more efficient in managing Medicare patients, that the patients were satisfied, and that all the government had to do was make an adjustment to the premium based on the health status of the people who were joining the health plans.

But I would also say that once you're in the health plan, then if you get sick, you behave the same way as those who were outside of the health plan. You do not want to lose the health plan because you have a relationship with a doctor and so forth.

So over time this will equalize itself. But the present system for arriving at premiums for HMO's and Medicare does not work very

well. It needs to be adjusted to take into account the health status of those who join the HMO's.

The CHAIRMAN. Thank you, Senator Dole.

Senator Chafee?

Senator CHAFEE. Thank you, Mr. Chairman.

Dr. Ellwood, I understand the Jackson Hole Group is, and I think you touched on this, is exploring the viability of a managed competition proposal with voluntary purchasing groups and without an employer mandate.

Now you touched on your views on the mandates a few minutes ago. But are you looking at this purchasing groups in the context of not even belonging to one?

Dr. ELLWOOD. Right. We have just begun the analysis on this. But at this point where we are, we are suggesting that there be multiple purchasing groups in an area.

On the voluntary issue we are following what is happening in Florida very, very carefully. Florida now has State wide HPPC's, 11 of them, I believe it is, and they are voluntary. And we want to see what sorts of risks are attracted to those arrangements and whether the good risks stay out and the bad risks go in. That is the only reason for making it compulsory, you want to get everybody in the same risk pool.

So we will look at that. I think where we will come out is we will suggest at the outset that there be multiple HPPC's and they be voluntary. Then if we see a lot of adverse selection going on and the good risks staying outside of the HPPC's then I think they may well have to be compulsory.

My personal view is that that is what will be shown, that the good risks stay out and, therefore, the pool of risk in the HPPC is an expensive pool and that it will ultimately have to be compulsory. But we have some beautiful experiments going on out there now that are pretty well along.

They are getting bids right now in Florida. In California they have already gone through it. I guess that is the whole point I am trying to make here today, is that the health system is changing, that most of these ideas that are proposed for reform are underway. Can we not move ahead with some reforms that are staged in such a way that we can gather information on how we are doing and become more and more compulsory as we go along, whether it applies to mandates on employers, price controls, or compulsory HPPC's? I do not see why we have to do it all at once.

Senator CHAFEE. Obviously, I agree with you because that is what our plan does. I thought you were sounding great there when you talked about coming forward with—your proposal as I understand it was to start with the low income people, covering those at 100 percent or less of poverty, then pausing and look around and seeing how it worked out.

That is exactly what we do. We start with 90 percent or less of poverty, take a pause, then go to 100 percent and we stop at the end of each year and eventually get up to a percentage of the premium for those at 240 percent of poverty. We are familiar with all those.

Did I understand you to say that you believe when all is said and done, and if everybody were enrolled in HMO's or PPO's, that you

think that you would only require 50 percent of the doctors that are currently in the U.S. now?

Dr. ELLWOOD. That is what I said.

Senator CHAFEE. That is what I thought you said. [Laughter.]

Dr. ELLWOOD. And I said it is going to get worse.

Senator CHAFEE. And did you say 50 percent of the hospital beds?

Dr. ELLWOOD. Gordon has already said it is more like 20 percent in Minneapolis.

Senator CHAFEE. Twenty percent of the——

Mr. SPRENGER. Of what we used to have.

Senator CHAFEE. What you used to have. Do you agree with that, Mr. Pyle, both of those statistics?

Mr. PYLE. I do not know what the national figures are, but it is different in each area. It is a very significant reduction in the number of hospital beds that is needed; and the technology of the field is changing so that number is going to be constantly reducing as we find new ways to do things on an ambulatory basis.

Dr. ELLWOOD. I suspect the situation is worse for hospital supply than it is for doctors. You know, as technology changes, the demand for more and more physicians keeps coming back. But the technology is taking people out of the hospital. There is no question about that.

Mr. SPRENGER. We are talking about hospital beds, Senator.

Senator CHAFEE. Right.

Mr. SPRENGER. A lot of hospitals are converting to ambulatory services.

Senator CHAFEE. Absolutely. I just received a letter from a friend that his wife went in the hospital for removal of her gall bladder. She went in at 7:00 a.m. and came out at 3:00 p.m. that same day.

Now it seems to me, one of the real problems as I see it here is this accountability that you are talking about. And it seems to me accountability relies on outcomes research. And outcomes research is a subjective matter to a considerable degree, is it not? I would like to be reassured on that, because we all want the purchasing alliance, or whatever it is called, to be able to give some assistance to the membership on which plans are successful and which are not. Is this a science?

Dr. ELLWOOD. I should defer to people like Brent James and so forth on the panel that follows here that are real experts on this subject, but it is something I have worked on for 20 years.

We have excellent measures now of health outcomes. What we call the SF–36, which stands for short form with 36 questions is a very, very powerful measure of people's health status and those things that health care affects. So we have the means of measuring outcomes. The biggest technical problem is adjusting for the differences in the health status of people as they enter the health system.

Senator CHAFEE. But that is all part of it.

Dr. ELLWOOD. But even that is coming along. And the big problem there is that we do not have agreement on simply how to describe patients. The key here is for we as physicians to agree to describe our patients in a way that allows one patient to be compared

to another. We can measure the outcomes and we certainly are constantly describing patients in terms of how sick they are.

So I felt at first that we could achieve this voluntarily. Interstudy, the organization that I headed, developed a system with Tom Pyle's help to measure patients' health status and their outcomes. We put it in the public domain. We gave it away for a $1, I think it cost.

It did not take hold, because people felt, well, we are going to put in this elaborate system for describing how sick our patients are and then somebody else is going to come along with a different one and we are going to have the wrong data on every patient.

So it is one of those areas where I am afraid, like financial accounting, some sort of industrywide standard is necessary to get the industry going. It is not a technical problem. The computing power, the measurement power is there, but it is reaching an agreement on how to do it. I do not think we are going to do that voluntarily.

Senator CHAFEE. Well, thank you, Mr. Chairman. I think that is a very, very important part of all this. Maybe the Federal Government has got to set a standard gauge of the railroad around here.

The CHAIRMAN. That comes under the heading of standard national statistics. We have been in that business since the census began in 1790.

Mr. SPRENGER. Which you are good at.

The CHAIRMAN. And we are pretty good at it, yes. May I make the point, though, just to put down a marker for the committee that we are going to hear more or learn more about the poverty level. In 1964, we started using the Orshanski Poverty Index. We just had to do something and Mollie was over at HEW and she just took the Department of Agriculture food basket for an urban family and said times three, and that is poverty.

But as a proportion of family budget, food has dropped from one-third in 1960 to one-sixth today. I see Tom Daschle agreeing. Thanks to South Dakota. So we better wonder—has that particular definition not changed, and do we want to address that issue? I am sure you agree.

Senator Daschle?

Senator DASCHLE. Thank you, Mr. Chairman.

I wanted to talk about the rural ramifications of accountable health plans. But, Dr. Ellwood, your answers to Senator Packwood about mandates intrigued me and I wanted to pursue that a little bit more if I could.

If we are to start over and that individuals participate in group insurance on a voluntary basis, then those who pay will pay for those who do not. Is that not also a mandate?

Dr. ELLWOOD. Yes, that is the way the system behaves right now.

Senator DASCHLE. So we already have a status quo mandate that is a very key part of the financing mechanism for the current system.

I agree with Senator Wallop that no system is perfect. But, can the system be improved? I guess the question becomes, how do we make more equitable the current responsibility for financing health care.

I think I heard you say that you support a shared responsibility between employers and employees; is that correct?

Dr. ELLWOOD. Right.

Senator DASCHLE. Why is that?

Dr. ELLWOOD. If I had to make a decision on a mandate today, I would favor one, as I indicated, where firms or individuals of less than 100 would be on an individual mandate and we would continue with an employer mandate with larger firms. That allows us to keep the HPPC smaller and all these things that people have been objecting to about the other arrangements.

I am just saying, let us get our database in place. Let us get the system restructured. Let us get the buying groups going, before we make the decision as to what form of mandate is necessary. But if we get down to one or 2 percent on insured, it may be that you want to take an entirely different approach to getting everyone in the system.

I suspect that we will ultimately need a mandate. As of today, I would prefer a combination.

Senator DASCHLE. A combination, employer/employee?

Dr. ELLWOOD. Individual and employer mandates. And I would subsidize everybody all up and down the line. If anyone is employing people below 200 percent of poverty, whether they be a large employer or a small employer, it seems to me that they should be subsidized.

Senator DASCHLE. It is interesting that you draw the line at 100.

Dr. ELLWOOD. I do not know what the magic number is.

Senator DASCHLE. All right.

Dr. ELLWOOD. But it is just, I told you that a large fraction of those who do not have insurance fall into that category. It is a good place to start. They are obviously the ones in greatest need.

Senator DASCHLE. You support community rating, obviously. I think for the record that is clear.

Dr. ELLWOOD. Yes, absolutely.

Senator DASCHLE. If you support community rating and suggest that an employer mandate start at firms of 100, then you are not concerned whether the mandate starts at 75 or 125.

Dr. ELLWOOD. Yes.

Senator DASCHLE. I assume that you suggest a cut-off because you believe that the financial implications of a mandate for businesses below the threshold, whatever it is, are consequential enough to warrant exempting them from the employer responsibility; is that correct?

Dr. ELLWOOD. Well, this whole thing as to whether or not you are mandating employers and effecting the wages of their employees, you cannot separate wages from other fringe benefits. It is just that in the small employer group, there is a great tendency not to insure and it would obviously create a greater burden on them to go to an employer mandate than it would be on larger firms.

Senator DASCHLE. Well, I guess what I——

Dr. ELLWOOD. Again, it is one of those things you can look at. Let us take the 100 cutoff point. Actually, the most carriers—I think I am right about this—do not experience rate until you get to about 700. The reason why we chose 100 was because it keeps these HPPC's down to a manageable size, whether they do not——

Senator DASCHLE. But let me push further. We seem to think that exempting small business is pain-free somehow, that there is no harm done by pushing financial responsibility onto the family. We are suggesting that while it may be difficult financially for a small businessman, to cover employees we see no difficulty in pushing that responsibility onto the family. We are asking families to participate and pay the community rate because we want to avoid a so-called small business mandate.

A family mandate, it seems to me, is far more serious than a small business mandate if we want that participation we are talking about.

Dr. ELLWOOD. Yes. But what I am suggesting is, if you take these other steps first, it may be that the easiest way to get there is an employer mandate on small employers, as well as large. But what you are doing is changing the structure of the insurance market so that it is easier for small employers to get in. You are going to subsidize employees that do not earn much and the picture might be entirely different after you get through that.

The opposition that we are hearing from small employers may dissipate and it may be the most realistic way at that point to go with a full employer mandate.

Senator DASCHLE. I am out of time. Thank you, Dr. Ellwood.

The CHAIRMAN. Thank you, Senator Daschle.

I have to note that there is another panel and we want to have everyone heard. So we are going to keep to our five-minute rule.

Senator Conrad?

Senator CONRAD. Thank you, Mr. Chairman.

One of the things that I find when I go to my constituency is that the overriding concern is the cost explosion. A vast majority of people in my State are covered, a significant majority are happy with the coverage they have. The concern that is brought to my attention with most frequency is the enormous increase in cost.

In fact, a survey just recently done by Families USA showed my State as number one in the country in percentage of income going for health care. We are currently as a country at about 14 percent of gross domestic product going for health care. All of the projections say we are going to 20 percent absent reform by the early 2000's.

With Clinton's plan supposedly we go to 19 percent of gross domestic product. All of those strike me as dramatic increases in the percentage of our gross domestic product going for health care. We are already far and above any other industrialized country in the percentage of our gross domestic product going for health care.

In the discussions that I hear today, I am wondering if there is some sense that the proposals that you are making there is some variance from others that are on the table would do a better job of cost control or would be roughly in line with others that are on the table.

Dr. Ellwood, do you have a feeling for that?

Dr. ELLWOOD. The problem with building these models that project costs is, if you are going to go with a model, the more compulsory, the more intrusive the system of determining what the numbers are in there, supposedly the more accurate they are.

What we are having to do here is speculate about how consumers will behave if they are faced with lower cost health plans versus how providers will behave if there is a ceiling on it.

My feeling is—I may come to regret saying things like this—we are never going to hit 20 percent.

Senator PACKWOOD. That we are going to get what?

Dr. ELLWOOD. We are never going to hit 20 percent of the GDP.

The CHAIRMAN. Write that down. Everybody take notes. We have an excellent reporter.

Dr. ELLWOOD. Now maybe when you are in a Medicare age group you can come here and say things like that. I might not have said it the first time up here before this committee. But I think like so many of these exponential growth curves that we throw out there, somehow they do not get there.

We are seeing that. They do not reach the peaks that they are projected to hit. We are already seeing moderation in these figures. I am sure that the figures the CBO is bringing you now on Medicare rates of increase are vastly different and lower from those of a year ago.

I believe that this—I do not want to sound laissez faire here, because I am an advocate of massive restructuring here—but we are not going to hit those numbers.

Senator CONRAD. That is the most comforting thing I have heard in several weeks of hearings here.

Let me ask, Mr. Sprenger, the community care networks that you describe, how would you differentiate those from the alliance structure with the accountable health care plans that the President has in his plan?

Mr. SPRENGER. I think they are very similar. The issue for us is that providers are allowed to come together, and to network together, and to respond to a given population base and to respond as an accountable health plan under the President's plan.

So there is not a lot of difference between what we are recommending and what they are.

Senator CONRAD. And in these cross-border situations, how would you handle that circumstance? That is, you know, we have a provider network that Senator Durenberger described in a situation where Fargo is on one side of the border, Morehead on the other side of the border, and if you look at the practice pattern you are really dealing regionally across State boundaries.

How would you address that in a way that is different or like what is in the President's plan?

Mr. SPRENGER. Well, as I alluded to a little bit earlier, just last week we had a meeting with some of your communities—Fargo, Sioux Falls was there, and others.

Senator CONRAD. Right.

Mr. SPRENGER. And we are also meeting with North Dakota Blue Cross and looking at ways we can come together in a network that can deal with those kinds of boundary issues. I do not think, as was said earlier, we cannot allow State boundaries to draw a line and say that your accountable health plan can only go up to that State line, because that is not the way people shop. That is not the way they get their health care.

So we have to be allowed to go over those boundaries. And that is where, I think Paul Ellwood said, the collaboration has to occur between provider groups and insurance groups across those State lines. I would hope that there would be no barriers not allowing that to occur, because it has to.

Senator CONRAD. When we have a plan that is before us that is in large measure State-based, how do we preclude those barriers from occurring? Because one concern is, if it is State-based, the State is going to want to keep those health dollars within its State boundaries. How do we prevent that from happening?

Mr. SPRENGER. I really cannot give you an answer of how you are going to prevent that, except I hope you do. Obviously, we should not have those kinds of barriers.

Senator CONRAD. Dr. Ellwood?

Dr. ELLWOOD. Well, the President's plan really does get at a number of these things. It overrides a number of the features that State law mandates on certain sets of benefits and so forth that preclude building multi-State networks.

I would let the health alliances cross State lines. I saw a proposal in just the last couple of days—I think it must be coming out of the Ways and Means Committee—where we maybe look at these regions more like Federal Reserve Regions. There are some very natural groupings, if you will, of States and health care activities. The necessity of crossing lines is especially apparent in places like North Dakota.

Mr. SPRENGER. And it is community based. I mean there are natural communities that need to come together and I think those border communities are exactly what you are referring to.

Dr. ELLWOOD. And I was looking at, you know, State balance of trade on health care. It is just all over the lot. Some States attract much more hospitalization, but have less physician service movement and so forth. There is no such thing as a State health system in the United States.

Senator CONRAD. Thank you.

The CHAIRMAN. Thank you, Senator Conrad.

Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

You said, Dr. Ellwood, that you were concerned what House Ways and Means was doing and what the Finance Committee was doing and that you are very upset about sort of the political ramifications of what appears to be going on. I am not aware if you have insights that the rest of us do not have about what is going on in the Finance Committee, I think my observation to you and to people who know health care is that you ought to be standing up for what you know is right.

What you are doing is you are trying to be au currant. You are making—you have used the phrase "people have been objecting to." In other words, it is like you and a lot of other health care groups, and business groups, too, have been playing. You have been the politicians. And since we are up here trying to figure out what is the best thing to do for the health care system, you know the health care system.

You were wavering on the mandate, at least that is what you have been quoted as doing, before I came to your group last sum-

mer. You and I had a conversation afterwards. You said, no, the mandate is absolutely necessary. To me you said that. And then now you are sort of, let us wait and see, and let us wait and see what the people are going to think and, yes, we will push it off onto the families or only individuals and families who earn 100% below poverty or less. But I actually do not mean 100.

Look, the head of one of the three business groups that came out against the health care plan spent about an hour with me and pointed out how they basically—businesses, the main groups have basically followed whim. They rolled over. They have gotten scared.

Everybody is trying to figure out what can pass, what is the best politics. I think a fellow like Dr. Paul Ellwood ought to be concerned about what is the best health care system and you ought to be putting steel into our spines to do the right thing.

In a sense, I feel like I have to put steel into your spine because I know I want to do the right thing. I am confident we can work something out here in the Finance Committee with or without your help. But what you are basically doing is in a sense asking us to go to the lowest common denominator. What will pass? Gee, what will people think?

Right now, I care about what people think, but I care more about what is a real health care system is going to look like, and how can it best work, and what is the best kind. I thought that is what you had been doing all your life.

Dr. ELLWOOD. Well, I have. But I have also found out that changing the economy is a trial and error process and it has been 4 years since Alain Enthoven and I proposed Managed Competition I. We have had a lot of opportunity now to see that analyzed in detail. I am not just talking about political analysis and polls, but the kinds of things that CBO and Lewin and Mathematica and others have been trying to do, and we have seen what is happening in the private sector.

What we have now tried to do is to come up with a Managed Competition II, if you will, that has identical objectives to Managed Competition I, if you will, that everybody have health insurance in the United States, and that we get costs under control, and that we have a health system that is more accountable.

I have not deviated from that a bit and the politics of it have not caused me to deviate. Our reason for coming up with a Managed Competition II is to help you decide what is the best thing for the people. That is your job. I know about health care a little bit.

Senator ROCKEFELLER. I stand on my point, Mr. Chairman.

I am sorry. I will not prolong this. You have indicated that you came out against premium caps or what opponents like to call price controls, which they are not, and then you said a few moments ago, well, obviously what people will do is they will just bump up against the premium caps.

So what you are basically saying is that in an alliance they will gouge most and what I am postulating to you is what you are saying is that competition does not. Because if I understand alliances and accountable health plans, there will be a series of accountable health plans vying for the business with these large purchasing alliances.

They will have to compete darn hard, based upon quality and cost. This is sort of a sealed bid type deal. They will be fighting each other like crazy. It was not until Cal PERS, and you know this perfectly well, Cal PERS has existed since 1962. But it was not until they put a line item in the State budget that Cal PERS started saving money and came in under budget because that is what drove competition.

You are saying that we are going to bump up against premium caps, which in a sense is like saying competition which you have purported to avow will not work.

Dr. ELLWOOD. Well, I want the competition to be the consumers not competition to see who can get the best price out of the government.

Senator ROCKEFELLER. I said price and quality.

Dr. ELLWOOD. Price and quality from the government. I feel that it changes the nature of the game when you have a governmental body setting a price as opposed to a market doing it.

Now the Cal PERS example is a very good one. The State of California, like many employers, got to the point where it is no longer prepared to pay the price of the highest priced health insurance policy and it said we just will not do that any longer. We are going to pick out the lowest priced policies and encourage people to use those plans. That is what is changing the health system. It is a change in employer attitudes that reflects itself in consumer behavior.

I just want to give that a real good chance. The dilemma with the caps in the Clinton plan as much as anything is timing. I cannot imagine that we will have health plans out there competing with each other the way we want them to in the time intervals that that plan has.

Senator ROCKEFELLER. But then, Dr. Ellwood, say that it is the time intervals, but do not change the system. Do not compromise on the system. Say that we need more time to do it. But we cannot come at this in 2 years and then come at it 4 years. Congress does not work like that. It is the catastrophic syndrome.

That is what happened to Bill Gradison, he got burned to death by that thing and he never got over it. I mean, you have to say what is right. Then we will figure out if we have to do it in over a period of time. If we have to do it over a longer period of time, we will do it over a longer period of time. But let us in doing that do the right thing.

Dr. ELLWOOD. Well, then to be precise, I would urge you to do this in stages and over a longer period of time.

The CHAIRMAN. Well, I think we might on that note ask if Mr. Pyle and Mr. Sprenger would like to give us our last comments.

Senator Breaux had to leave to preside and asked that his greetings be extended to each of you.

Mr. Pyle, would you like to make a statement?

Senator CHAFEE. Mr. Chairman, before that, could I just ask one quick question of the panel?

The CHAIRMAN. Of course you can.

Senator CHAFEE. That is, in connection with the effect of these major proposals on the community health centers, which you are all familiar with, that provide really an outstanding service in the

inner city and in rural areas. They are worried that if they are just left with the extremely poor and the reimbursement they currently receive from Medicare and Medicaid and those folks that go into some kind of a managed care set up, where are the community health centers going to be left.

The CHAIRMAN. Why do we not make that the last question?

Senator CHAFEE. All right, just briefly.

The CHAIRMAN. Each of you.

Senator CHAFEE. Mr. Pyle, are you familiar at all with this problem?

Mr. PYLE. Yes, and I think it needs to get worked out in each community. But carefully. I do not think it is a good idea to mandate. See, I think we see right in these questions the struggles going on from those who want a cheaper health care system and those who might mandate that certain providers be included, which says that community health centers, regardless of how effective they are, are going to be included. It takes away the ability of the health plan to bring its cost down.

I think it is an enormous dilemma and I think the health plans have got to be left free to work with those centers where they can. And in other places, if it is viewed as a vital community service that must be at a particular geographic location, then it must be funded by government separate from the regular health care.

Senator CHAFEE. Mr. Sprenger?

Mr. SPRENGER. I would agree with Mr. Pyle, that clearly they need to be woven into the fabric. If you look at the community as a whole and you look at the needs of the community, all of the resources available in the community must be brought together if you are going to look at community health status in its broadest context.

Senator CHAFEE. All right. Fine. Thank you very much, Mr. Chairman.

The CHAIRMAN. Well, we thank you. I think the point Mr. Sprenger made earlier is that there are attachments to these institutions as there are to public schools.

Thank you for a wonderfully informative panel. We are very much in your debt. We will stay closely in touch with you and we will soon smooth all edges. We know now that we will never reach 20 percent. We are going to put that up on the wall.

Now we have our second panel of the morning, three distinguished practitioners from assorted parts of the country.

Let us see, Mr. Bell, you are going to be first. Christy Bell appears on behalf of the Group Health Association of the United States of America and she is Director of the Fallon Community Health Plan in West Boylston, Massachusetts.

Dr. Brent James is the executive director of the Intermountain Health Care Institute for Health Care Delivery Research at Salt Lake City.

Mr. Allan Tull is a member of the board of directors of the American Association of Retired Persons.

Dr. James, Senator Hatch asks that his apologies be given for his not being able to be here to introduce you. You do not need to be introduced, but he would have liked to have done. He is not able to be here. You are nonetheless welcome.

Mr. Bell, I believe you are first on our list. So we will proceed, sir.

Mr. BELL. Thank you, Mr. Chairman. They are making Ms. Bell into Mr. Bell right now as we speak. It is a confusion that often takes place with a surname of Christy.

STATEMENT OF CHRISTY W. BELL, EXECUTIVE DIRECTOR, THE FALLON COMMUNITY HEALTH PLAN AND HEALTH CARE SYSTEM, WEST BOYLSTON, MA, ON BEHALF OF THE GROUP HEALTH ASSOCIATION OF AMERICA

Mr. BELL. Mr. Chairman and members of the committee, thank you for the opportunity to discuss the country's health care system, its delivery system, its and the integrated approach to health care provided by health maintenance organizations, HMO's.

My name is Christy W. Bell. I am the Executive Director of the Fallon Community Health Plan and the Vice President for Managed Care for the Fallon Health Care System. The Fallon Health Care System is a vertically integrated health care delivery system in central Massachusetts—Worcester, MA—some 40 miles from Boston. It consists of the Fallon Clinic, a physician directed group practice of some 300 physicians in 29 locations; a 483 bed acute care community teaching hospital; 3 skilled nursing facilities; and the Fallon Community Health Plan, which serves 170,000 residents in the area.

The members come from large and small employers, including self-insured individuals, self-employed individuals, a large Medicare and Medicaid population, and non-group individuals. We now serve almost one in every four persons in central Massachusetts.

I am here today testifying on behalf of the Group Health Association of America, GHAA. GHAA strongly supports health care reform that includes the following elements: universal coverage and access to comprehensive benefits; health insurance market reform; health plan accountability for the quality of a plan's care and the satisfaction of its members; and freedom for consumers to choose the health plan that best meets the needs of their families from an array of plans, including managed care and fee-for-service options.

I believe we would all agree a key element of the reformed system is stringent new requirements for health plans to protect consumers and ensure a level playing field for all health plans.

The importance of developing fair and consistent performance standards cannot be overstated. For reform to succeed, health plan standards must eliminate regulatory inequities and allow for fair competition under consistent rules.

GHAA and its member plans have developed proposed standards for all health plans under health care reform to ensure a uniform level of protection for consumers while creating a level playing field for health plans.

These standards build on key principles that seem to have broad agreement among policymakers—universal coverage, insurance reform, a standard benefits package and freedom of choice of health plans.

We believe health plan reform standards must contain several essential elements: state laws must be consistent with the goals of national health care reform; and all health plans that deliver care

through participating providers must meet comparable delivery system requirements in areas such as quality and credentialling.

In addition, all health plans must meet consistent requirements for capitalization, financial soundness and for fair marketing practices. And health plans must communicate clearly procedures for obtaining covered services and must provide mechanisms for resolving disputes.

Before describing the standards in more detail, GHAA would like to recognize the role that the National Committee on Quality Assurance, NCQA, has played in improving the quality of patient care provided by managed health plans. Their work is reflected in the design of GHAA's quality assurance standards.

Our proposed standards include requirements in the following areas. First, health care delivery standards for health plans, providing services through a delivery system of participating providers. Plans cannot exclude high-risk individuals or high-risk populations and they must effectively credential providers.

Second, quality assurance standards for health plans with their own delivery systems through the areas of quality assurance services and patient satisfaction. Third, requirements for all health plans to collect standardized data and prepare reports to allow consumers to compare health plans. A reasonable time must be allowed for plans, probably two to 4 years, to establish the system necessary for standardized data collection as well as for any new requirements for electronic data transmission.

Fourth, standards for health plans to protect confidentiality of individual patient information. Fifth, market conduct standards for all health plans, including written descriptions that clearly describe all coverage limitations and exclusions and out-of-pocket costs. In addition, promotional materials must be factually accurate and responsive to the needs of diverse populations.

Sixth, administrative procedure requirements, including encouraging input from enrollees. These requirements include developing procedures to review and resolve enrollee and provider grievances and ensuring participating physicians a voice in developing policies affecting patient care.

Plans also should measure and report levels of patient satisfaction. Seventh, capitalization and solvency standards to ensure that all health plans will be able to provide the full range of services required by consumer.

Given the comprehensive nature of the proposed capitalization and solvency protections, we do believe that guarantee funds are unnecessary. In addition to providing complete——

The CHAIRMAN. Would you help us on that, sir? Guarantee funds?

Mr. BELL. Guarantee funds, as a way of pooling funds at the State level to guarantee solvency would be unnecessary.

The CHAIRMAN. Got you.

Mr. BELL. In fact, they may actually be counterproductive and may encourage plans operating on the edge of the envelope because there is that protection in place.

GHAA's standards also would preempt State laws that work against providing efficient care or quality care. Laws that restrict health plans from selectively contracting with chosen providers pe-

nalize the plans for acting responsibly about the provider's credentials and/or adjusting resources to the needs of the members.

Other State laws that are inconsistent with the goals of national health reform should also be preempted. Examples of these might be the "open pharmacy" legislation in many States, which came within minutes of passage in Massachusetts this year.

For example, if we were forced to have our members go from our in-house pharmacies at Fallon to any pharmacy, we would actually anticipate having to increase our costs by 20 percent and we would probably reduce quality as well.

The any willing provider laws would force us to accept any licensed providers and I think these would run counter to managing quality care.

GHAA believes that health care reform can succeed only by ensuring that health plans earn and deserve the confidence of consumers. To do so, health plans would have to meet standards to ensure that they provide the full range of covered benefits and high quality care to consumers.

These standards would also protect consumers by focusing on quality measurement, quality improvement and quality accountability. Our proposed standards recognize the importance of ensuring that health plans provide high quality care and service to consumers.

HMO's already have internal quality programs designed to identify problems and design strategies for addressing these problems. We can look to our own plan for examples of how HMO's achieve effectiveness and delivery of maternity care, or immunize our children, et cetera.

When we look at Fallon, we find that 97 percent of our women have access to prenatal care in the first trimester compared to a statewide average in Massachusetts of 65 percent of women.

The CHAIRMAN. A very impressive number.

Mr. BELL. Ninety-nine percent of our 2-year-olds are fully immunized compared to a statewide standard of 72 percent. Our caesarean section rate for women is 15 percent, compared to a statewide standard of 23 percent; and our infant mortality rate is well below the State standard for white males only, the highest standard that we can measure ourselves against.

I think that there are really few settings that are as unique and conducive to managing and improving quality as HMO's are able to do. Many HMO's are being accredited by the Independent National Committee for Quality Assurance, NCQA, which has established strict accreditation standards.

GHAA supports allowing health plans either to meet the quality standards as laid out in Federal law or to obtain accreditation by NCQA or other private accreditation bodies. We also support providing consumers with the tools to enable them to make intelligent choices and to become active participants in selecting health plans that provide care efficiently and effectively.

The development of health plan report cards represents one such tool. Consumers can be informed. They can make intelligent choices. I would point to Worcester County as one example of this. Some 60 percent of Worcester County's residents are actively, currently enrolled in HMO's, including 25 percent of the elderly. And

only a small percentage of these members each year, some 2 to 3 percent, change health plans due to dissatisfaction.

Consumers can be informed and they can make informed decisions. Our member plans have been working with NCQA and others on developing and refining a health plan a report card through the development of something called "The Health Plan Employer Data and Information Set" or HEDIS. HEDIS includes 60 measures of health plan performance, including quality, patient satisfaction, access and fiscal performance measures. Recognizing of the importance of building on private sector initiatives in this area, we have incorporated HEDIS into our recommended health plan standards.

GHAA believes that health plan standards must be established in Federal law to ensure a uniform level of protection for consumers throughout the country.

Federal standards have reduced the cost of compliance for health plans operating in multiple States and in our own case probably would reduce the four levels of State and Federal oversight we now currently experience.

Without Federal standards, the regulatory climate would vary from State to State, creating problems and uncertainties for Congress, for consumers, for providers and for the health plans themselves. States should retain their role in implementing and enforcing health plan requirements, but they should not have latitude to impose additional requirements as under the President's bill.

GHAA has proposed health plan standards in many of the same areas as the Clinton proposal. We do have concerns about some of the bill requirements, however. First, the point of service requirement. We have serious concerns about the requirement of HMO's to offer out-of-network coverage.

With respect to the provision and the stated goal of increasing consumer choice, we long have supported giving consumers the right to choose among competing health care delivery systems and choosing a physician from among those plans with the right to change physicians at any time.

Because of the added cost and administrative burden the requirement for out-of-plan selection or point of service would impose, we support a voluntary point of service option, much as Dr. Ellwood has described, especially since no one has found an effective way to measure, report and be held accountable for quality with an opt out or a point of service within a plan.

Provider contracting is a second area of concern. The Clinton bill has conflicting provisions regarding provider contracting. On the one hand, the bill would preempt State laws that restrict the freedom of health plans to design provider networks. However, the bill also includes provisions that may be interpreted to restrict selective contracting, and the bill would require health plans to contract with the essential community providers and academic medical centers.

We oppose such requirements because they significantly impede health plans' abilities to select providers best suited to their members' needs and to negotiate favorable rates.

Again, in our case, we have an academic medical center in Worcester, a fine institution, the University of Massachusetts Hospital, but periodically we bypass U. Mass. and work with providers

in Boston because of the quality or cost of their services. And, in fact, we periodically send patients out-of-state—to the University of Minnesota, Cleveland Clinic, et cetera, for services that they are highly specialized in providing.

On the other hand, some of the GHAA standards are actually more specific or more stringent than the Clinton bill requires. For example, our proposed capitalization requirements are significantly higher than those included in the President's bill.

In conclusion, GHAA supports national health care reform that includes uniform Federal standards for health plans. We urge you to consider the GHAA standards in developing health care reform legislation. We believe these standards would provide a level of protection Congress and consumers deserve and need.

The standards would be measurable. They would be manageable. They would support continuous improvement and would weed out nonperformers and could be understood by consumers.

We appreciate the opportunity to share our views and look forward to working with you as your consideration of health care reform continues.

Thank you very much.

[The prepared statement of Mr. Bell appears in the appendix.]

The CHAIRMAN. Thank you, Mr. Bell.

And now, Dr. James.

STATEMENT OF BRENT JAMES, M.D., EXECUTIVE DIRECTOR, INTERMOUNTAIN HEALTH CARE INSTITUTE FOR HEALTH CARE DELIVERY RESEARCH, SALT LAKE CITY, UT

Dr. JAMES. Thank you. I feel a little bit like an outlier in this group. I am the only person who really does not represent a policy decision.

The CHAIRMAN. But you are a doctor.

Dr. JAMES. But I am a doctor.

I kind of work on the firing line, down where patients are actually treated, trying to discover how you can modify health care delivery processes to improve care. I would really like to try to make two arguments to you in the next few minutes.

The CHAIRMAN. Take your time, Dr. James. You have waited very patiently.

Dr. JAMES. Thank you.

The first centers around the idea of quality and cost. You know, the main goal that seems to be driving reform is the idea of access to care. I think many now recognize that if we do not control costs within our system, access becomes a moot point, really, at some level, in one form or another.

The point that most people overlook is that, in fact, quality drives cost. I would like to demonstrate that to you, that, in fact, systems that modify processes of care at a patient level, if they do not succeed, the other elements in health care reform very likely will not succeed.

The second is to identify synonymous that very well could stop them from succeeding. That is the second point I would like to make.

I would like to turn your attention to the written notes that they sent out for me to page 8 of 9. It is a graph.

The CHAIRMAN. Page 8?

Dr. JAMES. Yes. This is a graph that was put together by a fellow named Greg Poulson. He took the ed par database for the United States of America. That is all Medicare hospital admissions for the entire United States. We have it available to us for the year shown as well as subsequent years just in recent months.

He applied a particular cost adjustment methodology. Fundamentally, you take a base line group, in this case our system, Intermountain Health Care. A little aside, we are a system of 24 hospitals, mostly rural, located in Utah, southeastern Idaho, southwestern Wyoming. We also have the largest HMO in that part of the country.

IHC health plans now insures about a quarter of all of the population of Utah. We supply about 50 or 60 percent of all hospital based services in that region of the United States.

What we did was take the charge per case, for care delivered within IHC, and we risk adjusted it. We broke it out by DRG categories. Then we went around to other groups and said, what would have happened if those other groups had paid the same rate that we paid in terms of costs or charges for the care they provided by specific case types.

We end up with two columns of numbers. One is the one that they actually charged or their actual costs. The second column is what it would have been if they had charged the base rate. And, in fact, that is what that graph shows. IHC is the 100 percent mark.

The dotted line is other non-IHC hospitals within Utah.

The CHAIRMAN. Oh, that is all—IHC is the 100 and that is always adjusted. But that is IHC?

Dr. JAMES. IHC is the flat line at 100 the way that we chose to construct this graph. The solid line at the top is the United States as a whole compared to IHC.

The CHAIRMAN. And the other is Utah non-IHC?

Dr. JAMES. Yes. Now you can adjust that for some other important factors. For example, the Medicare wage price index with the cost of doing medical business within a community. Teaching mode is an important factor, other measures of severity adjustment. We have done that as well.

In fact, it may be of interest to you, we have applied this methodology to the United States as a whole, individual hospitals and to your States. Senator Packwood is basically correct, using that methodology Oregon is the cheapest State in the United States in terms of per case costs for health care, interestingly enough.

It is fascinating. I watched the Senators as they came into the room. As you appeared, there was a very heavy predisposition or a tendency toward States that were inexpensive coming into the room first. [Laughter.]

I did not track them as they went out.

The CHAIRMAN. With the exception of the Senator from New York.

Dr. JAMES. Maybe the people who were here first have it under control a little bit.

You will notice something about those lines, especially with regard to other hospitals in the State of Utah. They are showing a

tendency to come closer to the national norm. That is what you would expect. Statistically it is called regression to the mean. It happens as the States become more homogeneous in their health care operations. That is exactly what you would expect.

More important than that though you may notice the line from IHC at 100 percent and non-IHC Utah hospitals, in fact, to the country as a whole is diverging. The gap between them is getting larger over time. In fact, if you carefully measure health care costs within the State of Utah, at least within the IHC system, our per case cost has been dropping about one to 3 percent per year for the last five or 6 years.

The CHAIRMAN. Dropping?

Dr. JAMES. Dropping.

The CHAIRMAN. We heard that word from the previous panel, too.

Dr. JAMES. That is right. It is a rare event, but what we are discovering are ways to make that happen. That is what I really wanted to here today.

The second graph right behind the first one, page 8 of 9B, we apply this methodology within our own system. We took 1989 as a base year. We asked the question if for each case we would charge what we would have charged for that case during 1989. What we actually charged for it in 1990. What is the difference between the two? It turned out it was over the course of the year on average of 7.6 percent increase from 1989 to 1990.

That was quite reasonable, because in the fall of 1989 we applied a 7.6 percent price hike to our charge masters. We do that every fall. We use long term financial models to determine how much money we need to operate our system. We apply a price hike to our charge masters and that determines how services are priced for the following year.

We treat about 100,000 cases a year. So you would expect it to be fairly close over that number of cases. In the fall of 1990 though we applied an 8.8 percent price hike. But when we measured through the course of the year in 1991 it turns out our actual price per case had only gone up 8.3 percent. That is a half a percentage point difference, about $5 or $6 million for us. Across 100,000 cases it is statistically significant.

In the fall of 1991 we applied a 4.5 percent price hike.

The CHAIRMAN. How are you following the CPI among other things here? You are noticing CPI generally?

Dr. JAMES. Yes, we are.

The CHAIRMAN. So that is why you came down.

Dr. JAMES. Well, that is part of it. We actually know specifically why it came down.

The CHAIRMAN. But you thought you were getting into something here.

Dr. JAMES. We thought we had really found something. See, it is interesting because while our price hike was 4.5 percent, our price per case only went up 2.8 percent. My question to you is: Why the difference?

The CHAIRMAN. No, that is our question to you. [Laughter.]

Dr. JAMES. All right. Fair enough.

If we raised our price for everything that we supply—every blood test, every dose of a drug, a day in the hospital—by 4.5 percent,

how could it be that our price per case, that same case we treated last year, only went up 2.8 percent? The reason is, we are becoming more efficient in the fact. That comes from managing processes of care. In fact, that is what accounts for that first graph and that diverging line between the two.

Now, I do not have time, I do not think, today to go into detail.

The CHAIRMAN. Take your time, Dr. James. You have come a long way.

Dr. JAMES. To go into detail exactly how you accomplish this, I put it in my written notes for people who care to see it. It turns out there are three specific mechanisms by which quality interacts with cost.

For a substantial proportion as you move your quality out, your costs actually drop significantly. All right? In fact, people have estimated that this particular category called quality waste——

The CHAIRMAN. Senator Durenberger is nodding down there.

Dr. JAMES. We estimate that that may account for between 25 and 40 percent of all hospital costs fall into that category.

The CHAIRMAN. The category of that which the costs decline as quality rises?

Dr. JAMES. It causes your costs to fall. The example I included in my written testimony concerned a major complication that patients face when they come into a hospital for elective surgery—a hospital acquired infection, a wound infection, where bacteria somehow get into your incision. They can be very, very nasty. They can kill people.

The CHAIRMAN. That is "staph" infection as we used to hear.

Dr. JAMES. It could be staph. It could be a number of other different things.

The CHAIRMAN. And quality keeps that down.

Dr. JAMES. Well, to summarize it very quickly, at LDS Hospital we reduced our rate from roughly the national standard—in fact, the best national standard—around 2 percent to one-fifth of that, to 0.4 percent. We calculate that because we did not have to treat the infections that that reduced our health care operation costs about $500,000 a year at one of our hospitals.

In fact, if you take the four big complications that patients face in a hospital—it is an adverse drug event, some sort of a drug overdose, typically, is most common from that study that was done in our State. Number two are hospital acquired infections. Number three is a condition called deep venous thrombosis. Number four, bed sores. That probably saves one of our hospitals, LDS, Flag Ship Hospital, about $5 to $10 million a year in health care costs because we manage those processes of care.

Now that is what I meant when I said that your quality in very fundamental ways controls your costs. Another way of saying the same argument, if the decisions that you make here, if the reform that you eventually pass does not fundamentally affect the interaction between physicians and patients, providers in general and patients, in a positive way, you will not achieve your goals in reform.

That is the statement.

Senator PACKWOOD. How do we do that?

Dr. JAMES. The general theory that covers managing processes of care—that is what Gordy Sprenger was talking about as well, and what Paul Ellwood was talking about as well—is quality improvement theory. You can call it by other names—quality improvement theory. And at least I initially believe that that is why people liberally sprinkle through the original health care reform plan as quality improvement is just plain, instead of just plain quality.

Senator PACKWOOD. Can we mandate that? Is there some law we can pass that will cover that?

Dr. JAMES. That is the second piece right there. That is the third graph that I have included in the packet. The problem is that we know how people respond to mandates.

The CHAIRMAN. Oh, it is a cycle of fear.

Dr. JAMES. My favor description of it comes from a fellow named Bill Schercanbauch who wrote a classic text on quality improvement theory. In the manufacturing sector, he called it the cycle of fear. His point was, as we know, how providers react.

I see it every day in my own system as I try to change fundamental processes of care in a positive way. The first reaction is called kill the messenger, also known as pure denial.

I prepared a study that shows a group of physicians or quality outliers. I take that study to them and point out their defects, their personal defects as well as their defects in care probably. I suggest that they might want to change. Their first reaction is uniform. They tell me that my study is flaws. Usually, well, it is, my patients are sicker. You did not properly risk adjust. And there are a list of other statistical arguments that they can apply.

I have been with IHC now for 7 years. That means some of these fights have been going on for 7 years. We have not changed here with that method.

More than that, they will begin to block my access to their data. They will try to find subtle ways of preventing me from participating because I am the guy that gets the goods on them. I can overcome it with a strong administrative push. I can just roll over the top of them. Although I will pay a real price for that in my future interactions with those individuals.

Interestingly, I will spend 90 or 95 percent of my effort fighting, instead of improving. The second reaction, if you get past that one, it is called filter the data, also known as distort the system or game the system.

You know, the data that I am using to measure these folks, they generate themselves. I do not care how conscientious they are. I do not care how well trained or reliable they are. It will change how they write down their data in systematic ways.

And, in fact, that is one of the real defects in a national report card system. It just will not improve care. It will change how we report care in very systematic ways. And we know that. I have a number of good examples that I could give to you of that.

For example, we changed now the ICD–9 codes that we use to describe patients in hospitals. Dr. Lisa Iezzoni from Harvard has documented a continuous erosion of what those codes means. Primarily, it is a response to DRG payments. What hospital would retain an Administrator or a Director of Medical Records who could

not up code ICD–9 codes to the highest defensible code to maximize DRG reimbursements.

It is a rational response. Notice I said defensible. It is not inherently dishonest, just a rational response to the systems that you put in place. That is one of the things I really expect to see with the report card system quite honestly, is an erosion of what it means to be sick, an erosion of what good health care means. That is what you would expect to see in that kind of a system.

That is a regulation generator. That is the cycle by which you generate regulation. You put in place your regulations. Cleaver people in the industry find out how to end run them. You write more regulations to plug those holes. We figure out cleaver ways to end run those. We argue a lot in the meantime about what it really all means. That is where we spend out effort, you see.

And suddenly you have 300,000 pages of Medicare regulations as we do today. That is one of the clear generators of ongoing regulation and the paperwork that we face right now in those systems. That is the AMA's current estimate of the number of pages of Medicare regulation—300,000.

The CHAIRMAN. Did you say 300,000?

Dr. JAMES. I did.

The CHAIRMAN. One per elderly person, Mr. Tull?

Dr. JAMES. It is about 300,000 pages. It is to the point where it is not a matter of whether we are in compliance or not. You can always find something that any provider is out of compliance with just by the mass of the documentation.

More than that, it is to the point where no reasonable provider can even deal with it. As far as I can tell, that is largely how it was generated.

The final thing that you do is micro manage. You know you are an outlier. You have no idea how you got there so you do anything you can think of in an attempt to come back into compliance. An excellent example is to relax in medicine.

Well, here is the point of this whole thing. We are coming to understand how you manage systems of care in order to provide best outcomes to patients at a lowest necessary cost. Those systems are taking place in the marketplace right now today. In fact, the initial debate that reforms art has been a tremendous boon in that sense. But it is moving ahead. It is a tremendous competitive advantage to be honest.

If you can deliver better care to moms we better carry it at a lower costs. That is competition in a nutshell right there. That is probably why it is a major strategic initiative for my system and a number of others in the country as well.

Beyond that though, while I would not disagree that under reform we have to have a report card system, what I would tell you is, is that quality improvement will not run off of a report card system, that the two are inherently incompatible.

At least within the State of Utah as we prepared and proposed health care reform for the State, we have separated the two. We recognize that there is a political need, in fact, a marketing need or a consumer driven need for a report card so the people can compare. But we realize that that is not at the core of the improvement system. So we have separated the two out. That is just an idea to

think about as you move ahead on this, of separating those two out.

The final thing, I would like to echo something that Paul Ellwood said. You know, if you study this very long you become a real sudan of systems theory. One of the things that you discover about complex systems is that when you take an action over here with the best of intentions, very often you see results way over there, distant in space or time, that are a direct result of your action that you did not anticipate. It is kind of a science of unintended consequences, quite frankly.

The CHAIRMAN. Robert K. Merton, 1935. He is alive and well at Columbia University.

Dr. JAMES. Many others since then. I think the only rational approach to this, given the complexity of the American health system is a step wise experiment. The idea that we can make profound changes to that complex system without good data about how it is likely to respond and just toss it out there and see what happens, I do not think that is a responsible approach. I think the idea of doing a step wise approach where we experiment and see what works is a much more responsible approach to the reform that has to happen.

I speak as somebody who is down at the front lines trying to change processes of care. That is certainly what I have to do in order to deal with the unintended consequences of our own actions as a group of physicians, nurses and administrators who are trying to find best care for the patients within our system.

With that, let me say thank you and close.

[The prepared statement of Dr. James appears in the appendix.]

The CHAIRMAN. Thank you, Doctor. I know that first principle of systems analysis is that the feedbacks will get to you when you least expect them and usually in the opposite directions you have intended.

Now, Mr. Tull, we welcome you on behalf of those who ought to have very considerable say in this subject, which is the American Association for Retired Persons.

STATEMENT OF ALLAN W. TULL, MEMBER OF THE BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS, MADISON, CT

Mr. TULL. Thank you, Mr. Chairman. Good morning to the rest of the committee. As you indicated, my name is Allan Tull, a member of the board of directors of the American Association of Retired Persons.

I appreciate the opportunity to present the consumer's view on the kinds of quality assurance needed in a restructured health care delivery system. Health care reform is AARP's number one priority, as I am sure you know.

The Association supports real health care reform that assures every American health care coverage, not merely access; a comprehensive benefit package that includes prescription drugs, long-term care for Americans of all ages; and a system wide cost containment that makes coverage affordable for all.

We are committed to comprehensive health care reform in 1994. Today we are talking about the need for quality safeguards. In-

creasingly we read reports about the public concern about the impact of health care reform on the quality.

The word quality seems to have become a touchstone for all of the different anxieties people have about reform. People fear the loss of choice of providers and reduced benefits, as well as a lowering of medical quality of the care they receive. But reductions in choices of benefits are already happening for many people; and they will likely continue unless we have a comprehensive reform that includes a plan to preserve and enhance quality.

New managed care delivery systems have incentives to limit care. These incentives are intended to out inappropriate care, but to allow the right care to continue.

Despite these intentions, we must have safeguards to protect against inappropriate limitation. To also have the potential to improve overall health care, we must find a way to capture that potential for improvement.

We believe the following elements form an integrated package of quality assurance tools, all of which are necessary to safeguard the quality of care.

First, there must be public accountability. People who pay for and receive health care need to have a say in governing and the policymaking. Consumers should hold a substantial number of seats on any Boards and Commissions established to oversee quality.

Second, there must be a national standards and data collection. A national approach is required to assure the same appropriate high quality care in every State, whether the patient is in Louisiana or New York; and, of course, in Arkansas.

The CHAIRMAN. Of course, in Arkansas. We have been hearing that all morning.

Mr. TULL. That is what I am beginning to hear. States must hold plans accountable for meeting Federal quality standards. Standardized data should be collected from all providers to enable us to make national comparisons.

Third, there must be national uniform due process grievance and appeals procedures. These protections are needed in the event of quality problems or denial. There must be one Federal system that States and health plans are required to follow. There should also be an independent ombudsman program to assist consumers in exercising their rights.

Fourth, we must continue to develop consumer information. Eventually such information will be the cornerstone of quality assurance, but development will take some time and significant investment. We heard that previously today.

The consumer information that is available today is not very useful for important choices that face us. Even the projected "report card" will only cover a few of the many factors that make up a decision to choose one plan over another, one hospital over another, one physician over another.

Fifth, a critical area that has been overlooked in most proposals is independent oversight. An external body is needed to monitor quality, provide technical assistance for quality improvement and make appropriate referrals to an enforcement agency.

Market based approaches relying on consumers' ability to use information are no substitute for independent monitoring by a body of qualified professionals.

Sixth, the Federal Government should take a lead role, outcomes research and practical practice guidelines development, with the assistance of the professional community. This research is necessary for developing the provider and consumer information that will be needed. Federal guidance and funding will make it happen sooner.

Seventh, we need to encourage continuous quality improvement. As you have heard today, these internal efforts are promising, but they cannot substitute for necessary external oversight.

How do the current health care reform proposals fare with respect to these standards? Generally, they include some but not all of the needed components. Most of the major health care reform proposals call for some level of national standards, data collection, public information and federally supported outcomes research and guideline development.

Only the President's plan, however, contains extensive provisions for public accountability and due process. Critical elements of external oversight is missing from most of the proposal. In conclusion, we urge that any final legislation include an integrated package as we have described. With such an integrated package of safeguards, we will be well placed to meet the challenge of ensuring and improving quality of care in health care reform.

Thank you very much.

[The prepared statement of Mr. Tull appears in the appendix.]

The CHAIRMAN. Thank you, sir.

We heard a lot all morning about national data, and we are good at national data. We built it into our Constitution with the decennial census. You suspected it and it will be filtered, as you say.

Dr. JAMES. Well, more than that. it will never be adequate. In our hospitals, for example, a standard acute care hospital, we have identified over 1,600 major conditions. Which 40 do you want to report? What reasonable number of those can you report?

The CHAIRMAN. Who will read them?

Dr. JAMES. Exactly. More than that, you do not know that you are going to have a heart attack this year. So you do not know to select the plan that does best on acute myocardial infarct in choosing your plan for the coming year. So it is not clear exactly how they will work.

The CHAIRMAN. I do not even know what you just said. [Laughter.]

Dr. JAMES. I am saying that most patients do not expect to go into the hospital, the vast majority of them. They do not expect to have problems. So how do you use medical outcomes data to select a health plan in advance?

The CHAIRMAN. What about that, Senator Packwood?

Senator PACKWOOD. I am not going to the hospital. [Laughter.]

Dr. JAMES. In fact, in your own State, working with Dr. Mark Chassin, a friend and colleague.

The CHAIRMAN. Yes.

Dr. JAMES. Speaking with him not too long ago, he says that the main people who responded to his by-pass graph monitor which

would be thought of as sort of a report card system, were mainly providers. He had not seen a major response from purchasers or consumers to the data that he had supplied, and he is already dealing with people who are consistently gaming his system, you see.

The CHAIRMAN. Yes. You do not have the highest opinion——

Dr. JAMES. I do not believe it will be effective. It is quite useful. I think you need those sorts of data as particularly a force to change.

The CHAIRMAN. Mr. Bell, you are in a business not different from Dr. James. How do you find it?

Mr. BELL. I think I disagree a little bit. I am not sure we are as far off as the doctor might indicate. I think that the report card is a valid mechanism for reporting out and making some judgment calls. I think they do report some of the statuses of the health plans and there are some differences among the plans.

We have had this in our own experience in Massachusetts, where in two weeks for a business coalition, the first statewide HMO report card will be produced, which has very significant variations among the plans.

It has a rudimentary six measurements to start with, but those will be built upon each year. But it does point to some of the difficulties in collecting the data, in that it is very difficult to get agreement on what you are collecting, what the conditions really mean, how you will measure variations, how you will count the charts, et cetera, et cetera, so that it does take a great deal of time to put medical professionals together to agree on what they are collecting becomes comparable data and you are comparing apples to apples and someone is not gaming the system. So that part I agree is extremely difficult.

But I think what we look at is, we look at the very common procedures that people are concerned with and very difficult or high risk procedures. We have found very interesting variations in both of those and set about correcting them.

So I think that improving the most common factors that someone will be exposed to, whether it is access to care, immunizations, drug compliance, et cetera, are meaningful. I think in the high risk areas you do not want infections and complications in areas like cardiac surgery or neurosurgery where the consequences can be disastrous, both economically as well as in terms of quality. You want to make sure you are within standards there.

The CHAIRMAN. As our party caucuses have begun, could I just make the point in closing and let Senator Packwood actually close, to be a little bit more optimistic than it maybe seems possible.

Remember, if you think of modern medicine, having started in the 1930's, well maybe the 1920's, but modern sampling began about the same time.

I can recall in 1961, I became Assistant Secretary of Labor in circumstances where the Bureau of Labor Statistics was very nominally on point. Each month the unemployment numbers would come out. They would be the subject of intense, bitter debate and accusation—too high, too low, stuff like that, because no one knew—and after all, they were only about 10 years old.

Our first unemployment rate was published in the United States in 1949. That is how recent it is. But now they come out and people

say, we have that. We are not arguing anymore. So be of good cheer in this thing. You learn. And you also learn systems.

I very much appreciate Dr. James' notion that A affects B and B affects C. C is going to be something that comes back and affects A in a way that might surprise you. But still, I found that good testimony and I am very grateful for it.

Senator PACKWOOD. Can I ask Dr. James one question?

The CHAIRMAN. You can ask him any question you want.

Senator PACKWOOD. Doctor, we all understand the unintended consequences. But I want to know what would happen in terms of your management of IHC if what we passed was an employer mandate, cost year at 50/50 with employees and employers or there is some incentive not to overuse it, and the mandate had a minimum benefit package that you could structure—you said, these are the things I think—would that significantly affect the way you manage IHC?

Dr. JAMES. It would not, because there are two factors that we have done in recent years that have changed how we manage. One of them may be particularly important to this debate.

The first happened when we formed our health plan. Suddenly, we were capitated for most of the care we provided. It is interesting to see the profound affect that had in our thinking about how health care was delivered within our system. That was a very positive affect within IHC as far as I could tell. By the way, we did not intend that. That is not why we formed it, but that is the positive affect that it had.

The second is this. While our chief HMO competition in Salt Lake City has about a 20 percent annual turnover rate, without health plan, our discretionary turnover rate is about one to 2 percent. We try to hold people forever. It is part of our mission. That comes down in quality of service. That has a couple of impacts.

The first is, we tend to get the sick people, because if you are ill you are likely to come to us where you will get good service. You know you are going to get a constant position, the same person each time. There are a number of different ways that you can structure a plan that would be very difficult to measure to guarantee that people either come or do not come and we know how to do that, quite honestly.

The most important thing is this. We regard those patients as being with us forever. I mean, it does not make sense to withhold care today thinking that they will move to another plan tomorrow.

Now, quite frankly, in discussing this with others of my colleagues, both in Utah and in other parts of the country, many of them do not have that view and it changes your view about how you think about how you deliver preventive services or early services to patients.

That is a fundamental difference that I see. So when you ask would it change, how we do it and all, it is partly because of our mission and how we see our mission and how we have structured our system. I do not think that is normally true.

Senator PACKWOOD. That is what I wanted to know. If we were to pass an employer mandate, and assuming we did not get ourselves involved in lots of things that you say will be harmful, it

would not be harmful to you. You could handle that and it would not dramatically change the method that you delivered services.

Dr. JAMES. Not for Intermountain Health Care, no.

Senator PACKWOOD. Thank you very much. A good morning.

The CHAIRMAN. A very good morning. We thank you all. We thank particularly Dr. James, who has come from a very long distance. With great appreciation to all, we will call this hearing adjourned.

[Whereupon, at 12:50 p.m., the hearing was adjourned.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF CHRISTY BELL

Mr. Chairman and members of the committee, thank you for the opportunity to appear here today to discuss the U.S. health care delivery system and the integrated approach to health care provided by health maintenance organizations (HMOs). I am Christy Bell, Executive Director of the Fallon Community Health Plan and Vice President for Managed Care for the Fallon Health Care System.

The Fallon Health Care System is a vertically integrated health care system. It includes the Fallon Clinic, a physician-directed group practice with over 300 physicians practicing at 29 locations, the Saint Vincent Health Care System (a 483-bed acute care teaching hospital), three skilled nursing facilities and the Fallon Community Health Plan, a federally qualified HMO.

The Fallon Community Health Plan serves an estimated 175,000 people in the Central Massachusetts area. It is the area's largest HMO and was rated one of the top ten HMOs in the country. The health plan includes small and large employer groups, individuals and Medicaid and Medicare beneficiaries.

HMOs, which emphasize preventive care and offer comprehensive services to enrolled members at fixed fees rather than on a fee-for-service basis, have been at the forefront of combating the rise in health care costs and continuously improving health care for HMO members. HMOs offer a key element that is missing from the rest of the American health care system—coordinated care.

I am here today testifying on behalf of the Group Health Association of America (GHAA). GHAA represents 350 HMOs with 33 million members who account for about 75 percent of total HMO enrollment nationwide.

GHAA SUPPORTS REFORM

GHAA is a strong supporter of health care reform that includes the following elements: universal coverage and access to comprehensive benefits; health insurance market reforms; health plan accountability for quality of care and consumer satisfaction; and freedom for consumers to choose the plan that best meets the needs of their families from an array of plans that include managed care and fee-for-service options.

Clearly, a key element of a reformed system is stringent new requirements for health plans to protect consumers and ensure a level playing field for all health plans.

GHAA'S PROPOSED HEALTH PLAN STANDARDS

Health care reform will alter significantly the environment in which health care is delivered and health plans operate. The importance of developing fair, consistent performance standards cannot be overstated. In the absence of such standards, the regulatory climate will vary from state to state, creating problems and uncertainties for consumers as well as for providers. A system in which regulation varies from state to state will be confusing and frustrating to everyone. It also could result in different levels of protection depending on where health plans are located. We believe that for reform to succeed, health plan standards must eliminate regulatory inequities and allow for fair competition under consistent rules.

GHAA and representatives of our member plans have developed proposed standards for health plans under health care reform to ensure a uniform level of protection for consumers while creating a level playing field for health plans. These standards build on key principles that have broad agreement among policy makers—uni-

versal coverage, insurance reform, a standard benefits package and freedom of choice of health plans.

HMOs have demonstrated their ability to deliver high-quality, cost-effective care by integrating the delivery and financing of health care through a coordinated team approach. Most health care reform proposals have recognized the success of these plans and the central role HMOs and other managed care organizations will play in any reformed system. However, the term "managed care" has been applied to a variety of health plans and practices, creating confusion for consumers and policy makers alike. Therefore, it is important that all health plans meet uniform standards regardless of their structure.

We believe health plan reform standards must meet several essential criteria: (1) state laws must be consistent with the goals of national health care reform or preempted if in opposition; (2) all health plans that deliver care through participating providers must meet comparable delivery system requirements; (3) all health plans must meet consistent requirements for capitalization, financial soundness and fair marketing practices; and (4) all health plans must communicate clearly procedures for obtaining covered services and must provide mechanisms for resolving disputes.

Before describing the standards in detail, GHAA would like to recognize that developing and implementing standards to ensure the success of health care reform is a dynamic process and will evolve as reform moves forward. We also would like to recognize the role that the National Committee on Quality Assurance (NCQA) has played in improving the quality of patient care provided by managed health plans. This work is reflected in the design of GHAA's quality assurance standards.

Key elements of GHAA's accountable health plan standards include:

- **Health Care Delivery.** Health plans providing services through a delivery system of participating providers must: not discriminate against high-risk populations in creating their service areas; ensure availability of all covered services to all enrollees; promote choice of personal physicians; promote effective physician-patient relationships; continually monitor and improve the quality of care; and ensure that all participating providers and facilities are properly qualified and credentialed or licensed.
- **Quality Assurance.** Health plans with their own delivery systems also must meet consistent, stringent criteria for their quality assessment and improvement systems. Private sector accreditation based on comparable standards should be recognized in lieu of additional, duplicative review.
- **Comparative Information for Consumers.** All health plans must meet requirements for the collection of standardized data in specified areas, such as quality, patient satisfaction and utilization, based upon the Health Plan Employer Data and Information Set (HEDIS), and must prepare reports that will allow consumers to compare plans. Reasonable time must be allowed for plans to establish the systems necessary for standardized data collection as well as for any new requirements for electronic data transmission.
- **Confidentiality.** Notwithstanding the need to collect and analyze large volumes of data to assess the quality and cost-effectiveness of care, all health plans must establish explicit procedures to protect the confidentiality of individual patient information.
- **Market Conduct.** All health plans must provide written descriptions of benefits, services and procedures that clearly describe all limitations of coverage, exclusions and out-of-pocket costs. Promotional materials must be factually accurate and responsive to the needs of diverse populations.
- **Administrative Procedures.** All health plans must: communicate administrative procedures to enrollees and providers; encourage input from enrollees regarding delivery of services; establish internal procedures to review and resolve enrollee and provider grievances; and ensure participating physicians a voice in developing policies affecting patient care.
- **Capitalization and Solvency.** Some health plans are subject to stricter capitalization requirements or operate under marketing restrictions that may not apply to all competitors. Adequate capitalization and solvency are needed to assure that health plans will be able to provide the full range of services required by the consumer. Thus, to protect consumers against interruptions in coverage or continuity of care, all health plans must demonstrate their financial capability to provide all promised health care benefits. Enrollees must be protected by law against liability for the plan's legal obligations in the event of insolvency, and must be assured of uninterrupted coverage under another plan.
- **Guaranty Funds.** Given the comprehensive nature of the capitalization and solvency protections just described, guaranty funds are unnecessary for the protection of consumers. Proposals to require health plans to participate in guar-

anty funds for the protection of providers represent an unnecessary cost burden for plans. In addition, in a reform environment, providers would play an even more important role than they do currently in ensuring delivery of high-quality, cost-effective care. However, in providing complete financial protection to providers, guaranty funds would eliminate an important incentive for providers to play this role.

- **Preemption of Restrictive State Laws.** State anti-managed care laws restrict some health plans from selectively contracting with chosen providers, in effect penalizing the plans for acting responsibly about a provider's credentials and adjusting resources to needs of their members. Such restrictions are not in the best interest of consumers. Health plans must have the freedom to select participating providers based on clearly established credentials and the needs of their members. In addition, other state laws that are inconsistent with the goals of national health reform should be preempted.

GHAA believes that health care reform can succeed only by ensuring that health plans deserve the confidence of consumers. To do so, health plans would have to meet standards to ensure that they would provide the full range of covered benefits and high quality care to consumers. These standards also would protect consumers by allowing them to make real "apples to apples" comparisons among competing health plans. And importantly, the standards would focus on quality measurement, quality improvement and quality accountability.

FOCUS ON QUALITY

GHAA's proposed health plan standards recognize the importance of ensuring that health plans provide high quality care and service to consumers. HMOs already have internal quality programs designed to identify problems and design strategies for addressing those problems. Many HMOs also are being accredited by the independent National Committee for Quality Assurance (NCQA), which has established strict accreditation standards. GHAA supports allowing health plans either to meet the quality standards as laid out in federal law or to obtain accreditation by NCQA or other private accreditation bodies.

GHAA also supports providing consumers with the tools to enable them to make intelligent choices and become active participants in selecting plans that provide care efficiently and effectively. The development of health plan "report cards" represents one such tool.

GHAA member plans have been working for some time with NCQA, a group of leading employers and other health care organizations on developing and refining such a report card through development of the Health Plan Employer Data and Information Set, or HEDIS.

HEDIS includes 60 measures of health plan performance, including quality, patient satisfaction, access and fiscal performance measures.

The development and refinement of meaningful rather than potentially misleading report cards requires extremely sophisticated data collection and analysis, a process that inevitably takes time. But we are confident that within a few years report cards will become not only a major consumer education tool but an important cost containment tool. They will demonstrate the cost-effectiveness of preventive care and consumer outreach and will create new incentives for health plans to focus on outcomes rather than the number of services performed. And they will enhance the ability of HMOs to compete on the basis of quality as well as price.

In recognition of the importance of building on private sector initiatives in this area, GHAA has incorporated HEDIS into its recommended health plan standards.

FEDERAL ROLE

A rational marketplace requires regulatory consistency. GHAA believes that health plan standards must be established in federal law to ensure a uniform level of protection for consumers throughout the country. Federal standards also would reduce the costs of compliance for health plans operating in multiple states.

As noted earlier, without federal standards, the regulatory climate would vary from state to state, potentially creating problems and uncertainties for consumers and providers. Under our proposal, states would retain their role of implementing and enforcing health plan requirements. But they would not have latitude to impose additional requirements, as under the Clinton bill.

COMPARISON WITH CLINTON BILL REQUIREMENTS

GHAA has proposed health plan standards in many of the same areas as the Clinton proposal, although as noted earlier, GHAA strongly believes that these stand-

ards need to be established in federal law, without flexibility for states to impose additional requirements. We do have concerns about some of the Clinton bill requirements, as described below.

- *Point-of-Service Requirement.* The Clinton bill would require lower cost-sharing plans--generally understood to mean HMOs—to offer out-of-network coverage. GHAA interprets this language to require HMOs to offer a point-of-service product that permits enrollees to self-refer out of network for any or all covered services. GHAA has serious concerns about this requirement. We believe it would do little to meet its stated goal of increasing consumer choice. HMOs long have supported giving consumers the right to choose among competing delivery systems; those choosing an HMO have the right to choose their own physician from among the plan's primary care physicians and to change physicians at their option. Because of the added cost and administrative burden this requirement would impose, GHAA supports instead a voluntary point-of-service option.
- *Provider Contracting.* The Clinton bill has conflicting provisions regarding provider contracting. On the one hand, the bill would preempt state laws that restrict the freedom of health plans to design provider networks—exactly as the GHAA standards would. However, the bill also includes antidiscrimination provisions that may be interpreted to restrict selective contracting. The bill also would require health plans to contract with "essential community providers" and academic health centers. GHAA opposes such requirements because they significantly impede health plans' ability to select the providers best suited to their members' needs and to negotiate favorable rates. As noted in a February 4, 1993 Federal Trade Commission letter commenting on Montana's "any willing provider" law, such requirements:

> *"may discourage competition among providers, in turn raising prices to consumers and unnecessarily restricting consumer choice in prepaid health care programs, without providing any substantial public benefit."*

In addition, some of the GHAA standards are more specific or more stringent than the Clinton bill requirements. For example, our proposed capitalization requirements are significantly higher than those included in the Clinton bill. The bottom line is to protect consumers against interruptions in coverage or continuity of care and to ensure provision of high quality care.

CONCLUSION

In conclusion, GHAA supports national health care reform that includes uniform, federal standards for health plans. We urge you to consider GHAA's standards in developing health care reform legislation. We believe these standards would provide the protections consumers deserve and need—by ensuring that all health plans are financially sound; that they are able to provide the full range of services they promise; and that quality of care is reviewed and enhanced continually. These standards also would ensure that health plans would compete in a fair market environment—one in which competition is based on price, quality and service.

Thank you. We appreciate the opportunity to share our views and we look forward to working with you as your consideration of health care reform continues.

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GHAA PROPOSED STANDARDS FOR HEALTH PLANS UNDER HEALTH CARE REFORM

A POLICY PAPER

HEALTH CARE REFORM will significantly alter the environment in which health plans operate. The importance of developing fair, consistent performance standards cannot be overstated. In the absence of such standards, the regulatory climate will inevitably vary from state to state, creating problems and uncertainties for consumers as well as providers of care. The purpose of this GHAA policy paper is to advance the process of drafting and enacting standards that will provide a uniform level of protection for health care consumers throughout the United States while simultaneously creating a level playing field for health plans.

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FEBRUARY 1994

INTRODUCTION

Although the outcome of the health care reform debate remains to be determined, there appears to be increasing agreement among policymakers that true reform requires adherence to certain key principles, including:

- **UNIVERSAL COVERAGE** within a specified timetable, to ensure that all Americans have comprehensive health care coverage and to control cost-shifting from the uninsured to the insured;

- **INSURANCE REFORMS** to ensure that all individuals have coverage regardless of their health status, including prohibition of waiting periods and pre-existing condition exclusions and more equitable distribution of risk among insurance purchasers;

- **A STANDARD BENEFITS PACKAGE** to ensure comprehensive coverage and to create a basis for containing future cost increases by promoting fair competition among health plans;

- **FREEDOM OF CHOICE** among competing health plans — and among competing *types* of health plans, including both managed-care and fee-for-service models — to ensure that all consumers enroll voluntarily in the health plan of their choice and periodically have the opportunity to choose another plan.

Under President Clinton's and most other health care reform proposals, health maintenance organizations and other managed care organizations are expected to play a central role in providing superior health care to all Americans at broadly affordable cost. In light of the demonstrated ability of HMOs to deliver high-quality, cost-effective care, this emphasis on managed care is gratifying but not surprising. For reform to succeed, however, policymakers will need to develop health plan standards that eliminate regulatory inequities, so that all health plans can compete under consistent rules.

It is important to understand that 'managed care' is a phrase with multiple meanings. HMOs provide integrated financing and delivery of health care, coordinating care through a team approach; clinicians and administrators share responsibility for ensuring that all medically necessary care is made available to enrollees — whose individual care is coordinated by primary care physicians — within a predetermined overall budget. As such, HMO-style managed care, with its emphasis on coordination of services and cost-effective preventive care, is distinctly different from traditional fee-for-service coverage, in which the sources of the financing and the delivery of health care are unconnected. Under conventional indemnity insurance coverage, fees accumulate as services accumulate, making care management and cost containment difficult.

Between these two poles of health care coverage are various hybrids. Preferred provider organizations (PPOs) create networks of providers based on agreement to accept negotiated fees, thus in some cases emphasizing the managing of costs more than the coordination of care. Similarly, physician-hospital organizations (PHOs) create networks of physicians and institutions that may function as delivery systems for health plans or may form freestanding health plans.

From a consumer protection standpoint, it is important that *all* health plans meet uniform standards regardless of their structure. Under the patchwork regulatory structure that currently governs the health care marketplace, however, health plans are not all treated alike. Generally speaking, HMOs are the most stringently regulated, partly because they take responsibility for both financing and delivery of health care.

Some health plans today are burdened by state anti-managed care laws that restrict their ability to choose providers selectively — in effect penalizing them for being concerned about providers' credentials and about suiting resources to the needs of their members. Some health plans are subject to stricter capitalization requirements than others. Some operate under marketing restrictions that may not apply to their competitors. The playing field, in short, is far from level.

This should be a matter of concern to all consumers of health care. Consumers are entitled to the peace of mind of knowing that all health plans are adequately capitalized, financially sound, and able to provide the full range of services that they commit themselves to offer; that physicians rather than administrators make all clinical decisions; that quality of care is continually reviewed and enhanced; and that health plans have the freedom to select participating providers based on clearly established credentials, including providers' cost-effectiveness.

Consumer confidence requires regulatory consistency. A reformed health care system that seeks to guarantee universal access to high-quality health services will be able to earn and maintain consumer confidence only if regulatory consistency is achieved nationwide. Similarly, the goal of bringing costs under control can be met only if regulatory standards promote fair competition. To meet the needs of consumers and to achieve a level playing field for health plans, reform legislation and regulatory standards must meet several essential criteria:

- To establish consistent standards for all health plans nationwide, state laws that are inconsistent with the goals of national health care reform must be preempted.

- To ensure access to all covered services and to promote uniformly high-quality care, all health plans that offer health services coverage through participating providers must meet comparable delivery system requirements.

- To establish standards for fair marketing and protect consumers against the risk of insolvency, all health plans must meet consistent requirements for capitalization, financial soundness and fair marketing practices.

- To protect consumers and providers against arbitrary administrative actions, all health plans must clearly communicate procedures for obtaining covered services and must provide mechanisms for resolving disputes.

The proposed standards discussed on the following pages are intended to address these and related concerns. Developing and implementing standards to support health care reform is, of course, a dynamic process, and this document will necessarily evolve as reform gains momentum. Our intent is to encourage that process by suggesting basic criteria for reform that will protect all health care consumers and give all health plans an opportunity to compete fairly. ■

HEALTH CARE DELIVERY SYSTEM STANDARDS

Health plans offering coverage under which enrollees must obtain covered services (except emergency services) from participating providers, or offering coverage under which enrollees may obtain covered services from participating providers at their election, assume responsibility for the financing of health care as well as the delivery of all in-plan services. Consequently they must be able to ensure that their delivery systems afford access to all covered benefits; that decisions about how to provide services are made in the best interests of enrollees; that enrollees have the opportunity to select a primary care physician of their choice within the plan and to change physicians at their election; that all participating providers meet applicable licensure requirements; and that service area boundaries are drawn in a nondiscriminatory manner.

Proposed Standards:

A health plan that provides services through participating providers must meet the following standards with respect to its delivery system:

1. The health plan must have an organized system of health care delivery that provides services through participating providers (including hospitals and other institutions). Providers must have agreed to accept an agreed-upon payment from the health plan as payment in full for services to the plan's enrollees (with the exception of enrollee cost sharing amounts established by the health plan).

2. The health plan must not discriminate in the drawing of service area boundaries on the basis of race, ethnicity, socio-economic status, age, or anticipated need for health services.

3. The health plan must establish policies and procedures to ensure accessibility to and availability of all covered services for all enrolled members, including criteria for the selection of participating providers of the appropriate number and type and recognition of the needs of diverse populations.

4. The health plan must provide services in a manner that promotes appropriate patient care by establishing procedures to monitor the services provided and to continually improve the quality of care.

5. The health plan must establish policies that permit each patient to choose a personal physician from among the participating primary care physicians, and permit patients to change personal physicians.

6. The health plan must foster effective relationships between doctors, other clinicians and patients.

7. The health plan must, in accordance with quality assurance system standards, ensure that participating providers and facilities are appropriately licensed, certified and/or accredited as required by applicable laws and regulations.

QUALITY ASSURANCE SYSTEM STANDARDS

Health plans that assume responsibility for providing health care services through participating providers should also accept responsibility for establishing systems to monitor and continually improve the quality of the care that their enrollees receive. Plans such as HMOs, which provide most covered services from within the plan, are able to continually assess the performance of their delivery systems and, based on this direct experience, to improve quality of care on an ongoing basis. This unique capability will enable them to play a leadership role in developing comparative quality-of-care measures to help consumers make more informed choices among competing plans.

All health care delivery systems should be required to meet the same stringent quality assurance criteria, and all health plans should report performance measures annually in a manner that permits consumers to make comparisons among plans. Standards should also reflect the fact that existing quality assurance and performance measures are rapidly becoming more sophisticated, and should provide for continuing reliance on the capabilities of independent private-sector accrediting entities.

Health care reform offers an opportunity to improve on current oversight of quality assurance systems. For example, HMOs are now subject to multiple reviews based upon differing criteria. The staff and financial resources needed to respond to these reviews would be more wisely dedicated to internal quality improvement activities. Creation of uniform standards for quality assurance and improvement systems and recognition of private sector accreditation based upon comparable criteria can avoid such duplicative review, promote national uniformity and build upon private sector capabilities to modify accreditation criteria as advances occur.

Proposed Standards:

1. Any health plan offering covered services that must or may be obtained from participating providers must administer an internal quality assurance and quality improvement program that either:

   a. meets the following criteria:

   (1) is clearly identified and fully explained to all participants in the program;
   (2) is coordinated with other medical management activities;
   (3) communicates findings to providers and consumers with the primary goal of improving care outcomes;
   (4) measures the impact of such findings on the care delivered by providers;
   (5) documents the monitoring and evaluation of the quality of care to identify areas for improvement;
   (6) develops and implements explicit strategies to improve care;
   (7) collects and analyzes data to facilitate evaluation of improvement strategies;
   (8) measures the effect of such strategies on care outcomes and the quality of care;
   (9) incorporates a credentialing process that encompasses initial credentialing, recredentialing, recertifying and/or reappointment of providers;
   (10) is accountable directly to the governing body of the health plan or, in instances in which the governing body's participation in quality assurance activities is not direct, to a designated committee of senior management;
   or

   b. is accredited by an independent organization, such as the National Committee for Quality Assurance, that conducts objective quality reviews based upon comparable criteria.

(*Note:* Additional standards that address areas of special concern to the Medicare and Medicaid populations must be developed through a private/public sector partnership in order to take advantage of ongoing improvements in private sector quality improvement programs.)

2. Within a specified time after enactment of reform legislation, all health plans must develop the capacity to report on an annual basis the plan's performance in a manner that permits comparison with the performance of other health plans similarly configured and offering similar coverage. Such reports must be based on the most recent version of the Health Plan Employer Data and Information Set (HEDIS), with respect to both the standard measurements and the areas specified by HEDIS which include:

   a. quality
   b. access and patient satisfaction
   c. membership and utilization
   d. finance
   e. health plan management activities.

   Improvements in performance measurement must be incorporated into the criteria as they become generally accepted and available, and health plans must have a process for incorporating such improvements into their systems. (Additional criteria appropriate for Medicare and Medicaid populations that are consistent with the criteria applied to the private sector must be developed through a private/public sector partnership.)

CONFIDENTIALITY

The confidentiality of the clinician-patient relationship must remain inviolable, and consumers have every right to assume that information about the health care services they receive will remain private. Given the need to collect and analyze large volumes of data for the purpose of assessing the quality and cost-effectiveness of care, effective privacy safeguards will take on even greater importance in a reformed health care delivery system.

Proposed Standard:

All health plans must establish, maintain, and periodically review procedures to protect the confidentiality of patient information pursuant to applicable law.

MARKET CONDUCT REQUIREMENTS

In a reformed health care marketplace in which consumers will be choosing from among plans which have varying rules for obtaining services from participating and non-participating providers, it will be particularly important that all health plans observe fair marketing practices and provide clear information about cost-sharing and procedures for obtaining covered services.

Proposed Standards:

1. All health plans must provide written descriptions of their benefits, services, and procedures that clearly and fully describe any and all limitations of coverage, exclusions, and out-of-pocket costs, including copayments, deductibles, co-insurance, and established aggregate maximums on out-of-pocket costs.

2. All advertising, promotional materials, and other communications with health plan members and/or the public must be factually accurate and responsive to the needs of diverse populations.

ADMINISTRATIVE STANDARDS

Although increased choice will be inherent in a reformed health care marketplace, all health plans should also be committed to the principle of periodic consumer choice among HMOs and other health plans, including those offering indemnity coverage of services obtained from unaffiliated providers. In order for enrollees to be able to take full advantage of the coverage option they select, all health plans should have the administrative capability to provide clear information about the nature and extent of covered services and the procedures for obtaining services. Established internal dispute-resolution procedures should be available to enrollees, when disputes arise between health plans and enrollees.

Similarly, health plans should ensure that participating physicians and other clinicians are fully informed of the nature and extent of covered services and of plan rules for providing covered services to enrollees. Only well-informed physicians and other clinicians and well-informed consumers can make optimal use of available services. In addition, physicians should be assured a voice in the development of policies that affect them and their clinical practices.

Proposed Standards:

1. All health plans must effectively communicate their administrative procedures to enrollees and to participating physicians, other clinicians, and facilities.

2. All health plans must establish procedures to gather input from enrollees on the nature and extent of covered services and the procedures for obtaining covered services.

3. All health plans must provide meaningful internal procedures for reviewing and resolving enrollee grievances.

4. All health plans providing covered services through participating physicians must have effective mechanisms for appropriate participation by those physicians in policymaking affecting patient care.

CAPITALIZATION STANDARDS

For health care reform to succeed, health plans must have the financial capability to provide promised health care benefits. Consumers must have confidence in the viability of the health plan serving them and must be protected against interruptions in coverage or continuity of care because of the failure of a plan offering covered services through its own delivery system.

Given the wide range of coverage options anticipated under health care reform, it is essential that capitalization standards address the full spectrum of these offerings, including traditional HMO coverage, traditional indemnity coverage and plans combining both HMO and indemnity features. For the purpose of establishing such standards, the most important consideration is the variability of risk that actual expenditures will differ from projections.

The NAIC Model HMO Act offers an approach that focuses on this distinction. For example, it reduces capitalization requirements where a health plan capitates providers. In this context, capitation must be interpreted to mean capitation of providers who in turn pursue strategies to promote high quality cost effective health care delivery, such as quality assurance and improvement programs and utilization review.

GHAA proposes modifying the Model Act to impose higher capitalization requirements based upon the extent to which health care expenditures are made for services obtained from nonparticipating providers on a self-referral basis. The underlying premise is that as total health care expenditures involve a smaller amount of capitated expenditures and an increasing amount of claims-based expenditures for services obtained from out-of-plan providers on a self-referral basis, expenditures become less predictable and higher surplus requirements become appropriate. With respect to this standard, as well as those currently included in the NAIC Model Act, both the nature of the expenditure and the presence of delivery system characteristics that promote both quality and cost effectiveness are of importance in determining the level of the ongoing net worth requirements.

GHAA proposes the following standards as a starting point, with the intention of continuing to refine these requirements as the health care debate moves forward.

Proposed Standards:

1. As a condition of participating in the reformed health care marketplace, all health plans must be required to provide evidence of adequate capitalization and other indicators of fiscal health, including:

   a. Total assets greater than total unsubordinated liabilities;
   b. Sufficient cash flow and adequate liquidity to meet obligations as they become due;
   c. An insolvency protection plan; and
   d. Insurance or other acceptable arrangements to protect the health plan against liability and casualty risks, including professional liability.

2. When they commence operations, all health plans must be required to deposit with the state sufficient earnest money to demonstrate a good faith commitment to become an established provider of comprehensive health benefits coverage. (*Note:* The $300,000 initial deposit requirement in the National Association of Insurance Commissioners Model HMO Act will serve this purpose without creating an unreasonable barrier to marketplace entry.)

3. All health plans must be required to meet appropriate net worth requirements (which must be applied after accounting for all accrued expenses) in order to demonstrate that their operations are adequately

capitalized on an ongoing basis. Plans must be able to demonstrate initial net worth of at least $1,500,000 (an amount which includes the $300,000 set aside for the initial deposit), and must be able to demonstrate operating net worth at least equal to the sum of (a) and (b) below:

a. The greater of (1) $1,000,000; or (2) 2% of annual premium revenues on the first $150,000,000 of premium and 1% of annual premium on the premium in excess of $150,000,000; or (3) an amount equal to the sum of 8% of total health care expenditures on the first $150,000,000 and 4% of total health care expenditures in excess of $150,000,000 (except those paid on a capitated basis or on a managed hospital payment basis or those expenditures made for self-referred non-emergency services) plus 4% of annual hospital expenditures (paid on a managed hospital payment basis);
b. An amount equal to the sum of 15% of health care expenditures up to $50,000,000 for self-referred non-emergency services and 8% of health care expenditures for such services in excess of $50,000,000.

(*Note:* As indicated above, these standards are based upon the NAIC Model HMO Act. However, they have been modified to broaden their applicability to a wider range of coverages than originally contemplated, and in this form can be appropriately applied to the full spectrum of health plans, including those that combine managed care and indemnity insurance features. With the similar goal of creating 'seamless' regulation of all types of health plans, NAIC is currently developing risk-based capital standards which can be added to existing capitalization requirements. This approach will require careful review, since currently available risk-based capital factors may not be appropriate for all health plans, and new factors are being explored.)

PARENTAL GUARANTEES

For health plans that are owned or controlled by other entities, parental guarantees can be an effective mechanism to ensure fiscal soundness and provide insolvency protection.

Proposed Standards

1. In order for the health plan or the legal entity of which the health plan is a part to use an organization as a guarantor of fiscal soundness, that organization must be a legal entity which:

   a. agrees to submit to the jurisdiction of the state for purposes of enforcing the guarantee;
   b. owns or controls, directly or indirectly, the majority of voting power in or is under common control with the health plan or the legal entity of which the health plan is a part; and
   c. has a net worth, including land, buildings, and equipment legally available to be pledged to cover operating expenses, equal to the greatest of the following:
      (1) $5 million; or
      (2) net worth in an amount needed to bring the health plan's net worth to the amount required to meet the net worth test and to assure sufficient cash flow and adequate liquidity to meet current obligations.

2. To ensure insolvency protection, only the greater part of 1(c)(1) or 1(c)(2) must be met.

3. The guarantor must have adequate financial resources to meet its obligations for all health plans whose fiscal soundness and/or solvency it guarantees.

PROTECTION OF CONSUMERS IN THE EVENT OF INSOLVENCY

Given the challenges and complexities of the health care marketplace, it is inevitable that some health plans will not succeed. Accordingly, statutory and regulatory protections should be established to ensure that consumers covered by a health plan that becomes insolvent are protected from incurring liability for the plan's legal obligations and that they are able to obtain uninterrupted coverage under another plan.

Proposed Standards:

1. As a matter of federal law (and as incorporated in the President's proposed legislation), all enrollees must be held harmless from incurring liability for the payment of any fees that are the legal obligation of the health plan.

2. To assure the availability to consumers of uninterrupted coverage under another health plan, all health plans offering coverage to the same pool of purchasers (e.g., within an alliance or other purchasing arrangement created under health care reform) must agree to accept enrollment of enrollees of an insolvent plan that had been offering coverage in the same marketplace, subject to capacity limits.

3. All health plans must make arrangements satisfactory to the state to satisfy obligations incurred prior to insolvency (including compliance with net worth requirements, insurance, reinsurance, insolvency reserves and other reasonable arrangements).

GUARANTY FUNDS

President Clinton's health care reform proposal would require each participating state to establish a guaranty fund "in order to provide financial protection to health care providers and others in case of a failure of a regional alliance health plan." Each participating regional alliance health plan would be assessed up to 2 percent of premium revenue to cover the outstanding obligations of an insolvent health plan. However, if consumer protections, such as statutory hold-harmless provisions, ensure that consumers will have continuity of coverage and suffer no financial harm as the result of a plan's insolvency, should guaranty funds still be retained as a mechanism to protect the financial well-being of providers?

GHAA is opposed to the concept of guaranty funds as mechanisms to protect health care providers. Effective enforcement of the initial deposit and net worth standards that we are proposing will help protect against financial failure; in the event of the insolvency of a health plan, the requirements for an initial deposit and arrangements to satisfy obligations incurred prior to insolvency (such as reinsurance and insolvency reserves) will provide sufficient funds to meet the remaining responsibilities of the plan.

We believe that establishing guaranty funds primarily to indemnify providers will not only disadvantage sound health plans by adding unnecessarily to their costs, but will undermine a major building block of reform: modification of the behavior of providers to deliver high quality health care services in a more cost-effective manner. Achievement of this objective is essential if competition among health plans is to be based upon quality and cost-effectiveness, and should not be jeopardized by creating guaranty funds to protect providers rather than consumers.

PREEMPTION OF RESTRICTIVE STATE LAWS

In many states, laws have been enacted that restrict the development of HMOs and other organizations that seek to provide health services through participating providers. For example, state laws requiring managed care organizations to contract with 'any willing provider' prevent plans from contracting selectively with providers. These laws strike at a core concept of HMOs and other managed care plans: their ability to create and manage provider networks best suited to the needs of the plan and its enrollees. The same problem is created by laws mandating the inclusion of specified types of providers in such plans.

Similarly, there are many state laws governing utilization review which, although generally intended to govern the conduct of freestanding utilization-review organizations, may also apply to, and interfere with, the internal utilization-review activities of HMOs and other managed care plans. In such cases, these laws unnecessarily encumber the utilization-review process rather than enhancing consumer protection. HMOs and other managed care plans are also subject to a variety of duplicative and/or inconsistent state and federal audit, data and quality assurance standards. Many states also require health plans to provide certain mandated benefits that are inconsistent with the national goal of requiring plans to compete on the basis of a uniform, consistent, comprehensive benefits package. State statutory prohibitions against the corporate practice of medicine should also be preempted.

Clearly, states have important roles to play in implementing and overseeing health care reform. To encourage innovation and experimentation, regulatory flexibility is desirable. Only uniform national standards, however, can create a truly level playing field on which managed-care and fee-for-service options can compete everywhere on the same basis of quality, service, and cost-effectiveness.

Proposed Solution:

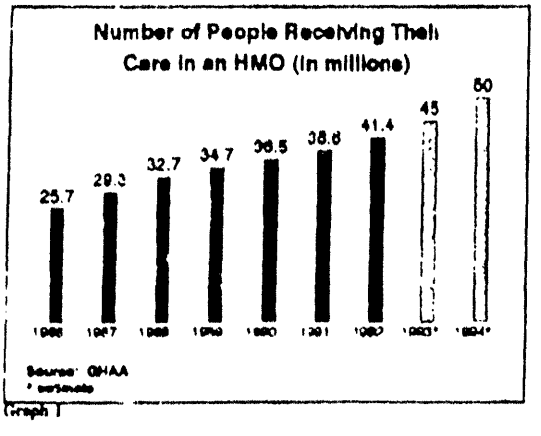
State 'any willing provider' and mandated provider laws which restrict the freedom of health plans to design provider networks best suited to the needs of their enrollees must be preempted by federal law. Other state laws that are inconsistent with the goals of national health care reform must also be preempted, including any state laws that:

- mandate benefits inconsistent with the establishment of a uniform comprehensive benefits package;
- impose standards in areas such as capitalization, solvency, and quality assurance that will be the subject of federal requirements;
- restrict the use of 'gatekeeper' mechanisms;
- ease anti-trust prohibitions applicable to providers or that permit formation of provider bargaining units without requiring the sharing of material economic risk by the persons/entities doing the bargaining;
- allow providers to form health plans that assume risk without meeting the capitalization requirements applicable to nonprovider-sponsored plans;
- interfere with the goal of consistent regulation by establishing different standards for different plans based on the structure of the plan.

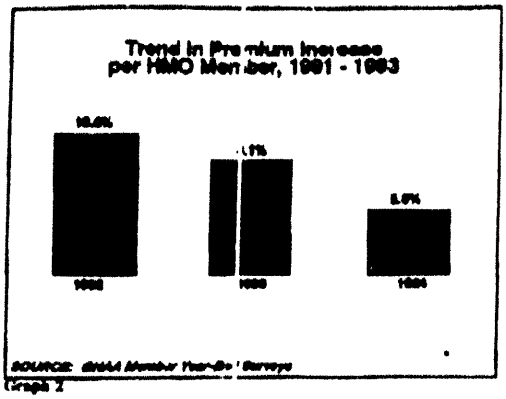
PREPARED STATEMENT OF PAUL M. ELLWOOD

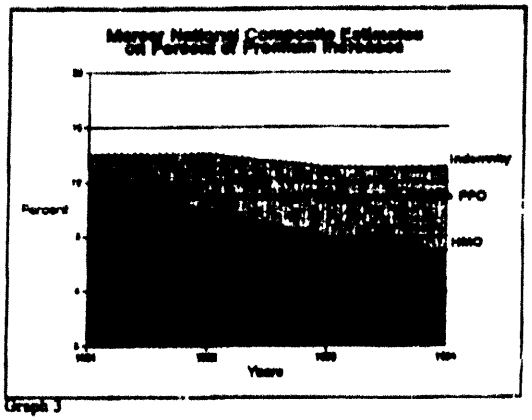
This hearing is a first in the health reform debate: a powerful policy-making body is evaluating the characteristics of the organizations that are likely to provide health care to most Americans. If health care costs are to be constrained and quality improved through competition between health care organizations, most health care will be delivered by provider/insurance groups resembling HMOs or Accountable Health Plans. There is also some historic irony in today's hearing. In 1970, then Presidential assistant Daniel Patrick Moynihan's deputy Chester Finn helped devise the first and only Presidential policy that advocated health delivery reform based on competing HMOs. The Senate Finance Committee, after hearing testimony from HEW Secretary Elliot Richardson in June 1970, rejected the idea of exploiting the federal government's massive buying power in Medicare to reform the structure and incentives of the American health enterprise. President Clinton, like his predecessors, has not chosen to use the health programs for which the government has direct financial responsibility to improve the organization, motives and accountability of the American health system. Failure of Medicare to participate in reshaping health care can only continue to slow or distort reforms.

We have consistently underestimated how long it will take to restructure the American health delivery system. In 1971 the debate in HEW was between the those who advocated 1,300 HMOs within 5 years serving 65 million people and the proponents of 5,000 to 10,000 HMOs serving the entire population within 10 years. Both lost. The American government like the single-payer systems elsewhere in the world, has never been a serious health delivery change agent. The reform of the health delivery system has been driven by employers desperate to get health care costs under control and medical social entrepreneurs. The pace of change has accelerated and we now enjoy in the private sector the most dynamic health system in the world. But we only have 540 HMOs serving 42,356,552 Americans, and the sluggish Medicare HMO Risk Program has enrolled 2,175,115 seniors (see Graph #1).

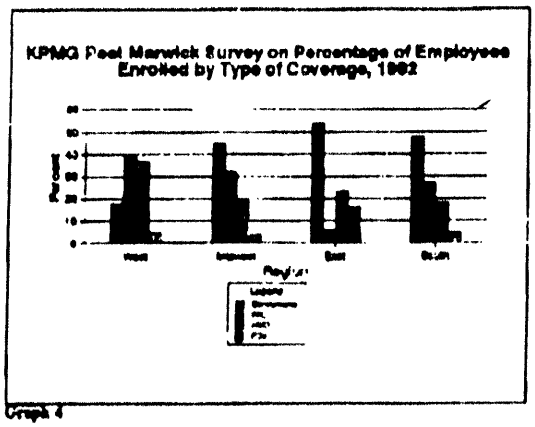


HMOs enjoy such a clear and growing cost advantage over their timid offspring, the Preferred Provider Organizations, and their ancestors indemnity insurance, that we expect them to outlive both in a price competitive environment. HMO premium increases are rapidly declining (see Graph #2), PPO and indemnity premium increases have stabilized (see Graph #3).





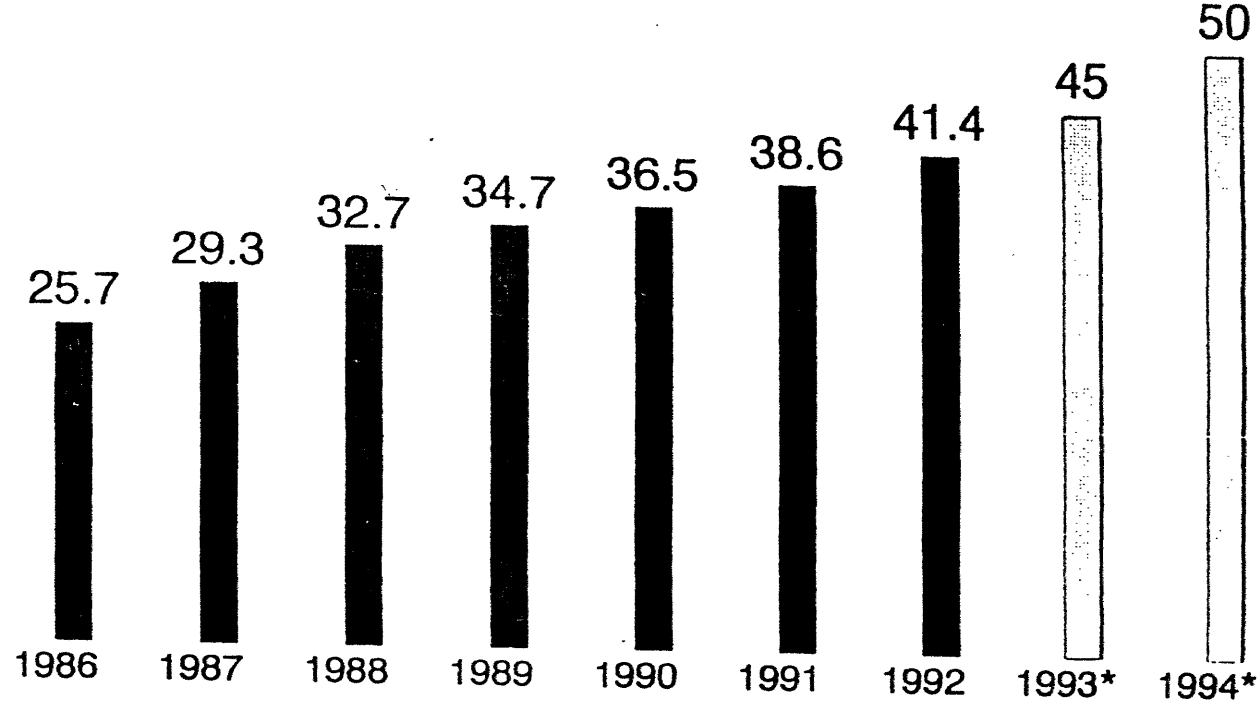
The delivery system effects of this trend in premium increases is most evident in the highly-competitive Western market where indemnity is moribund and PPO plans are taking on the provider risk-sharing characteristics of HMOs (see Graph #4). While the HMO's defects are not serious enough for them to join indemnity insurance in the graveyard, HMOs do need to be substantially improved in both clinical effectiveness and consumer quality accountability if they are to carry the burden of health delivery reform in the twenty-first century. HMOs have saved money by reducing hospitalization, by operating with lower provider prices and by matching the needs of their annually-enrolled patient populations with health resources. As a consequence, an HMO-dominated health system will require approximately half as many physicians as are now available and less than half of our current hospital bed supply.



Most consumers who have not participated in health plans, and many who do, have exhibited concerns that cutting the cost of health care is synonymous with cutting quality. They are also fearful that their opportunity to find a suitable physician will be limited. Both problems are correctable. The government must establish, in collaboration with providers and consumers, a uniform system of public accountability for health plans, hence the term "Accountable Health Plans." The accountability must report on the risk-adjusted impact of health care on patient health, functioning and well-being. The same accountability system can be used by physicians to improve clinical decision-making, which is the next vital step in reducing the rate of cost increases while avoiding rationing. A growing number of HMOs have found they can allay consumer concerns about choice of physicians and hospitals by allowing members to go out of the health plan for care at modest extra costs. We call these arrangements "point of service" plans. The Jackson Hole Group believes that each region of the country should have at least one accountable health plan with a point of service option to assure consumers of a full array of provider choices. The hollow promise of continuing fee-for-service indemnity insurance available to all cannot guarantee consumer choice except in the outmoded costly Medicare program.

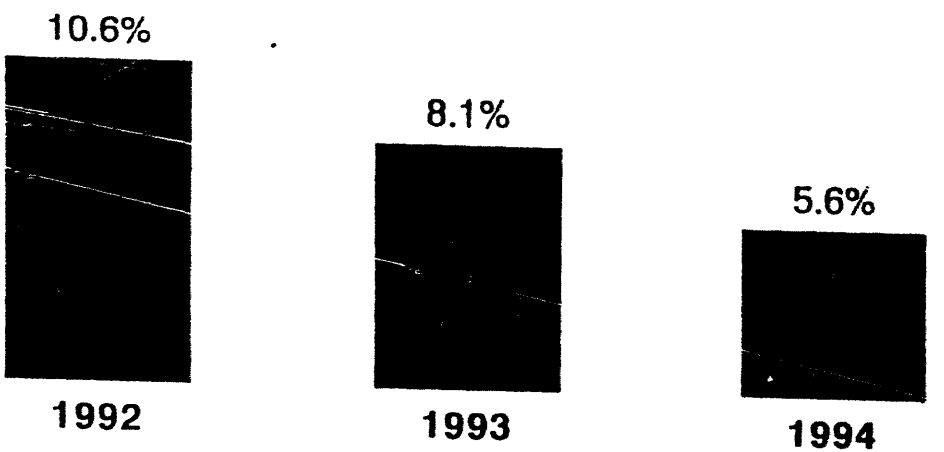
Figure 1.

Number of People Receiving Their Care in an HMO (in millions)



Source: GHAA
*** estimate**

Figure 2.
Trend in Premium Increase per HMO Member, 1991-1993



SOURCE: GHAA Member Year-End Surveys

Figure 3.

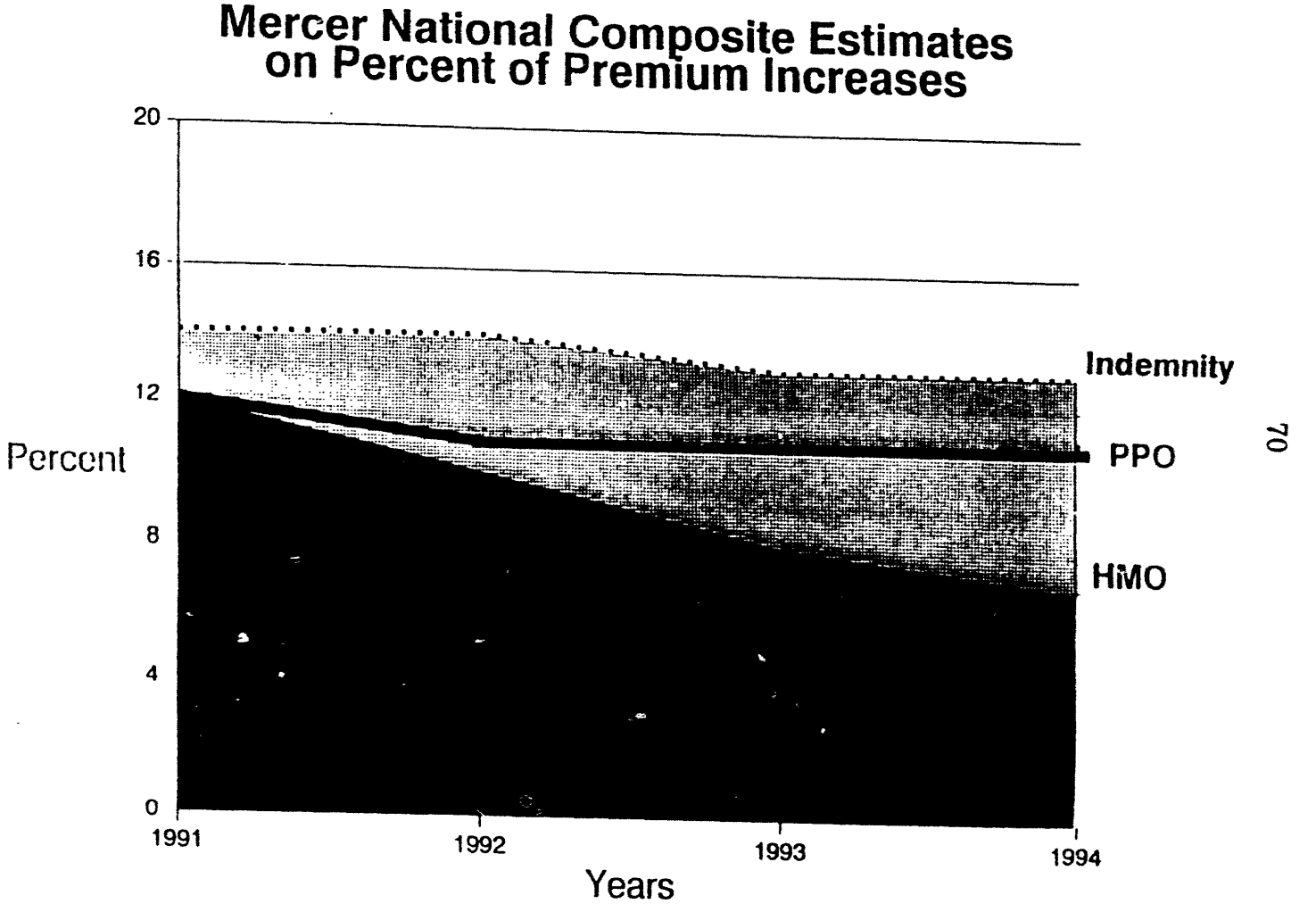
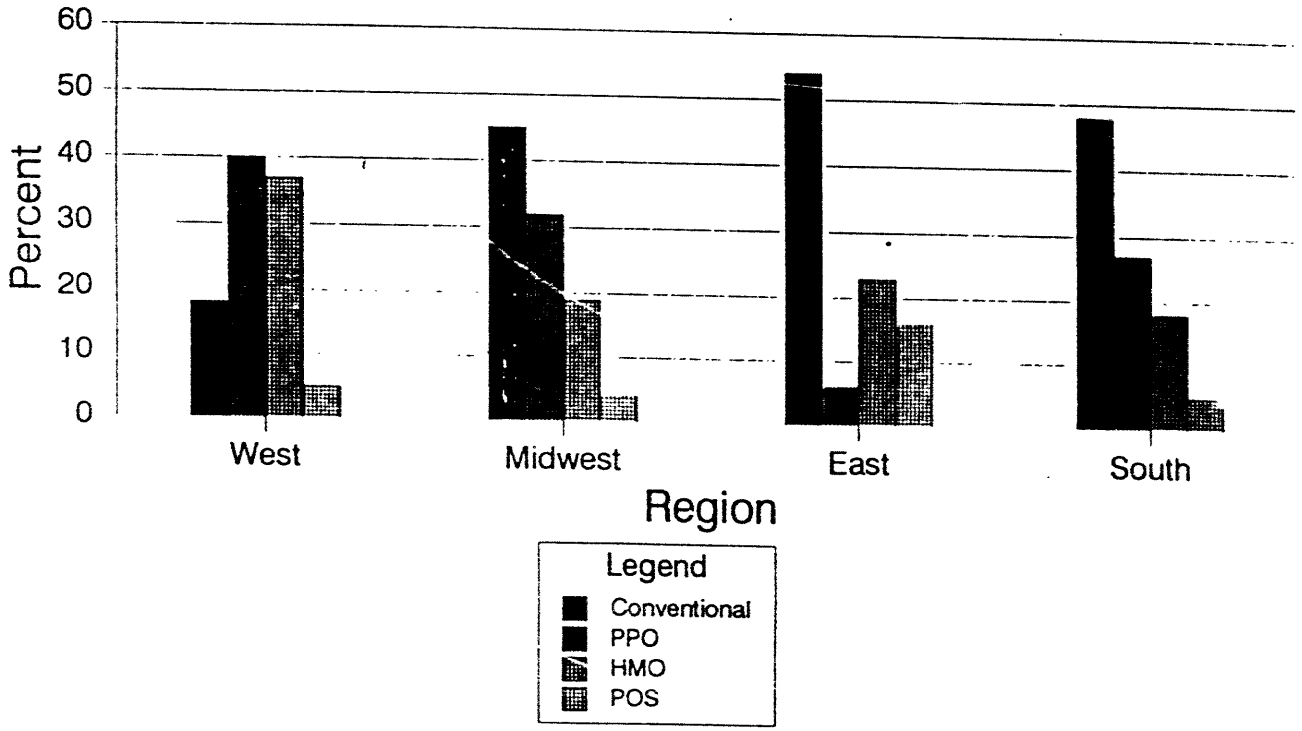

Mercer National Composite Estimates
on Percent of Premium Increases
20
16
12
8
4
0
Percent
1991
1992
1993
1994
Years
Indemnity
PPO
HMO

Figure 4.

KPMG Peat Marwick Survey on Percentage of Employees Enrolled by Type of Coverage, 1992



PREPARED STATEMENT OF BRENT C. JAMES

QUALITY CONTROLS COSTS—AN ILLUSTRATION

When a patient enters a hospital they are automatically at risk for a series of serious complications, just by being in a hospital. The most common such risk is an adverse drug event—a drug overdose or allergic reaction. The second most common is a hospital-acquired infection. The third most common is deep venous thrombosis, where blood spontaneously clots in the deep veins of the calves and thighs due to immobility. Pieces of clot a break free, travel through the heart, and lodge in the lungs—a pulmonary embolism, one of the most common causes a preventable deaths in hospitals. The fourth most common is bed sores—pressure or decubitus ulcers.

Hospital-acquired infections fall into four major categories: Post-operative wound infections, where bacteria fall into an open incision during or after surgery and start a full infection; urinary tract infections, usually associated with Foley catheters (tubes to drain urine at times when a patient cannot urinate); lower respiratory infections (pneumonia or bronchitis) picked up from other patients in the hospital; and bacteremias and septicemias (infections of the blood).

In 1985, a clinical team at LDS Hospital in Salt Lake City, Utah, began to examine deep post-operative wound infections within their facility (Figure 1). They especially focused on one factor: The use of antibiotics in conjunction with surgery (prophylactic antibiotics). With antibiotic prophylaxis, the aim is to maintain high levels of antibiotic in a surgical patient's blood and tissue, so that if bacteria do fall into the surgical incision those antibiotics will immediately kill them, before they can start an infection. The team developed data (since published as an article in the New England Journal of Medicine) that showed that there is an optimal time at which to start prophylactic antibiotics in order to achieve maximum effect. If prophylactic antibiotics are started within two hours before the start of surgery (where the "start of surgery" is marked by the initial surgical incision) then infection rates will be significantly lower than if the antibiotics are started either earlier or later than that optimal two hour time window.

On the basis of their findings, the team tracked every case that received elective surgery at LDS Hospital during a six month period in 1985. They discovered that, when prophylactic antibiotics were used, they were started during the optimal two-hour time window only 40 percent of the time. At that time, careful patient follow-up demonstrated a 1.8 percent deep post-operative wound infection rate—well below the accepted national standard that demands that a hospital maintain a deep post-operative wound infection rate between two and four percent.

Despite their better than national standard outcome performance, the team regarded a 40 percent "on-time" prophylaxis rate as a process failure. They therefore undertook a series of interventions designed to (1) convince surgeons to order prophylactic antibiotics to start within the two-hour optimal time window and (2) help operating room staff actually start the drug on time (a surprisingly difficult task, given the complexity of starting a surgical case). By 1986 their "on-time" compliance rate had improved from 40 to 58 percent. By 1991 they reached a 96 percent compliance rate. As their "on-time" prophylaxis improved, they saw the hospital's deep post-operative infection rate fall from 1.8 percent (in 1985) to 0.9 percent (in 1986). By 1991 the rate had fallen to 0.4 percent (Figure 2).

A 0.4 percent deep post-operative wound infection rate-five times better than the best national standard-represents a level of quality patient care that every American hospital should strive to achieve. But it also has significant effects on health care costs. At LDS Hospital in 1986, we estimate that the marginal cost (not charge) to treat a deep post-operative wound infection was $14,000 per case (we estimate that it had fallen to about $9,000 by 1993). In 1986, LDS Hospital had an estimated 33 fewer deep post-operative wound infections that it would have had if the old, better than national standard, 1.8 percent wound infection rate had continued. At $14,000 per infection, those 33 fewer infections represented almost $500,000 in health care costs—costs that LDS Hospital never incurred, because the infections never occurred. By 1991 the estimated savings exceeded $700,000 for this single clinical process of care.

In fact, LDS Hospital now has teams in place to manage the clinical processes that underlie all four of the major complications that patients face when they enter a hospital, with their several subprocesses. Initial estimates indicate that, by pushing to the best performance possible, as opposed to acceptable national standards, LDS Hospital saves between five and ten million dollars in health care costs each year. Those savings come from managing just four of the thousands of processes that make up a tertiary hospital. Even more interesting: The savings come as a direct result of better quality patient care-as quality improved, costs fall.

Quality theorists call the phenomenon illustrated by LDS Hospital's deep post-operative wound infection project "quality waste:" A step in a process fails. Not every time, but some proportion of the time, that process failure directly causes an outcome failure. What can be done with the resulting low-quality output? Only two options exist: The quality failure is either discarded or repaired. But both of those options cost money. The first option wastes the resources that went into initial production. The second involves additional costs for repair.

Experts estimate that quality waste accounts for between 25 and 40 percent of all American health care expenditures.[1] That tracks closely with estimates of quality waste in American manufacturing industries that do not use process management methods, usually placed between 25 and 35 percent, as opposed to less than four percent in quality-based American or Japanese companies. Quality waste is the first of three specific mechanisms by which quality drives cost. With quality waste, as quality improves costs fall. Under productivity/efficiency, quality holds stable as costs fall. Only under cost-benefit mechanisms do costs rise as quality improves. Each mechanism can work in reverse, too. Within IHC, we have found many examples where well-intentioned but poorly informed interventions to reduce health care costs have damaged a process of care and increased quality failures. The costs of treating those quality failures have far outstripped the purported "savings" that the original intervention achieved.

The fact is, quality drives costs (or, more accurately, quality and costs are two sides of the same coin-it is impossible to act on one without acting on the other). And, as those deeply involved in the health care reform debate have recognized, costs drive access.

That it why it is so important to include quality in the national health care reform debate. Any reform that does not fundamentally change the interaction between providers and patients, in a positive way, cannot control American health care costs without seriously damaging care delivery (or redefining down the meaning of "adequate health care").

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[1] Anderson, Craig A. and Daigh, Robin D. Quality mind-set overcomes barriers to success. *Healthcare Financial Management* 1991; 45(2):21–32 (Feb).

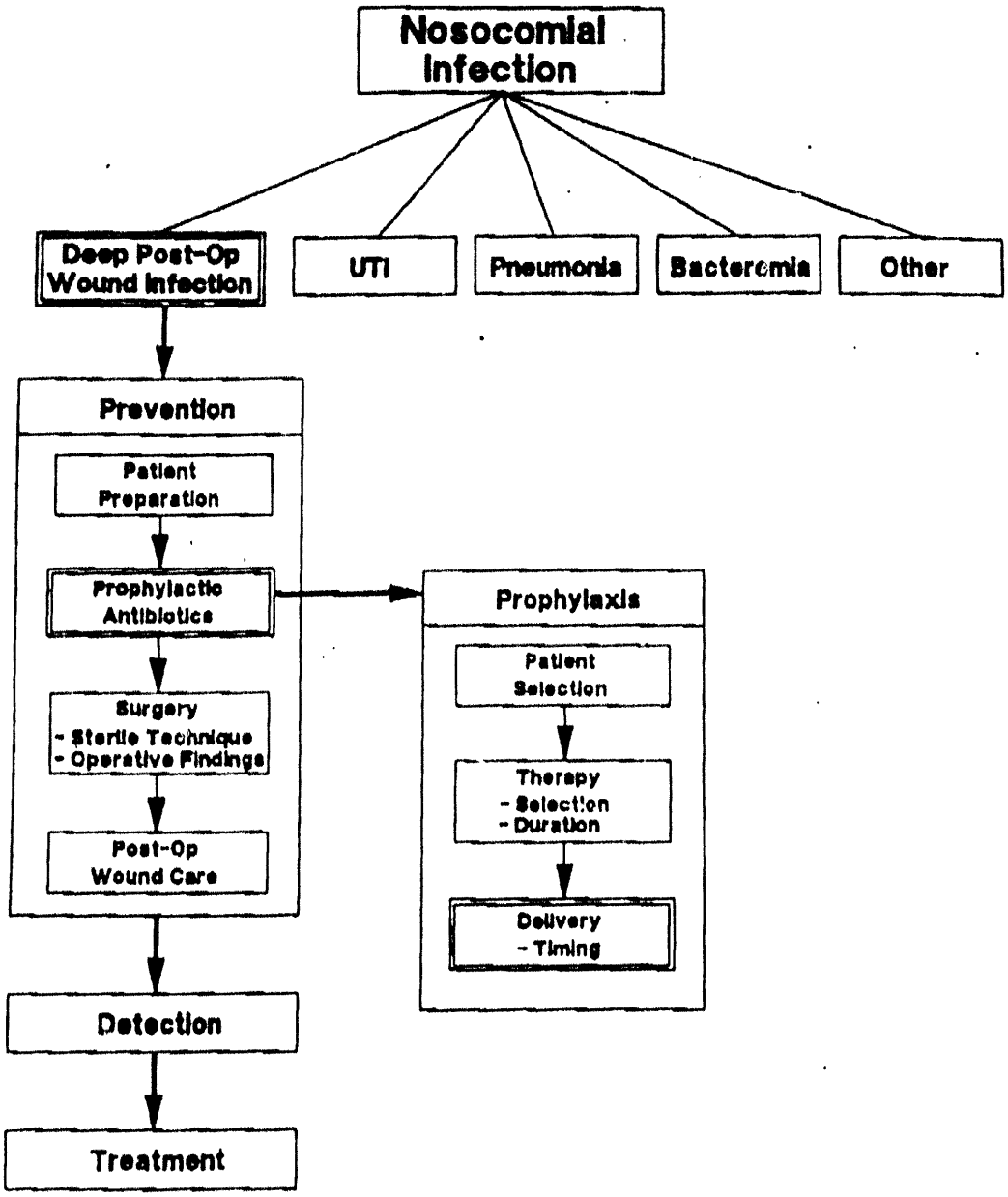


Figure 1. Process for managing deep post-operative wound infections at LDS Hospital in Salt Lake City, Utah

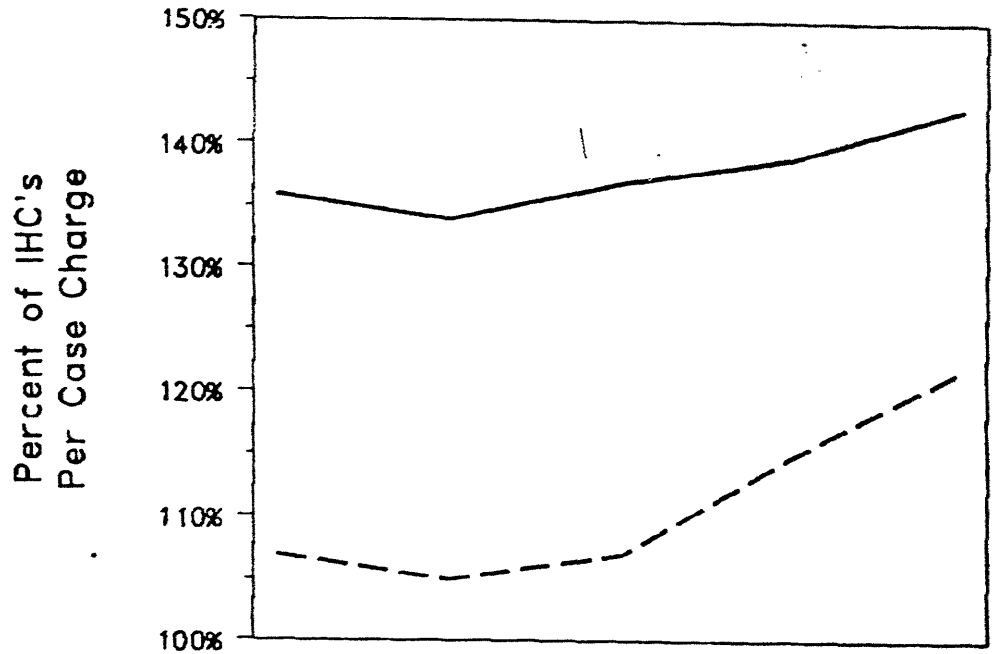
Deep Post-Operative Wound Infections at LDS Hospital

	1985	1986	1991
% prophylaxis given at optimal time	40%	58%	96%
% infections	1.8%	0.9%	0.4%
Est. decrease in infections relative to 1985	--	33	51
Est. savings at $14,000 / case (in thousands)	--	462	714

National standard: 2 - 4% infection rate

Larsen RA *et. al.* Improved perioperative antibiotic use and reduced surgical wound infections through the use of computer decision analysis. *Infect Cont & Hosp Epi* 1989; 10(7):316-320.

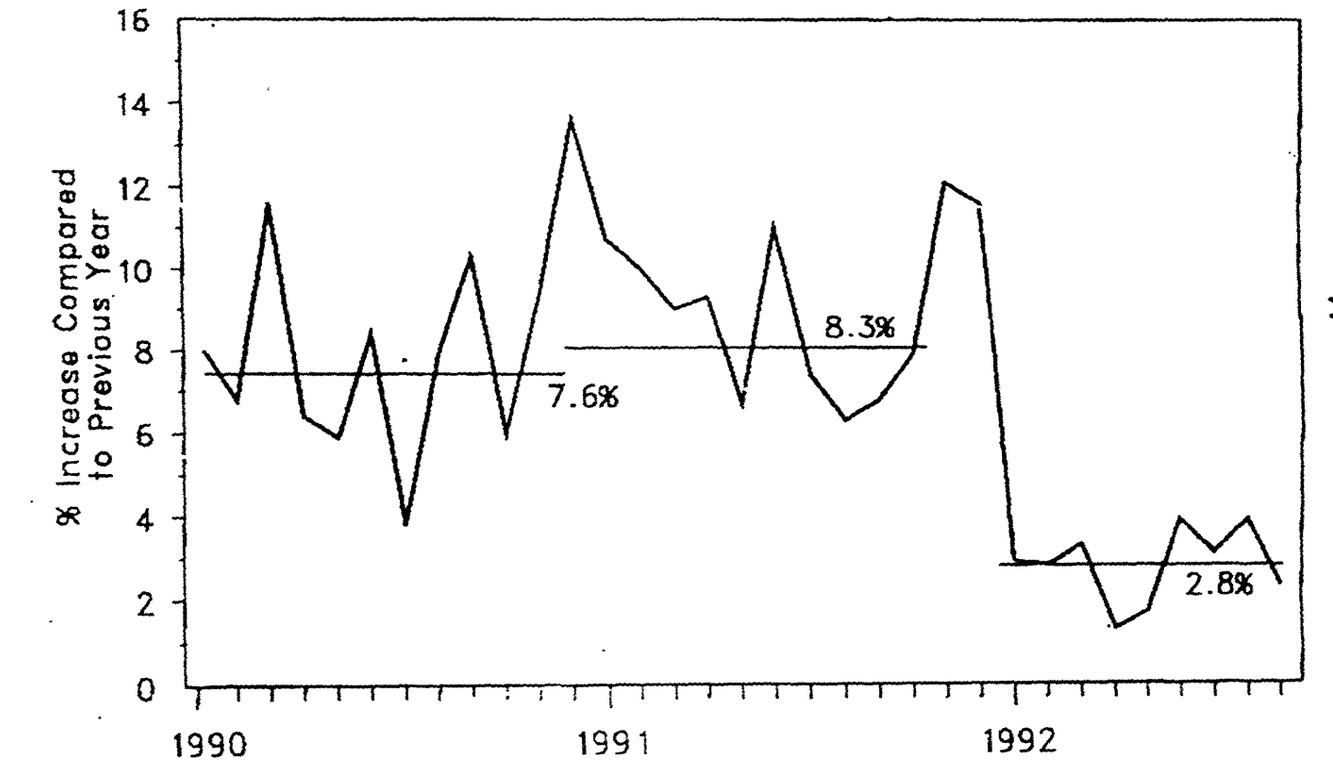
Classen DC *et. al.* The timing of prophylactic administration of antibiotics and the risk of surgical-wound infection. *New Engl J Med* 1992; 326(5):281-6 (Jan 30).



	1986	1987	1988	1989	1990
U.S. —	136%	134%	137%	139%	143%
Utah–nonIHC --	107%	105%	107%	115%	122%

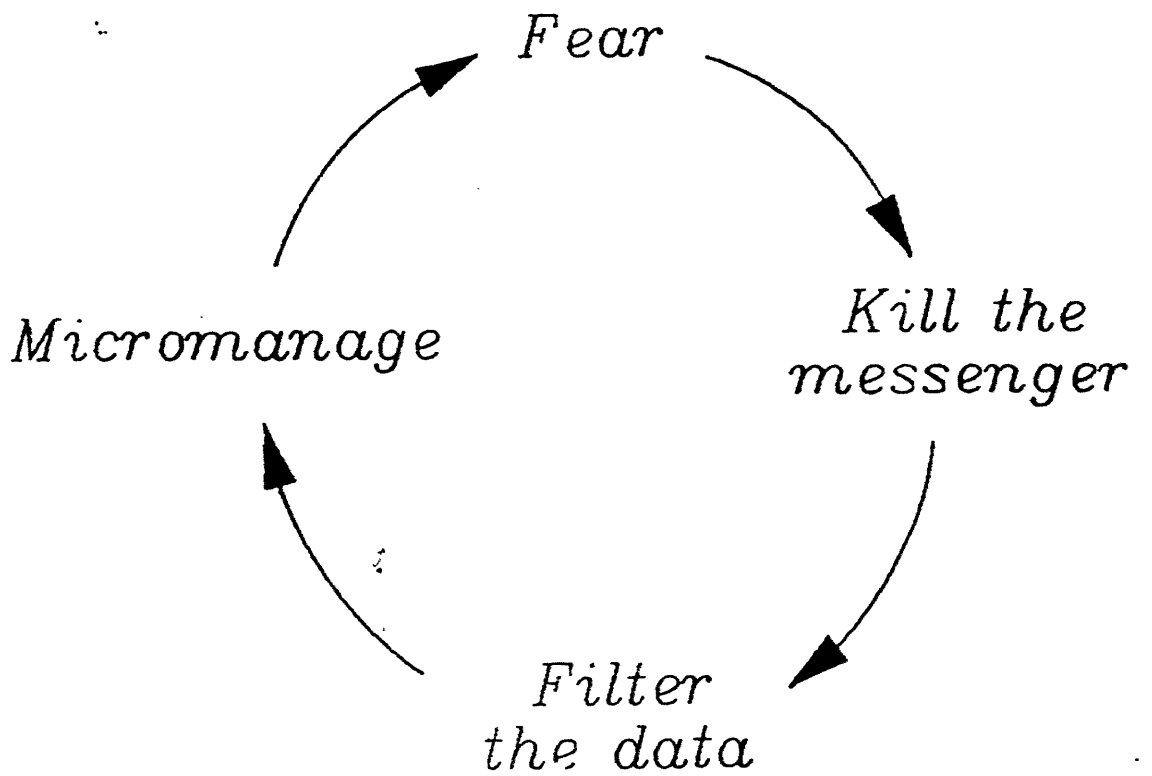
Case mix based on all 1990 Medicare patients

DRG–Adjusted Per Case Charge
Compared to Entire Previous Year



Planned increase: 7.6% 8.8% 4.5%

Cycle of Fear



PREPARED STATEMENT OF THOMAS O. PYLE

Good morning, Mr. Chairman. My name is Tom Pyle. I am CEO of MetLife Health Care, MetLife's managed care subsidiary, with some 1.4 million people enrolled in our managed care networks.

As a former President and CEO of the Harvard Community Health Plan and the current Chairman of the Health Outcomes Institute, I am especially pleased to be here today to discuss a long-time interest of mine, the definition and role of Accountable Health Partnerships (AHPs) in a newly created system of health care delivery.

WHAT METLIFE HEALTH CARE SUPPORTS

MetLife Health Care supports the federal enactment of a health care reform bill, based on the principles of managed competition. Such a bill would provide the needed structure for a competitive market of Accountable Health Plans which integrate the delivery and financing of health care. Through its structure and requirements for accountability, managed competition allows competing private programs—the Accountable Health Partnerships—to bring the creativity, innovation, and responsiveness to consumers needed to meet American citizens' expectations for full access to high-quality, affordable care. It will be these Accountable Health Partnerships, and not layers of government bureaucracy and regulation, that will be the true engine of health care reform.

MetLife Health Care endorses wholeheartedly the principles the President embraced in his address before Congress and the nation on September 22—security of health insurance coverage, simplicity for the health care system, savings, choice of providers and plans, quality of care, and individual responsibility. As Congress debates the enactment of health care reform in this session, we believe these principles will, and should, guide the debate. Our differences will be over how to achieve them.

THE DEFINITIONS AND ROLE OF ACCOUNTABLE HEALTH PARTNERSHIPS

Accountable Health Partnerships, the key to and foundation of reform, are organized health care delivery systems based on current HMOs and managed care networks. An AHP may be a vertically integrated organization (e.g., staff and group models such as Kaiser, Group Health of Puget Sound, or the Mayo Clinic) or an affiliation of providers, carriers and hospitals, similar to MetLife Health Care's networks. Under managed competition, MetLife and other plan administrators will operate local AHPs.

AHPs are accountable in the marketplace for the quality of services delivered to enrollees. Accountable means being responsible for providing both the access appropriate to the delivery of quality health care and the quality delivery of that health care, both clinically and administratively. An AHP assures that providers meet standards of credentialing, and complies with national standards for quality services.

A key, essential operating characteristic of the AHP is an effective program of total quality management and continuous quality improvement. An AHP gathers data on its performance for competitive comparison, including data on health outcomes, and publishes it. This outcomes data is also used by the AHP in evaluating its best medical practices.

AHPs would be required to offer uniform sets of benefits to allow consumers to make meaningful choices among competing plans. With standard benefits, plans could be clearly compared by consumers on the basis of cost and quality rather than on the more clouded basis of variation in coverage and benefits. Optional, additional coverage could be offered, but separately from the uniform benefit set.

Medical underwriting and the related pre-existing condition exclusions would be limited or discontinued. Guaranteed issuance of coverage would be provided for small employers and individuals, as well as for large groups. Community-based rating systems would be required in some form, at least for the small employer and individual portion of the market. These insurance reform proposals are consistent with what we at MetLife have supported for a number of years.

In summary, the AHP is an organization structurally committed to the high quality and efficient use of our health care resources, in which providers and plan managers have common incentives to work cooperatively in the delivery of quality care.

THE RECENT GROWTH IN MANAGED CARE

The market's movement to a managed care delivery system is already occurring. We see that 51% of employees are in network-based delivery systems, up from 28%

in 1988 and almost double the number four years ago. Enrollment in HMOs has more than quadrupled in the last twelve years and now totals about 45 million Americans nationwide. According to a report conducted by KPMG Peat Marwick and recently released by the Group Health Association of America, from 1988 to 1993, HMO premiums increased at a rate 40% lower than did fee-for-service (or traditional indemnity) plans. Of large employers surveyed in 1992 by Towers-Perrin, virtually all (91%) say that employee satisfaction with health benefits is the same, or better, under managed care plans.

It is understood by MetLife Health Care and should be understood by others that managed competition will dramatically change the way in which the insurance industry does business. We see our future as a managed care company operating the high quality, cost-effective Accountable Health Partnerships that are the true engine of health care reform and in the best interest of the American consumer.

THE ADMINISTRATION'S COST CONTAINMENT PROGRAM

We agree with the Administration that the marketplace interaction among cost-effective, quality AHPs should be the basis of health care cost-containment. We oppose, however, the global budget program in the Administration's plan that is implemented through insurance premium controls, and the regulatory requirements of the bill that hamper our ability to run our health plan operations.

Far from being an effective solution, we are convinced that the Administration's global budget program, implemented through insurance premium controls, will assure that managed competition cannot succeed. Significant private investment is required to effect the health care delivery system reforms necessary in this country, almost without regard to the shape the reform takes. Price controls will seriously undermine incentives for these investments and serve to deflect them.

In addition, the Administration plan imposes on managed care arrangements, or Accountable Health Partnerships, a series of requirements that undermine the capacity of health plan managers to run their own operations. The requirements range from stipulations that all health plans must offer a point-of-service option making payments to providers on the basis of an alliance-set fee schedule, to the mandatory inclusion in health plan networks of whole classes of providers with which a health plan does not currently do business. It is difficult for me to conceive of being held accountable for the management of a health plan on the basis of both price and quality when these unreasonable restrictions are placed on a health plan's operation.

CONCLUSION

MetLife Health Care urges the Administration and the Congress to propose and enact a form of managed competition that will enable a positive marketplace interaction among Accountable Health Partnerships for the benefit of the American consumer, and not one in which the heavy hand of government will undermine the creativity and beneficial competitiveness of the private sector. In that regard, we think the Breaux/Durenberger bill is an excellent bipartisan effort to facilitate marketplace competition of health plans on cost and quality issues. We also commend the efforts of Senator Chafee and his colleagues towards health care reform through organized marketplace competition.

We pledge our support for fundamental reform of the health care system and will work on a bipartisan basis with the Administration and Members of Congress to produce the best possible result.

Mr. Chairman, thank you for the opportunity to appear today before your committee.

RESPONSES OF MR. PYLE TO QUESTIONS SUBMITTED BY SENATOR GRASSLEY

Question No. 1. I don't think we have had very much discussion yet on the Committee about the threat of underutilization that may be present in managed competition systems. In one of our hearings last year, both Stuart Altman and Karen Davis expressed some concern about this possibility. Others have also, including analysts at the Institute of Medicine.

In any case, I'd like to come away from this hearing feeling a little more comfortable than I do now that we are going to avoid this underutilization possibility.

Let me just ask first whether you agree that this could be a problem. If so, why do you? And would you make a distinction between different types of managed care systems on this point?

Answer. I do not believe underutilization will be a problem in a managed competition system for several reasons. First, the system is based on Accountable Health

Plans—what Chairman Moynihan asked that we refer to as Health Maintenance Organizations (HMOs). By definition, AHPs are accountable to their customers. As I noted in my prepared testimony, accountable means being responsible for providing access appropriate to the delivery of quality health care, and the quality delivery of that care. Second, there will be published information on performance, especially outcomes information, which will be available to patients and anyone considering joining a plan. Third, low copayments in managed care remove financial barriers to care, and combined with coverage of preventive services, result in incentives for seeking care earlier and thus, lower intensity and less expensive care. Finally, in managed competition, customers will genuinely be able to vote with their feet. If their AHP is not satisfactory, they can change plans.

Question No. 2. Karen Davis and Stuart Altman both said also that keeping fee-for-service medicine available is important. Their idea was that competing fee-for-service plans would help to check any tendency of managed care plans to underserve. That means, of course, that fee-for-service medicine would have to have sufficient *realistic* latitude to continue to exist.

Would you agree with that?

Answer. I believe there should not be artificial barriers to a fee-for-service option; nor should they be protected from the competitive marketplace. There is evidence that among members of managed care plans with a point of service option, 90 percent do not use that option. I believe that competing AHPs—and the other factors I noted in the answer to the earlier question—provide sufficient incentives against underutilization.

Question No. 3. What's happening now, and what's likely to happen, to the professional autonomy of physicians and other providers in these systems, in your view? Is there a loss of physician autonomy taking place, how should we think about it? Is it a good thing? Bad thing?

Answer. In the reformed managed competition system, as in many managed care plans today, physicians will be participants and decision-makers in a system in which there is higher accountability to the consumer than exists in our current system. Physicians will be accountable in more measurable ways for providing quality care. We are developing and improving methods of tracking that quality, as well as patient satisfaction. A key feature of AHPs is a "report card" that will provide information to customers on outcomes and other quality measures, and there will be more information available to physicians to augment their own professional skills, tools, and judgments. In short, autonomy and accountability must be balanced.

Question No. 4. What about joint patient-physician decision-making about treatment? Have treatment decisions become insurance company-physician decisions, rather than patient-physician decisions now, or will they?

Answer. Responsible practice of medicine should always include patient involvement. That will not be any less the case under managed competition. In my experience, HMOs give their patients more information so that patients are better equipped to participate with their physician in decisionmaking. For example, Dr. Jack Wennberg has developed a videodisc to assist the patient in understanding prostate conditions and their treatment; this videodisc is now being used by Kaiser Permanente and the Group Health Cooperative of Puget Sound.

Question No. 5. Let me ask a little more specific question. Some of these managed care plans present physicians with financial incentives of one kind or another to influence their treatment decisions — bonuses or withholds that might then be kept by the company if the provider meets their target or their budget.

Should we regulate those kinds of incentives?

Answer. All methods of payment to physicians are incentives, including salaries, bonuses, withholds, and other arrangements. From a policy perspective, there is an argument favoring regulating bonuses or withholds to the extent that they do not result in appropriate decisionmaking by providers. However, micromanagement is too rigid and is not the answer. I believe monitoring outcomes and satisfaction measures increases accountability.

Question No. 6. What about requiring plans to publish the details about how they use such incentives? As well as any policy they have about testing, referrals and physician selection? Is that a good idea. That way the consumer would have a better idea of what might be happening in the exchange with the physician. That way consumer organizations could better evaluate these plans.

Answer. I believe the more information customers have about the plans available to them in the market, the better.

Question No. 7. There will be some bad actors out there — providers who should not be practicing medicine. What kind of system should we have to get rid of those people, without at the same time subjecting the competent practitioner to all sorts

of hassles? And should the system for identifying the incompetent practitioner be different from the system we use to foster continuous quality improvement?

Answer. The improved data systems and quality measures that are now under development and improvement will help us a lot in this effort. It is beginning to be possible to identify incompetent practitioners through means that do not overburden the system.

PREPARED STATEMENT OF GORDON SPRENGER

Mr. Chairman, my name is Gordon Sprenger. I am the executive officer of HealthSpan Health Systems Corporation in Minneapolis, Minnesota. On behalf of the American Hospital Association and its 5,300 institutional members, I am pleased to testify today on the issue of defining health plans.

The health care reform debate and the issue of defining health plans seem to have focused on simply financing broader insurance coverage. But, it is important—in fact it is vital—that we not lose sight of what we will do with that broader coverage. And that's what I'd like to speak about today.

AHA's vision of health reform is the creation of health care systems in each community that overcome many of today's problems while maintaining the high clinical quality of care we currently enjoy. These local systems would be based on collaboration among providers, capitated payment systems, and accountability to the public.

Defining health plans under national reform is a complex task that will significantly affect the future of health care delivery in the United States—and our ability to bring our vision of community-based care to fruition.

This issue also will affect the relationship between health care insurers, health care providers, and the individuals they serve in their communities. As specific proposals attempt to create a competitive market for health care coverage as the means of controlling costs, the definition of health plans will affect entry into the market, the choices available to consumers, and the relative position of major players in a market that constitutes one seventh of our economy.

Given the stakes involved, Congress is facing a formidable task. We commend you and the Administration for engaging it and we pledge our assistance in working through the many complexities it presents.

WHAT'S WRONG WITH THE CURRENT SYSTEM?

If we had to sum up in one word what's wrong with the current system, that word would be "incentives." Put simply, the incentives in health care are skewed at almost every level.

—The incentive for insurers is to avoid risk by avoiding unhealthy populations, often leaving those most in need of coverage unable to get it. This is true in part because large purchasers of care have pushed insurers toward experience rating in an effort to keep premiums down. It is also true because limiting exposure to risk through marketing and underwriting practices is easier than working with providers to manage the consumption of services so that all needed services—and only needed services—are provided. The effect has been to diminish the value of insurance coverage as a means of spreading risk across large populations so that it is affordable to most. It is important to note, however, that while this problem is prevalent, the degree to which individual insurers avoid unhealthy populations or cancel coverage with the onset of serious illness varies within the insurance industry.

—Provider payment methods, particularly under the Medicare program, create conflicting incentives for hospitals and physicians. The DRG-based prospective payment system under Medicare (which has migrated to other payers, including Medicaid) was effective in focusing hospitals on managing the total cost of each hospital admission. By leaving physicians under a fee-for-service payment system, however, the Medicare program created a classic conflict.

Hospitals have the incentive to limit inpatient days, procedures, and ancillary services to only those that are clearly needed and to the most cost-effective means of treating a patient, because they generally are paid the same rate no matter what services are provided.

Physicians, on the other hand, are paid for each procedure and service and, therefore, do not share an incentive to constrain resources. The current malpractice environment also creates the incentive for physicians to do everything available, particularly diagnostic tests, even if they are relatively confident it will yield little or no benefit.

—Most providers have little incentive to prevent illness—they only get paid to provide care once someone is ill or injured. As many would put it,

we have a "sickness" system, not a "health" system in this country. Preventive services often are not covered under typical insurance plans. Even health maintenance organizations, originally designed to focus on preventive care, often lack the incentive to aggressively address prevention because enrollees leave their plans long before the plans would economically benefit from investing in preventive care. In many communities, the only attention paid to health status issues comes from underfunded public health departments and providers with a community service mission—both of which are often struggling to provide basic care to the uninsured who are ill.

WHAT'S THE SOLUTION?

The American Hospital Association believes health reform must guarantee coverage for every American, restructure the health care delivery system to align incentives, and finance the system fairly and in a broad-based manner so that we do not promise more than we can afford.

Restructuring health care delivery. With respect to health care delivery, our ultimate goal has several parts, each of which is likely to be affected by the definition of health plans:

Develop community-based delivery systems that coordinate care among providers—what we call community care networks℠—and tailor care to the needs of the community

The fragmentation of the current health care system has created, in effect, a nonsystem that is difficult for patients to figure out—paperwork, for instance, is just the tip of the iceberg. It has also yielded too much unhealthy competition as providers are pitted against each other by the buying practices of large third-party purchasers of care. We believe it is time to put patients and patient care back at the center of our attention and focus on what's important: creating a user-friendly system that doesn't waste energy or resources.

To encourage the development of networks, reform legislation should:

Ensure that all plans meet minimum coordination of care requirements. Because "coordination of care" is often linked automatically with techniques designed to limit access to care, we have lost sight of the need to make the system better for patients to use. We believe that all plans, not just managed care plans, should be required to establish mechanisms that coordinate care and paperwork across provider settings and over time. Efforts here should be focused on reducing the hassle, confusion, and sometimes conflicting therapy that results from a lack of communication between multiple caregivers involved in an individual's care, or inappropriate intrusions into the care process by external utilization control agents. Coordination of care requirements should support and encourage the role of caregivers in managing patient care.

Such mechanisms could include common patient registration systems or unified medical records. They also could rely on enrollee selection of a primary caregiver (not necessarily a gatekeeper) who would accept the responsibility to assess an individual's health status, take steps to prevent illness, seek to change poor lifestyle habits, and help patients receive needed services from other practitioners.

With the exception of some administrative simplification provisions in the various bills before Congress, this issue remains unaddressed.

Encourage the formation of provider networks. Central to this, of course, is the need to remove legal and regulatory barriers to the formation of community-based networks, including antitrust, anti-kickback laws and physician referral prohibitions, and corporate practice of medicine laws.

Some collaborative arrangements and selective contracts used by providers forming a network may place them at risk under antitrust laws. Likewise, referral arrangements established by a network to coordinate care can trigger antikickback and physician referral prohibitions. And state corporate practice of medicine laws may interfere with the hiring of physicians. Transition periods can by particularly difficult because newly formed networks, after integrating financially, may need time to integrate the care process before they are in a position to assume risk, which is a key element in overcoming legal barriers. While these barriers can usually be overcome, the resulting organizational and operational structures can be cumbersome and inefficient.

On balance, the Breaux and Chafee approaches are helpful in forming a base for committee action on the antitrust and corporate practice of medicine issues. The

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Community Care Network, Inc. uses the name Community Care Network as its service mark and reserves all rights.

Clinton plan provides a basis for addressing the anti-kickback and physician referral issues, but requires broadening.

Ensure reasonable capitalization and other financial requirements so that provider networks can become health plans for their communities. It is appropriate that health plans demonstrate the financial capacity to reasonably ensure their ability to provide covered benefits to their enrollees and to ensure adequate protection against the risk of insolvency. It is also important, however, to distinguish between insurance plans based on contracts to finance coverage, and service benefit plans based on commitments to provide services.

Insurance plans rely significantly on cash reserves and reinsurance because they have to be able *to purchase* needed services from providers on the open market. Service plans rely on their capacity *to produce* services, pledging their assets and stop-loss coverage in addition to more limited cash reserves.

We support capitalization requirements that protect the public interest. However, we are concerned that the current debate is so focused on the insurance model that the ultimate requirement adopted will require unreasonably high cash reserves—thus creating a significant barrier to the formation of plans by community-based provider networks.

We understand the desire on the part of many to adopt a single method for calculating capitalization requirements that would take into account a variety of factors inherent in evaluating the risk assumed by individual plans. Since such methods are still under development, predominantly by the National Association of Insurance Commissions, we are not convinced that moving from the current system of different methods for different models to a single method is appropriate or workable. One size seldom fits all. Other alternatives to addressing the issue of risk may need to be developed or left to the states, as in the Clinton bill.

Focus the system on keeping people well in addition to providing high quality health care services when they are ill or injured

It is important to distinguish between plans that exist solely to provide covered benefits to their enrollees, and those that accept a broader community service mission, serving the community as a whole and addressing health status issues through a variety of avenues not limited to covered benefits.

Clearly, minimum requirements for health plans should be focused on the legal obligation of the plan to its enrollees—that is, providing covered benefits. At the same time, we believe it is reasonable to move all plans toward a greater role in improving health status by including preventive services in the benefit package and holding all plans accountable for their approach to improving *enrollee* health status.

We do not believe, however, that Congress should require all plans to accept a broader community service mission—even though it is central to our community care network concept and our vision of the optimal health care system for a community. Tax exemption may be the appropriate means to encourage a broader mission. It may also be the means to move community health improvement efforts into a new era of collaboration with other community organizations and agencies, particularly local public health officials, schools, and social service agencies, and of evaluating whether the initiatives undertaken have any effect on improving health status. We support a continuous quality improvement (CQI) approach to community health status. This approach identifies problems, designs and implements interventions, monitors and evaluates the effect of those interventions, and then starts all over again. We believe the evaluative phase of this process is essential to making the best use of local resources and, by reporting the results to the public, holds the health care system accountable to its community.

Encourage capitated payment arrangements for networks that create incentives for the prudent use of health care dollars and, in essence, form a community-level health care budget enabling community-level decisions on the use of available resources

AHA believes that capitated payment at the community network level is the key both to community self-determination in how resources are allocated, and to slowing the rate of growth in health spending. Central here is the need to protect the ability of community-based networks to contract on a capitated basis with health plans to deliver care to a portion of the plan's enrolled population, without becoming subject to regulation as an insurer or jeopardizing their tax status. Also important is the need to create incentives for Medicare beneficiaries to select capitated plans as an alternative to Medicare.

Ensure a high standard of public accountability for all health care providers and plans

AHA believes all plans should report publicly on plan performance with respect to cost, quality, enrollee health status, and enrollee satisfaction. Our position is consistent with the majority of proposals before Congress. While there still is significant work needed to develop appropriate measures, it is time to respond to the public's need for better information to help them decide where to seek their coverage and their care.

A missing ingredient from most of the proposals, however, is the need to generate information at the community level. Many of the proposals before Congress tie analysis to the geographic area served by an alliance or purchasing cooperative. Depending on the decisions made by state governments in drawing the boundaries of those areas, alliances could serve multiple markets. Under those circumstances, a consumer would not know whether the plan's performance was reflective of his or her own area. While this presents some technical issues, we believe the value of the information to consumers would be significantly enhanced if analyzed at the community level.

Insurance Reform. We also believe it is essential to implement a series of reforms in the insurance market that would end barriers to coverage based on health status or expected use of services. These reforms—generally included in even the most limited plans now before Congress—are critically important to the majority of people in this country who are under age 65 and have private insurance, but are increasingly insecure about whether they will be covered when they most need care. Such reforms include open enrollment, broad risk-sharing (e.g., community rating), guaranteed renewability, and no pre-existing condition clauses. It is equally important that safeguards be included against the manipulation of service areas to discriminate On the basis of race, ethnicity, socio-economic status, age, or anticipated need for health services. We believe that by limiting the ability of health plans to avoid risk, a strong incentive will be created for insurers and providers to work together to develop systems that manage care efficiently—and that manage risk, rather than avoiding it.

CONCLUSION

We recognize that accomplishing our goal of restructuring health care delivery is very dependent on the initiative of health care providers. Many of AHA's members have already started down this path and have made major progress. In other words, health care reform is already happening in many communities. The role of national reform legislation, we believe, is to support this movement by creating incentives and removing barriers.

As you wrestle with the definition of health plans and with other reform issues, Mr. Chairman, we urge you to maintain a broader view of not just financing insurance, but of helping us rebuild health care delivery at the local level. We know that doing so will make things better for our patients and for our communities, and we look forward to working with you in that effort.

RESPONSES OF MR. SPRENGER TO QUESTIONS SUBMITTED BY SENATOR GRASSLEY

Question No. 1. Does AHA think that underutilization is a problem under managed competition or managed care? Would you make a distinction between the effect of different types of managed care on utilization patterns?

Answer. Managed competition and managed care affect utilization patterns in very different ways. Managed competition—the way the market is structured—provides a check on the potential for underutilization in managed care. Under managed competition, health plans are no longer able to compete on the basis of risk selection, but must compete on the basis of price and quality. Competing on the basis of quality means collecting and publicly reporting data designed to measure whether the care provided was appropriate, or the "right" level of utilization. This information would include data on patient outcomes, patient satisfaction, clinical performance measures, and availability and accessibility of services. Using this information consumers choose among health plans and if they are dissatisfied move to another one. This ability to select among plans is an expansion for many individuals currently limited by employer offerings or their lack of market clout as individuals. It is also an important check on the potential for underservice.

Regarding the effect of managed care on utilization patterns, AHA believes that every financing mechanism creates incentives that may affect the quality of care. Under fee-for-service payment arrangements, the financial incentive is to provide more care, and quality concerns focus on the provision of unnecessary care. Under capitation, the financial incentive is to reduce costs to keep spending within the

capitated amount by providing only needed care and doing so efficiently. The fear is that providers will economize by reducing necessary as well as unnecessary spending, compromising access to and quality of care. The key to identifying underutilization and/or appropriate practice patterns are well-designed internal and external quality assurance mechanisms that track broad practice patterns.

Different types of managed care do incent providers differently which could have an effect on utilization patterns. However, as stated previously, We would suggest that any payment mechanisms carries incentives for under or over service. The goal is to identify the "right" level of care. The system AHA envisions as most capable of identifying and providing the "right" level of care are Community Care Networks. Community Care Networks would not only be responsible for improving the health status of their enrollees but also for improving the health status of their community. Community Care Networks would provide services in an environment where providing needed services would become the collective responsibility of all plans and providers. If one measure of an effective delivery system is how well it provides services to vulnerable populations, this type of accountability is one way to work towards that goal.

Question No. 2. Does fee-for-service have to continue to exist to act as a check on managed care's potential to underserve?

Answer. Incentives exist for inappropriate delivery of services in both systems. AHA does not believe that fee-for-service arrangements need to exist to "check" managed care. Competition between managed plans is as effective a check as fee-for-service plans would encourage. AHA believes that consumers should be able to choose to go to providers outside their system or purchase fee-for-service plans. But they should not be granted any special status just for the sake of maintaining fee-for-service arrangements.

Question No. 3. Do managed systems hinder physician autonomy and the patient-physician decisionmaking process?

Answer. The current level of evolution of managed care does involve a high level of second-guessing of physician decisions. This is because much of managed care to date has been based on reviewing individual practitioner decisions rather than broad practice patterns. As these networks evolve and become more integrated, physicians and other providers will regain their clinical autonomy, but in return will be asked to take responsibility for the collective whole. The system will operate within a budget, but practitioners will decide how care is delivered.

This is only possible as we move from case by case review to examining patterns of care. Analyzing broad practice patterns helps systems identify areas of need and if necessary particular providers that may not be operating within appropriate parameters.

These systems will enhance patient involvement. Integrated networks have an incentive to encourage patients to become more educated about their health as keeping a patient healthy will be the goal of both the individual and the plan.

Question No. 4. What about physician incentives? Should we regulate or publish such incentives?

Answer. Every payment mechanism utilizes incentives. The trick is to design incentives so that the practitioner is encouraged to treat the patient in the most appropriate way. Health plans are currently experimenting with incentives that balance individual provider autonomy with collective responsibility. While no perfect balance of incentives has surfaced, the way to make sure that the payment incentives are encouraging the appropriate response is through a solid quality assurance program. By looking at data including broad practice patterns, Outcomes information, and patient satisfaction, and feeding that information back into the system, inappropriate patterns are identified. These patterns can then be compared with varying incentive structures to determine their effect on patterns of care.

Some incentives mentioned in your question, especially in the areas of physician self-referral and under the category, fraud and abuse, are regulated. However, we would stress the need to focus on broad patterns of care instead of specific incentive structures to determine the need to expand that regulation. It seems reasonable to require health plans to publish information on what incentives they use.

Question No. 5. How should the system identify the bad actors without submitting competent practitioners to all sorts of hassles? Is this a part of a continuous quality improvement system?

Answer. Networks are particularly well-suited to both prevent inappropriate practices and identify them once they may occur. Careful selection of network practitioners prevents potential abuses later on. This is one reason why tightly integrated managed care networks often have a higher percentage of Board certified physicians than the nation as a whole.

Once the network of practitioners is selected, the health plan will focus on broad practice patterns to identify outliers instead of case by case review. This process does not involve second-guessing provider decisions, thus eliminates much of the hassle for competent practitioners. This type of pattern analysis should be used in a continuous quality improvement process to measure the progress of the organization and/or to identify and work with practitioners who routinely practice outside established parameters.

Question No. 6. In your testimony you mentioned that an enrollee could choose a primary caregiver who is not a gatekeeper. Could you elaborate on your point?

Answer. AHA believes that given the growing complexity of health care delivery, people need some one or some mechanism to help them navigate the often confusing maze of health services. Consumers need a place to go to help them access care; ensuring that they get the right services, at the right place, and at the right time. This was one of the most striking results of focus groups AHA conducted this past year. Participants expressed a high level of confusion about where and when to seek care.

This function could be performed by a primary caregiver that is a gatekeeper, but it could also be separate from the gatekeeping function. It could even be a 1(800) IAM-SICK number where people could call if they were unclear about how to access services. In Washington state, the Weyerhaeuser Company uses nurses at the work site to provide this service for their employees. Harvard Community Health Plan in Massachusetts is experimenting with at home computer terminals that are programmed to give people advice on particular groupings of symptoms. The computer suggests when the enrollee should come into the Health Plan and also contains simple at-home medical advice.

PREPARED STATEMENT OF ALLAN TULL

Good morning, Mr. Chairman and members of the Committee. My name is Allan Tull and I am a member of the Board of Directors of the American Association of Retired Persons. On behalf of the Association's members, I appreciate the opportunity to present the consumer's view on the kinds of quality assurance needed in a restructured health care delivery system.

Because this is the first opportunity AARP has had to address the Senate Finance Committee in its health care reform deliberations, I would like to state for the record that the Association has taken an active role in all aspects of this debate — from the broad issues of coverage and financing, to the more specific issue that is the subject of today's hearing.

Health care reform is AARP's number one priority. We are mobilizing our grassroots to listen to our members, to inform them about health care reform proposals and ideas, and to urge them to tell their Members of Congress what they want. Reflecting the clearly expressed wishes and concerns of our members, AARP supports real health care reform that assures every American health care coverage, not merely access; a comprehensive benefit package that includes prescription drugs and long-term care for Americans of all ages; and system-wide cost containment that makes coverage affordable for all. The Association is committed to enactment of such comprehensive health care reform in 1994.

We look forward to the opportunity to discuss these broad issues of health care reform in future hearings before this Committee.

HEALTH CARE REFORM AND THE NEED FOR QUALITY SAFEGUARDS

Increasingly, we read in the press reports of public concern about the impact of health care reform on the quality of care. The word "quality" seems to have become a touchstone for all of the different anxieties people have about the changes articulated in health care reform proposals. In some circles, "quality" has become the rallying cry of those who oppose any change at all. AARP does not support such attempts to capitalize on people's fear of the unfamiliar. We are convinced that, without comprehensive health care reform that includes a structured plan to preserve and enhance quality, the decline in quality that people fear will inevitably take place as the system becomes overburdened by increasing demand and declining resources. In fact, to the extent that "choice" is a proxy for quality, peoples' choices are already being restricted in the current system.

Today we have heard about how the provision of health care will be restructured and how new delivery systems may operate under very different incentives than exist in the current, predominantly fee-for-service marketplace. Today's hearing is considering whether these incentives create a need for new safeguards to assure that patients receive appropriate, good quality care.

AARP believes the answer is yes. While health care reform offers the potential to improve the quality of care and health status of the population as a whole, the new system must contain rigorous shields against the risks of individual instances of underservice and poor quality care. It is fair to say that public perception of the quality of the new health care system will be driven not by stories of unnecessary care avoided but by "horror stories" of needed care deferred or denied.

What exactly are we seeking to achieve in asking that a comprehensive package of quality measures be included in health care reform? Our quality of care goals are:

- To prevent the withholding of necessary and appropriate care, as well as to avoid delivering unnecessary or inappropriate care.
- To assure *individuals* that they will be able to have their health care needs met, as well as to improve the overall health of various *populations*.
- To preserve meaningful choices for consumers, as well as to provide for the skilled management of care.
- To facilitate the efficient and rational delivery of health care services to groups of consumers, as well as to empower individual consumers to challenge specific decisions affecting their care.
- To promote the application of continuous quality improvement approaches to health care delivery, as well as to ensure the detection and cessation of practices threatening patient well-being.
- To enhance consumer decision-making capability through disclosure of treatment options, risk-benefit considerations, and outcomes, as well as to strengthen mutual respect and trust between practitioners and patients.

The safeguards needed to achieve an integrated quality of care program reflect the dynamic tension apparent in these goals. While some of the safeguards are present in one or more of the reform proposals currently before Congress, reliance on a limited set of safeguards would, in our view, be a major mistake. The safeguards need to be viewed as a necessary *package*.

QUALITY ASSURANCE SAFEGUARDS

The Association considers each of the following to be necessary safeguards to quality in a reformed health care system.

1. Public Accountability

In a reformed health care system, consumers need to have a say not only in their selection of health plans, but also in governance and policy making throughout the system. In a system that seeks to achieve a uniform nationwide standard of care, but is likely to see significant powers granted to fifty different states and perhaps to entities such as health alliances, such public accountability and consumer participation in governance takes on heightened importance. The principle of substantial consumer representation should be applied with respect to any and all Boards and Commissions established at the national and state levels to oversee health care quality; appropriate opportunities for consumer input into the operation of health plans should also be provided.

Further, public participation should extend to decisions about adding or restricting benefits and introducing new technology. Such decisions should emanate primarily from a commitment to quality and not only to cost containment.

2. National Standards and Data Collection

A comprehensive, national approach to quality assurance is required to assure delivery of the same appropriate, high quality care regardless of the site of care. States must be held accountable for meeting Federal quality of care standards.

A core set of quality and performance measures should be developed and collected from all providers. The goal is to develop data systems with uniform definitions and reporting requirements to permit comparisons across all health encounters, regardless of payment source or setting, while also protecting privacy and confidentiality. There must be stable and sufficient funding for quality oversight, information and data infrastructures, and consumer protection activities.

3. Due Process and Appeals

There should be nationally uniform due process protections for all consumers in the event of quality problems or denials of care, including access to grievance procedures and independent and timely appeal mechanisms. Individuals directly affected by a specific coverage or payment decision are entitled to full, clear and timely written information regarding appeal rights, procedures, and standards of decision making, as well as an explanation of the basis for any initial determination or decision on appeal.

Individuals should have the right to appeal coverage and payment determinations to an impartial body. Appeals procedures should be simple and understandable, and should incorporate standards of due process, including the right to an in-person hearing.

We believe an ombudsman can help assure that all consumers, not just the legally sophisticated, will be able to exercise their rights to be heard. We recommend that any final legislation include an ombudsman provision modeled after the State Long-Term Care Ombudsman in the Older Americans Act, and that it be housed and funded independently of the organization(s) whose services it has a mandate to monitor.

4. Consumer Information

An extensive consumer information program, when fully implemented, will be a cornerstone of assuring quality. We must recognize, however, that it will take a long time, and a significant financial investment, to develop and implement the necessary data systems. Many critical performance and quality measures—particularly those which measure the quality of care for persons with chronic illnesses—have not yet been developed. At this point consumer information is neither sufficiently sophisticated nor sensitive enough to be a determining tool for discriminating among plans and providers.

The ultimate success of consumer information as a self-help means of quality assurance will depend substantially on the standardization of both data and benefits (definitions and packages). Consumers will not be able to make wise choices, either on the basis of benefits or plan performance, until they are able to make "apples-to-apples" comparisons.

5. Independent Oversight

While consumer information is an essential component in the overall quality assurance strategy, it is only one piece. External quality oversight, independent from provider and payer responsibilities at both the federal and state levels, must also be a central component of a comprehensive quality system. Such oversight includes: (1) monitoring to assure a basic level of quality and detect patterns and significant instances of poor care; (2) quality improvement activities to assist practitioners and plans in reaching quality levels achieved by the best performers; and (3) referrals to appropriate enforcement entities when action may be needed to protect consumers.

We recommend Federal establishment of state-based quality organizations, governed by independent Boards of Directors, one-half of whose members represent consumers. These quality organizations would be charged with ongoing quality monitoring of all plans within their jurisdiction and would be able to hold plans accountable for quality of care. They would provide technical assistance tailored to the specific needs of each plan, in order to improve quality. Quality organizations could also be structured to provide independent medical review of care denials during the grievance and appeals process, and to investigate consumer complaints regarding the quality of care.

The quality organizations would be obligated to refer appropriate information to state licensure boards and the federal inspector general for disciplinary action. In order to make enforcement more effective than it is today, the new system must ensure, through mandate and sufficient funding, timely and thorough investigations of reports of poor care, and the imposition of appropriate sanctions.

6. Outcomes Research and Practice Guidelines

The growing movement to expand medical effectiveness and outcomes research—in order to identify when services are beneficial and when they are not—holds great promise for improving quality and reducing the costs of medical care. The major "products" of this movement are clinical practice guidelines, which are systematically developed statements to guide practitioner and patient decisions about appropriate health care for specific clinical conditions. The Association supports cooperative efforts between public and private sectors to conduct research and develop these guidelines. However, as with consumer information, the state of the art places us a long way from the day when comprehensive judgments can be made based on outcomes data.

7. Quality Improvement

The Continuous Quality Improvement (CQI) model has gained increasing support as a major breakthrough towards better hospital quality assurance. CQI emphasizes ongoing improvement of provider performance through statistical analysis of problems and non-punitive feedback of information; its application is bound to prove very beneficial. However, pursuit of the benefits of CQI must not prevent interrupt-

ing performance where necessary to protect patients from harm, and the making of appropriate referrals for disciplinary action.

HEALTH CARE REFORM PROPOSALS AND QUALITY ASSURANCE

Many major health care reform proposals agree on several of the elements necessary for quality assurance. They all call for national quality standards and at least some level of national data collection and consumer and provider information. They also agree generally on the need for medical effectiveness research and practice guidelines development. The President' proposal is the most detailed in its requirements but both the Chafee and Breaux proposals cite Federal standards, research, plan and provider data collection, and information disclosure.

In the area of public accountability, only the President's plan comes close to meeting the principle of substantial consumer representation. Consumers are accorded one-half of all seats on alliance Boards of Directors. However, the President's plan does not carry this principle over to the other Boards and Commissions created in the bill.

In the area of due process, again the President's bill is the only one to specify a grievance and appeals system. This is a well-designed, important provision which substantially meets the needs of the individual to be heard fairly in the system. With some fine-tuning, this section should become a cornerstone of consumer protection in any proposal that is enacted. A related consideration is the operation of an ombudsman, which is referenced in several of the bills, but not fully developed.

A significant area of concern, which is not addressed in any of the above-mentioned proposals, is the need for external oversight. This is one of the key safeguards to assure quality. Market-based approaches relying on the consumer's ability to use information are no substitute for independent monitoring by a body of qualified professionals. Any final legislation that does not provide for independent monitoring and oversight of the health care system will place the patient in jeopardy, and puts public support for the program at risk.

CONCLUSION

AARP supports comprehensive health care reform and believes that reform is necessary in order to preserve and enhance our quality of care. However, with all of health care reform's promise for improving the well-being of Americans, the reform effort nonetheless does contain some double-edged swords concerning the critical issue of preserving and enhancing quality of care. In particular, by reversing the current incentives towards overservice, new health care delivery systems will require "checks and balances" to maintain a fair and humane competitive marketplace. Comparative information, medical effectiveness research, and internal quality improvement will be necessary but not sufficient elements of this system; of equally vital significance will be top-to-bottom public accountability, accessible grievance, appeals and due process mechanisms, and skilled professional oversight. With such an integrated package of safeguards, we will be well placed to meet the challenge of assuring and improving quality of care in health care reform.

COMMUNICATIONS

STATEMENT OF THE AMERICAN GROUP PRACTICE ASSOCIATION

The American Group Practice Association submits the following statement for submission in the record of the Senate Finance Committee hearing of March 1 regarding health care delivery systems. AGPA thanks the Committee for permitting us this opportunity to submit comments.

AGPA shares the desire of Congress and the President to reform the nation's health care system. We commend the President for his focus on universal coverage, quality care and cost containment. As this Committee and Congress consider the President's health reform bill and the other reform proposals, the challenge will be to balance carefully the powers of health alliances, insurance reforms, and the mechanisms of cost control, with the need to support and encourage effective delivery systems already emerging in the marketplace.

It is our conviction that group practice leaders of the future will be agents of change, directing facilities that deliver cost-efficient, high-quality care focused on wellness and prevention for large populations. Physician led—and I emphasize physician led—group practices are already leading a transformation in the marketplace.

Group practices are optimistic about their role in a reformed health care system, but they fear that some of their potential for innovations may be stifled. We urge Congress to look carefully at the mission, organizational structure and accomplishments of group practices and integrated delivery systems. Please recognize these systems have not been created overnight. Successful group practices are the result of planning and attention to mission, vision, and culture. Legislation that would *compel* (as versus to creating incentives) their creation, as well as a dramatic restructuring of the rest of the market, will certainly lead to massive business failures by new entrants to the market, who fail to appreciate the sophisticated governance mechanisms required to manage such groups.

Currently, more than 30 percent of all physicians practice in group practices. Modern group practices operate in rural, urban and suburban locations and have satellite clinics that serve large geographic areas and population groups, including locations categorized as under-served. We believe that in the future most practicing physicians will belong to group practices and integrated delivery systems. The growing trend is for smaller groups to unify into a larger multispecialty group, and for a group to integrate with other health care entities such as hospitals or insurers, with the goal of creating a delivery system that can offer a seamless flow of services, including acute care and tertiary care and in some cases, long-term care and home care.

With or without federal legislation, reforms are sweeping the states and the medical marketplace. Payers, especially those businesses that have combined to create purchasing coalitions are increasing their demands for efficient use of health care dollars because of the harsh effect of health care costs on their competitiveness. They want to buy care based on documented outcomes. They want consistent quality and processes across the system, and they don't want a health plan deal—they want a real partnership with their providers. In short, they want VALUE. Payers have also recognized one way to get value is to pay one organization for the complete spectrum of care—primary, acute, rehabilitative and nursing care—that their employees or enrollees need. A growing trend is for employers to directly contract with group practices for their employees' health care, working in a collaborative manner to deliver effective and high quality patient care.

Group practices and other integrated delivery systems have accepted the obligation to reduce costs and demonstrate verifiable improvements in the functional outcomes of the patients who utilize their services. Group practice initiatives are compelling other providers to meet the same high standards. In Michigan, General Motors asked Henry Ford Hospital in Detroit to provide health services at no increase

in cost for the next three years. In California, CalPERS asked providers to reduce charges by 5 percent in 1994. And in Minnesota, a coalition of businesses in the Twin Cities is driving providers to provide quality at lower costs.

Group practices have found that the best way to deliver cost effective, high quality care is to manage patient care within the organization. This requires the development of a practice culture that is motivated to maintain the health of the community. A group practice culture is based on teamwork—an interdisciplinary approach to patient care that focuses on improving the functional status, quality of life and the health of patients. The best measure of the success or failure of these providers is the quality of the clinical outcomes of the practice. We believe that health reform should facilitate the development of accountable health plans based upon this philosophy of health care delivery.

The group practice setting is ideal for large scale outcomes measurement and the application of continuous quality improvement because care tends to be delivered in a comprehensive manner to large and stable populations. Many AGPA members are involved in outcomes measurement and are using their findings to define best practices. The development of outcome studies and on-line databases for tracking clinical effectiveness have enabled group practices to utilize resources to improve quality and outcomes in targeted populations, enhance access, and cut costs by eliminating the procedures unlikely to benefit anyone. Continuous improvement methods strip out the steps in daily practices which do not add value, and help group practices improve the quality of care at a lower cost.

Group practices are capable of integrating the financing and delivery components of health care and then being held accountable for the care they provide by consumers informed with comparative cost and quality data. They function effectively in both fee for service and capitated payment structures. Therefore, they are strategically positioned to adapt to the changes called for under reforms contemplated by the President and the transitions expected in the years to come.

In the current markets that are dominated by fee-for-service systems, group practices provide care more efficiently and effectively than non-affiliated providers because they eliminate redundancies in care. Because their services are comprehensive, they are also capable of delivering a complete range of services for a fixed, capitated payment. Many participate in managed care programs under capitated payment structures which shift the financial risk of health care delivery to the physician group where patient care is delivered by an interdisciplinary team offers many advantages. Within this framework, physicians can direct resources more appropriately, streamline paperwork, and focus on population-based health outcome improvement. The incentives which group practices respond to in a capitated environment emphasize comprehensive, longitudinal, patient-oriented care. In this environment, the incentives of insurers, providers, and patients are aligned such that everyone benefits by keeping patients healthy or, once sick, by making them well as quickly as possible.

While delivery system reform is necessary, we do not believe that Congress can succeed if these changes are brought about rapidly. Noted economist and Physician Payment Review Commissioner Uwe Reinhardt recently testified to the Ways and Means Committee that many of the reforms proposed as managed competition would lead to the collapse of the fee-for-service system. Already, market reforms on their own have significantly changed the way health care is provided in many communities and, as recently documented by the U.S. Labor Department, health care costs have begun to moderate. Most importantly, we urge Congress not to impede the successful market based reforms that many communities have already undertaken. The mechanisms created by health reform should support and promote the continuation of active involvement by the private sector by allowing participants to reap rewards for innovations and improvement associated with lower costs and high quality.

HEALTH REFORM

A desire for high quality care, coupled with the absence of incentives to contain costs, has produced vast technological breakthroughs, but has also resulted in a level of cost escalation that is unsustainable. This is aggravated by a climate in which the public expects immediate access to the latest technology and therapy, and then anticipates near perfect outcomes no matter how perilous the clinical situation. The growth in health care expenditures has contributed to vast numbers of young, unemployed, and underemployed people not participating in our health system.

AGPA believes that Congress must establish a sound public/private sector health care system. We commend Senators Dole, Chafee, Breaux and Durenberger for their efforts to preserve a market based orientation in their health reform plans. Provid-

ers, insurers, and purchasers need to move from providing care on a case-by-case basis to physician-directed health plans and integrated delivery systems. The current health care crisis is as much a problem of fragmented health care delivery as it is a problem of insurance coverage. To foster the development of integrated delivery systems, barriers to integration must be eliminated. Additionally, before the United States can create a national system with universal access, the disincentives to appropriate care in the current system must be corrected.

Arnold Relman, M.D. recently stated: "No new system can succeed unless it encourages doctors to function as trustworthy advocates for their patients, uninfluenced by the economic interests of the owners of the plans while still responsive to legitimate cost concerns." The group practice model is an organizational structure that fosters the development of such patient centered health plans. Any reform plan that features Accountable Health Plans must insure that the focus of health plans remains on the needs of patients.

Based on the experiences of many of our members, AGPA can cite some of the essential elements of a physician-led accountable health plan:

- **A health plan must be able to manage total costs, rather than maximize the revenues and profits of each part of the system.**

To accomplish this a health plan must encourage give and take among the departments and organizations in the system. Resources must be rationally planned to drive right sizing and reconfiguration of physicians and technologies. Productivity must be redefined from dollars booked per physician to total population which receives excellent care per physician, regardless of dollars booked. Finally, the aim of the health plan must change from *all the care that's in the best interest of our patients, to all and only the care that's in the best interest of our community of patients.*

- **Focus on a population, not just on individual patients.**

To accomplish this the health plan must ask "Why does this community have a health system?" The health plan must face tough resource allocation questions, such as non-ionic contrast versus mammography. Delivery processes must change radically from a ratio of one physician per patient (1:1) in offices to 1:100's in communities. Last, the health plan must work to change the public mindset about health care to address the tension between "Health care costs too much and doctors should do something about it," and "Don't skimp on me!"

- **Become customer-centered, process focused, data driven and innovative.**

We believe that organizations become what they measure. This will require health plans to learn and apply continuous improvement theory and methods, not to just pay lip service to CQI as a marketing tool. Health plans must also become process and system literate, rather than loosely organized as a series of department and revenue centers. Measurement and data skills in daily work are also essential, and should not just be the job of the statistics and research personnel.

Health plans should be held publicly responsible for the costs and effectiveness of their medical services and for levels of patient satisfaction. Health plans should be required to provide an array of "uniform effective health benefits." AGPA believes that by law, the standardized benefit package should have a co-payment for all services except specified preventive services. The personal out-of-pocket payments should be subject to an annual maximum amount. Financial incentives to improve lifestyle should be incorporated into the benefit package and its pricing.

The services included in the basic health benefit package should be chosen based on scientific evidence of treatment effectiveness, societal values regarding appropriateness, and on an analyses of relative costs and net benefits. Current research by the Agency for Health Care Policy and Research, and organizations such as AGPA, will facilitate the design of an appropriate benefit package.

Health Reform Issues for Group Practices and Integrated Delivery Systems

With the needs of our patients as the priority, AGPA has closely reviewed President Clinton's "Health Security Act," the Breaux/Durenberger, "Managed Competition Act," the Chafee/Dole, "HEART" bill, and the single payor options. AGPA has targeted several issues in these proposals which are key to assuring high quality, cost effective patient care:

- *Quality: Accountability in Medicine*
- *Role of Health Alliances*
- *Fostering Innovation and Competition*
- *Graduate Medical Education*

Quality: Accountability in Medicine

To our patients, quality care includes factors such as quality of life and a patient's perception of their health status. To group practices, quality health care is not a privilege for patients, but rather is a an obligation to every patient. As we have demonstrated in our own quality programs, interaction and communication between physicians, health care personnel and researchers is beneficial to the systematic collection and sharing of quality data. Through the proper collection and use of such data physicians can continuously improve the quality of care that they deliver to their patients.

The search for high value practices has lead group practices to participate in the collection, pooling and use of objective data regarding the impact of medical treatments on the function and well-being of patients. Such information can be used to promote informed decision-making by patients and physicians. The information can also be used to compare outcomes of different institutions and physicians using different treatment approaches for similar patients in an effort to identify optimal practices as well as discover opportunities for improvement.

The essence of this work is to achieve high quality outcomes while using fewer services per patient episode. The organizational structure of a group practice creates a framework for promoting simultaneous improvements in quality and efficiency. The group practice structure provides a vantage point which permits physicians to see the impact of resource allocation on the health of the whole population of patients under the groups' care. This population orientation leads group practices to emphasize cost-effectiveness and efficiency issues in order to identify practices that represent a good value to the population.

Today, AGPA's effort includes 50 medical groups and seven health conditions: total hip replacement, total knee replacement, cataract surgery, diabetes, adult asthma, low back pain, and hypertension. Along with its distinguished member medical groups, AGPA has gone beyond testing the feasibility of a patient-centered outcomes approach to designing models for integrating outcomes information with practice improvement.

Medical groups recognize that they have the tools needed to revolutionize the delivery of medical care. It is possible to control the cost of health care only if providers know which interventions produce effective clinical outcomes at what cost. We must be able to understand the value of the health care we are delivering. Information on the outcomes of care (functional status, well-being, clinical outcomes, satisfaction, and cost) will make possible the difficult task of lowering costs while preserving quality. Medical groups that have a scientific basis for managing care will have a competitive advantage.

Another reason behind the enthusiasm for outcomes measurement is the distinct difference between measuring the results of care and tracking the performance of a particular physician or health care system. It is important to know such information as how many immunizations, mammograms and flu shots are delivered to a certain population and to know whether patients have timely access to the physician they want to see. All of the efforts, such as HEDIS, NCQA accreditation, and report cards, will give consumers and purchasers information with which to make educated decisions about where to purchase health care.

However, these efforts will *not* assure quality care for all Americans at a reasonable cost. Taken out of context, or left to stand on their own, these "performance indicators" may perpetuate inefficiency and waste. Without ongoing outcomes measurement we may find ourselves with a health system that provides a set of minimum benefits to all Americans and never know the effectiveness of the services delivered. Outcomes measurement that drives continuous improvement assures that providers render care in the best interest of their patients.

The AGPA urges Congress to take steps to further develop clinical information systems to improve medical decision-making, compel insurer and provider organizations to be accountable and effective, and to develop a competitive market structure that rewards insurers and providers for balancing medical care costs, quality, and patient satisfaction. AGPA supports additional funding for research in the outcomes sciences.

Role of Health Alliances

Health alliances and purchasing cooperatives are organizations that would act on behalf of purchasers to rate and offer certified health plans. Reform proposals differ as to whether the alliances would compete, be voluntary or mandatory, who they would be open to, the nature of their buying responsibilities, their regulatory authority, and the kind of certified health plans they can offer. The basic policy objective in all the plans is to facilitate pooled purchasing, minimize administrative over-

head, maximize choice of health plans to purchasers, and provide evaluative information on the quality of plans to buyers.

In the President's plan, the authority delegated to alliances will interfere with successful group practice strategies to reduce costs and demonstrate verifiable improvements in the functional outcomes of the patients who utilize their services. Group practices are confident that they will prosper in a basic health plan/health alliance structure, but would prefer for alliances to operate more simply as buying cooperatives with limited regulatory powers. Some of our concerns with the health alliances are:

Quality assurance: AGPA believes that health reform should foster a system of enhanced accountability for the quality of health care provided through the coordination of public and private sector efforts to evaluate and enhance quality. AGPA is concerned that the health alliances and the National Health Board in the president's plan may preempt or stifle the work on outcomes measurement already underway by many group practices. Outcomes data collection provides valuable insights into the efficacy of specific situations of care, but cannot be directly extrapolated to a large universe of care or other clinical situations. Because the information is site specific, we have strong reservations about government utilization of this data outside of the clinical situation. Just as HCFA hospital mortality data led to years of expensive data collection without a justifiable clinical basis, our information could be similarly misused, and consequently lead processes of care in the wrong direction.

It is vital to group practices that quality control be physician driven with a focus on improving functional outcomes. The government's role should be limited to taking steps which promote the establishment of a competitive market based on good information about costs and quality.

Border issues: Recently, the GAO reported to the Senate Finance several problems that may arise from the creation of alliances, including potential "gerrymandering" of boundaries, the definition of MSAs, the intermingling of politics, the ability of patients to get care outside their alliance or for providers to provide services to patients outside their alliance, the ability to coordinate regulatory requirements across alliances and states, the potential concentration of higher-risk populations and the redistribution of health care costs. Since many group practices are large networks spread over large geographic areas or are nationwide or regional referral centers for specialty care, they are concerned about the impact that alliances may have on their ability to effectively function.

Group practices need the option to participate in more than one plan and in more than one alliance, especially across state lines. AGPA is also concerned about the effect of strict health care budgets. We are not confident at this time that there is sufficient data to measure health care expenditures in regional health alliances accurately. Also, state budgets, with state enforcement powers, may create protectionist policies on the part of states to keep the allotted budget at home. AGPA believes that assurances must be made that neither health alliances or plans can restrict access to health care services across state boundaries, and that the plans will be able to function effectively in as many health alliances as they choose.

Point of Service (POS) Requirements: AGPA is concerned about the development of a point-of-service requirement for health plans. For many group practices, especially those that are high level tertiary care centers, it is crucial that patients have the freedom to go out of network. However, for other groups, especially those that are capitated, the requirement that health plans must offer a POS option may create problems in controlling costs and quality. In addition, under current tax law, nonprofit group and staff model HMOs can keep their tax-exempt status only if out of network use of services is "insignificant."

Today, the market is driving more health plans to offer POS options, and where it is determined to be manageable, health plans are offering such a product. Setting up POS options requires investment of time and capital. They must be carefully crafted to respond to the needs of local markets and of local providers. For such an option to work, health plans must be able to utilize mechanisms such as coinsurance and deductibles to manage the extra costs that may be incurred by patients going out of network. To control quality and costs, some health plans currently require plan members to use in-network providers for prescription drugs, well-baby care and prenatal care.

We therefore recommend that a POS option be voluntary and not a mandatory provision. If health care reform truly facilitates the development of a competitive health care delivery marketplace, then the point-of-service option will be provided because that will be what the market demands. A major part of making the marketplace work is to require that alliances accept all certified health plans.

Risk Adjustment: The ability of health alliances to make accurate and timely risk adjustments in premium payments to health plans is crucial to the viability of cost effective, high quality providers. The accuracy of risk adjustment takes on more significance in the context of global budgets because of the squeeze on resources that could take place for those providers who care for high risk populations. The Clinton plan calls for the National Health Board to develop a mechanism that takes into account the demographic characteristics, health status, geographic residence, socio-economic status and the proportion of cash-assistance recipients enrolled by a plan. Unfortunately, no current model of risk adjustment exists that takes into account all the risk factors of a regional patient population.

It is a risky venture to have an element of a comprehensive health reform plan depend on a mechanism that does not currently exist. If risk adjustments are not implemented correctly there are cushions, such as the health alliance borrowing money or the president requesting a change in the budget level. However, it is not comforting that providers in high risk areas must rely on supplemental appropriations to cover the full costs of care for patients, or for citizens in high risk areas to be required to repay loans given to the health alliance. These provisions have serious implications for the cost containment goals that are such an important part of the president's plan. Serious consideration should be given to reinsurance mechanisms to protect providers and consumers until we are confidant that adequate risk adjustment mechanisms are in place.

Graduate Medical Education

The functional requirements of health plans will lead to decreased requirements for specialty physicians, and perhaps even decreased requirements for primary physicians. Health reform will also cause us to focus more on the numbers of "other care providers" that are utilized.

AGPA commends the President for the recognition he gives to medical education in his health plan. His plan preserves a strong role for academic health centers and begins the development of a national system for directing medical education. We support the emphasis on primary care, but are not comfortable with some of the prescriptive elements of the bill. AGPA believes that the market place should drive the supply and demand of physicians and that freedom of choice for those pursuing medical training should be preserved.

Medical education reform proposals fail to adequately engage the health care delivery system in workforce planning and training. Fundamental changes in the reform proposals will be required to reach the goals of increasing the supply of primary care providers, and improving the ratio of generalists to specialist physicians graduating from U.S. medical education programs.

We recommend a strong role for integrated health systems in the training of practicing physicians in the principles of managed care, as well as for training physicians in the principles of Continuous Quality Improvement utilizing practice guidelines, outcomes measurement and other improvements. Integrated health systems will also be important structures in retraining physicians for needed medical services.

The deficiencies of the existing academic program model for effective workforce planning are particularly evident when planning for future workforce needs including nurses and other primary care providers (as is envisioned under the Clinton bill). Primary care needs under health reform and demands for cost effectiveness mean that some of the primary care needs will be filled by people who are not trained as physicians but who can do the job within the context of an integrated health system as part of a team led by physicians.

An effective training program model would place purchasers and the integrated health systems (as customers) in a position to project comprehensive workforce needs and help manage supply. The new model should allow integrated health systems that provide training to apply to the federal board for training slots that not only fulfill their physician and other provider training missions, but also bear a relationship to their own projected workforce needs.

A new program model should permit integrated systems that do training to have independent standing with the universities regarding allocation of training slots and funding. Funding should be made available for training in ambulatory settings.

From our own experiences the marketplace is already working. Integrated systems which are focused on providing care to given populations have already begun to restructure their medical staffs at the lowest specialty to primary care ratios practicable. As health systems became cost centers, instead of revenue centers, the market for excess specialty services dried up. Health System Minnesota is currently at 50 percent primary care providers and is no longer recruiting specialists. Another large system with 2500 specialists under contract has reduced its specialists to 1500

and they will further reduce this to 1000 by 1995. At this level they will have 50 percent primary care physicians, and 50 percent specialists.

Many AGPA member group practices have as a part of their structure both hospital and clinic services. What these groups have to offer are unique training settings where a resident can experience learning in both ambulatory and hospital settings. We would suggest that much of the debate concerning graduate medical training has been too limited to the consideration of medical schools and hospitals. Recent data reveals that 56 percent of the nation's residents train in non-university settings. We consider it vital to point out to the Committee that currently many group practices which do not have their own graduate medical education programs are involved in the GME program of an affiliated hospital, and often provide the training in the ambulatory setting for those residencies.

Other well known group practices offer GME programs not affiliated with a university program. We urge Congress to recognize the important role played by non-university GME programs located in group practices. Techniques should not be adopted for allocating resources that might bypass these centers of excellence in an attempt to optimize outputs. AGPA also supports the need to increase the emphasis on training in ambulatory care settings.

The American Group Practice Association endorses medical education reform legislation that will:

1. Create an independent federal commission, composed of both private sector and government representatives, broadly based, to establish goals and provide oversight for training and future health care workforce needs.
2. Create a broadly-based advisory committee, similar to PPRC and PROPAC, to oversee implementation of the national medical education goals.
3. Using input from existing formal accrediting bodies, provide for federal administration of limits on the total number of physicians and type of physicians trained, including funding.
4. Assure financing is adequate to support both training and its attendant costs. All payors should contribute their "fair share" to the costs of training.
5. Provide that entities eligible for payment for training will be broadened beyond hospitals. As financing moves to additional entities, a separate fund should be established to provide transition relief to academic health centers and support continuation of their academic missions.
6. Place primary responsibility for workforce planning with the health care delivery system and purchasers.
7. Provide recognition for workforce training by integrated health systems which addresses their patient care needs, as well as their training and research missions.
8. Encourage integrated health systems to participate in managed care and continuous quality improvement training for currently practicing physicians, and assure retraining of physicians.
9. Assure that training supports the changing practice of medicine.
10. Provide increased incentives to encourage physicians to choose the generalist field of practice, including tuition forgiveness and higher incomes for generalists.

Cost Containment

AGPA prefers a market-based system for cost containment, wherein all the participants can respond to market incentives to continuously improve standards of care in a cost-effective manner. Group practices do not support a federal all-payor rate setting system or global budgets. We view such proposals as inconsistent with the concept of managing patient care, especially if such a budgetary cap leads to wage and price controls. Strict budget controls implemented and enforced away from the clinical setting could severely distort incentives and possibly weaken the quality of care delivered.

We must focus on the goals of cost containment, access and quality simultaneously—a balancing act that brings into play several dynamic forces. On a smaller scale, group practices, employers and managed care organizations are conducting this balancing act and are producing favorable results. They have created innovative delivery systems utilizing available resources and responding to local market forces.

A system with government enforced budget constraints means the government must have an accurate measure of the resources that are necessary to accomplish the goal of universal access and quality from both a national and a local perspective. For example, sufficient resources must be available for achieving technological advancements, creating new infrastructure and managing traumatic medical events. If resources do not meet the demands placed on providers, the country will fall short of the president's goal of universal coverage, and quality of care may be sacrificed. Cost containment is an absolute, but it must be a dynamic process that takes into consideration all the forces of health care delivery.

Managed care has been successful in achieving cost containment in isolated circumstances but has yet to cause significant cost savings on a national scale. A major reason for this is that market competition has not been truly allowed to work. The practices of purchasers, the tax laws, and other market imperfections have led to "cost-unconscious" demand. The result is that the demand for managed care becomes price-inelastic. To make purchasers more cost-conscious, employer and government sponsors must convert to defined-contribution health benefit programs; tax-free employer contributions must be limited; benefit coverage within sponsored groups must be standardized; and premiums must be risk-adjusted.

We have evidence from group practices of the success that is achieved through the proper managing of patient care. Mayo Clinic's growth in spending per capita did not exceed GDP growth from 1988-92. At Henry Ford Health System's HMO, the capitation which physicians in the Henry Ford Medical Group receive, to cover all professional services, inpatient care, ambulatory care and covered ancillary services has grown at an average rate of 7.15% between 1985 and 1993. This compares to an 9.95% annual growth rate in per capita national expenditures for comparable services. Henry Ford also has evidence that once efficient practice patterns are developed, there are verifiable carry-over cost benefits to fee-for-service populations served by the same physicians. For example, for services provided to the Medicare patient population, the annual increase in the average Medicare payment to Henry Ford Medical Group averages 4.5% since 1988, compared to a national average of 7.9% annual growth in Medicare costs.

There is evidence from various markets around the country that the transition from fee for service dominated markets to capitation dominated markets can occur quickly and with dramatic cost containment results. For example, in Los Angeles the top seven accountable health plans provide comparable care for annual premium amounts that range from $1200 per person per year to $1428. The premiums for similar plans in less competitive markets range from $1500 per year to $3500 per year. The savings that could result from competition in these localities could exceed $200 million per 100,000 people.

BARRIERS TO INTEGRATION

As described earlier, group practices face many barriers on the federal, state and local level to the successful integration of health care services. In order for Accountable Health Plans to be successfully created the following barriers must be broken down:

Antitrust, Fraud and Abuse Laws: In order to organize systems that can comprehensively meet the needs of a population of patients, group practices need clear guidance and flexibility for assembling the necessary elements. Recently published antitrust guidelines are helpful, but they give little guidance for the creation of vertically integrated networks. Strong laws regarding physician ownership and self-referral are needed. The current exceptions in the law are helpful, but continued diligence is necessary to insure that any new laws or regulations do not impair the innovative efforts of group practices. HHS and the IRS also need to carefully apply tax laws for acquisitions so as not to deter efforts at increasing access and improving quality.

Deferred Compensation: OBRA '93 limited the compensation which can be taken into account under a qualified retirement plan. The pension cap was reduced to $150,000 from its current level of $235,840. This change limits the ability of tax exempt group practices to recruit physicians because they do not have the same opportunities for deferred compensation under the tax laws as do for-profit entities. It also stifles the collaborative efforts between physician groups and hospitals because physician groups that might otherwise integrate with not-for-profit hospitals will be required to give up significant retirement benefits to which they may be entitled.

Health care institutions organized as not-for-profit corporations have long been the principle providers of health care services and leaders in the development of new techniques to prevent and treat serious illness. Many are pioneers in cost-effective capitation models and serve inner-city low income populations where physicians share costs for uncompensated care. If not-for-profit institutions and integrated delivery systems are to be fostered, tax laws for deferred compensation must be applied equitably for not-for-profits and for-profit organizations; otherwise for-profit organizations will have a distinct advantage in the health care market.

Tax-exempt status: Many group practices rely on tax exempt financing to support the replacement of capital and the development of new programs and services. These groups have invested in the welfare of their communities through public/private partnerships aimed at expanding access to underserved populations and con-

ducting educational and research programs to improve medical care and innovate medical science. If universal access is achieved in a reformed health care system, group practices have concerns about the criteria that will be used to establish tax-exempt status. To illustrate, we are concerned that the interpretations of "community benefit" may change so that fewer providers are able to achieve tax exemption. This result could significantly impair the development of competitive delivery systems not only because fewer groups may qualify for such status, but because those who still do qualify may encounter a capital market disrupted by changes in the marketplace.

Anti-managed care laws: An important aspect for the creation of integrated delivery systems, especially where the system includes managed care products, are the federal and state laws that regulate the operation of managed care entities. Any-willing-provider laws limit provider selectivity and the ability of a organization to use mechanisms to encourage the use of the cost-conscious, quality driven provider networks. Multiple, and oftentimes redundant quality assurance reviews from the federal and state level are costly and inefficient. Furthermore, state requirements that HMOs offer indemnity products do not recognize the difficulty of establishing such products nor that it is unnecessary for all HMOs to offer all products.

CONCLUSION: GROUP PRACTICE, THE CORNERSTONE FOR REFORM

Recently, Phil Lee, M.D., Assistant Secretary for Health and Human Services, stated that group practices were the "single most important innovation" in American health care delivery. Medical group practices have the characteristics necessary to be the cornerstones of high quality, cost-effective accountable health plans. They are physician-led organizations whose main priority is patient care and clinical management.

Group practice physicians are accustomed to directing health care utilization and then being held accountable by patients, colleagues and payers for quality and costs. To facilitate the development of physician led Accountable Health Plans, barriers to integration must be eliminated and the powers of alliances and the mechanisms of cost control must be carefully balanced with the private sector reform initiatives already underway.

Thank you for this opportunity to submit written comments. We stand ready with the resources of the Association to support your efforts to improve the nation's health care system.

STATEMENT OF THE AMERICAN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGEONS, INC.

HEALTH DELIVERY SYSTEMS

The American Society of Plastic and Reconstructive Surgeons (ASPRS) represents the nearly 5,000 (97%) board certified plastic surgeons in the United States. Plastic surgeons provide highly skilled surgical services which improve both the functional capacity and quality of life of our patients. These services include the treatment of congenital deformities, burn injuries, traumatic injuries, and cancer.

The following are statements by ASPRS on various issues included in reforming our nation's health care system. Our primary and overriding concern is that all citizens secure access to appropriate services and that plastic surgeons retain the right to provide those services with a minimal amount of regulatory or statutory restrictions.

ASPRS believes that all individuals in this country must have access to basic levels of health care services. These services must be available in a timely manner and by an appropriately trained physician. Gatekeeper systems should not be allowed to unduly obstruct access to specialized care.

The United States health care system currently provides prompt and direct access to medical and surgical specialists for the vast majority of the population. Health care reform may place limits on this access and patient freedom of choice. While some limits or controls may be appropriate, others are not.

Health care reform legislation should not set barriers or impediments to appropriate specialized medical services. The physician who serves as the patient's first point of contact should be encouraged to make all needed medical referrals and should not feel constrained financially from doing the best job for the patient. Patients should be able to opt out of any closed system to seek the specialist of choice. The financial penalties that accrue to such an opt out, or "point of service" should be capped. This is the ultimate consumer protection against poorly managed care plans.

Direct access to specialty care is essential for patients in emergency and non-emergency situations and for patients with chronic and temporary conditions, as well as those with unexpected acute care episodes. Specialty care must be available for the full duration of the occurrence and not be limited by time or frequency of visits.

Specialization, specialized training, and specialized care have produced the great leaps that have taken place in medicine and have resulted in the development of life-saving and life-inhancing procedures.

Health care reform legislation should encourage appropriate utilization of medical and surgical specialists by assuring that the following elements are incorporated in the bill:

- Financial incentives should not interfere with medical judgment. For instance, health plans should be prohibited from establishing arrangements in which the gatekeeper has a financial incentive not to refer patients. If laws can be passed to limit physician self-referral because of concern about over-utilization, then laws can be enacted to protect patients from under-referral for financial gain.
- Point of service options should be mandatory for all plans with limitations on out-of-pocket expenses.to patients. A point of service option that is financially prohibitive is not an option.
- All health plans must establish arrangements to provide the full range of specialized care for enrollees with rare, unusual or highly complex conditions, and should provide all specialty services not generally regarded as experimental.
- Medical and surgical specialty societies should be responsible for the development of guidelines on the appropriateness of referrals.
- All health plans should be evaluated in a consumer "report card" in part on the basis of the timeliness of access to specialty care and the quality of that care as established through the credentials of the physicians and the outcomes of their treatments.

Every American should have access to a universal set of benefits. Within the scope of plastic surgery, those benefits include all reconstructive procedures and exclude all cosmetic procedures as defined by ASPRS and AMA. Guidelines, practice parameters and indicators, as developed with input from specialty societies, should be used when there are questions about specific procedures.

Plastic surgeons, as a result of providing burn and traumatic injury care, understand that access to trauma care needs special consideration. Access to an appropriate regional trauma center should not be denied under any circumstances for economic reasons.

Even without legislative mandates, the health care delivery system is undergoing sweeping changes. In order for these changes to continue in an orderly and equitable fashion, physicians need the ability to have an equal voice in negotiation and the creation of new delivery systems.

Currently, physicians are faced with restrictive antitrust laws and the threat of criminal prosecution if they begin to discuss issues necessary to the creation of new and innovative delivery systems. Legislation must be passed to change this.

Physicians need the following:

- Legislation and regulatory relief which allows physicians to form health care delivery networks and health plans without unnecessary and burdensome interference.
- Legislation to ensure that physicians are not impeded from networking with others of the specialty by restricting their participation through an unduly low safe harbor floor. The current safe harbor of 20% is much too low. Such changes are needed to allow specialties with relatively small numbers, such as plastic surgery, to become involved in this process.
- Legislation to direct non-physician sponsored health plans to create committees of practicing physicians in the plan, similar to a hospital medical staff, to provide input about medical policy, utilization, credentialing, reimbursement, and management issues.

Legislation introduced by Senator Hatch (S. 1658) and Representative Archer (H.R. 3486) is an important first step in providing appropriate relief for physicians.

Access to care from appropriately trained specialists is critical to maintaining the quality health care to which Americans are accustomed. The positions discussed above are essential toward maintaining the highest quality care.

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