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

2 DR. HYMAN: I'm David Hyman, special counsel here

3 at the Federal Trade Commission. Let me welcome you all to

4 the reconvening of the Hearings on Health Care and

5 Competition Law and Policy jointly sponsored by the Federal

6 Trade Commission and the Department of Justice.

7 This is the latest in a series of hearings that

8 started in February and are going to last through September,

9 perhaps October, unless I can make it September, and

10 represent an ongoing investigation of the performance of

11 differing parts of the health care market with regard to the

12 cost of the services that are provided, the quality of those

13 services, and the extent to which ordinary Americans can

14 access information about those services and obtain those

15 services at a time and in a fashion that is desirable to

16 them.

17 This morning we have a very distinguished panel and

18 extensive bios for each of the speakers, not all of whom,

19 unfortunately, are here just yet, and are published in this

20 beautiful book that's available outside. Our rule is,

21 accordingly, short introductions because you can read about

22 the people in the book.

23 The format we're going to follow this morning is

24 our first speaker, Newt Gingrich, is going to make somewhat

25 extended remarks. And then there will be a panel discussion

1 Health Transformation, which advocates for market-oriented
2 health care.
3 And just two other preliminary announcements. If
4 everyone can turn off their cell phones. The Speaker likes
5 nothing better than being interrupted by the sound of your
6 cell phone. And second, time will be kept by Cecile Kohrs
7 over at the table there. So if the speakers can just keep an
8 eye out for that, it will ensure that we'll have adequate
9 time for discussion.
10 Newt, you can either sit or stand at your option.
11 MR. GINGRICH: If it's okay, I'll just sit, if
12 that's all right. And I'll try to go through this pretty
13 rapidly as an outline.
14 But first of all, Dave, let me thank you and the
15 Federal Trade Commission and the Department of Justice
16 Antitrust Division for hosting us today. I think trying to
17 think about impediments to competition in health is a very,
18 very important topic, first because of the rising cost of
19 health care, second because the scientific and technological
20 breakthroughs are likely to increase the cost of health care,
21 and third, because the aging of the baby boomers guarantees
22 that the sheer volume of health care over the next decade of
23 15 years is going to continue to go up.
24 If you look at the current crisis in Europe and
25 Japan, one of my mentors, Steve Hanser, just spent a month in

1 Europe. I called him when he got back. I said, "What did
2 you learn?" He said, "Well, I was in four countries and
3 there were four issues: pensions, pensions, pensions, and
4 pensions," he said, "with the cost of health care and
5 unemployment being a distant second and third."
6 And I think if we don't in the next few years bring
7 to bear a much different approach to how we have a
8 competitive health system, that in fact we will rapidly move
9 towards some kind of bureaucratic redistributionist and, I
10 think, mediocre system.
11 So what you're focusing on is exactly at the cusp
12 of either finding really dramatic solutions or getting in
13 trouble. As you mentioned, we just finished a book called
14 "Saving Lives and Saving Money," and we just opened up a
15 website called the Center for Health Transformation, which is
16 at HealthTransformation.net, or you can go to just my first
17 name, Newt.org. But in "Saving Lives and Saving Money," we
18 outline a model for transforming the health system.
19 Let me start by making an argument that I think
20 gives the Federal Trade Commission a particularly important
21 role in the next ten or fifteen years. It should be the
22 natural product of a scientific, technological,
23 entrepreneurial, free market system to produce more choices
24 of better quality at lower cost.
25 And I'm going to repeat this because I think in

1 both health and education you see a tremendous impediment of
2 government blocking what should be a natural pattern. The
3 natural pattern should be more choices of better quality at
4 lower cost.
5 And in a sense, Wal-Mart is, for the 21st century,
6 what Alfred Sloan and General Motors were for the 20th
7 century, in the sense that Sloan's investigation of consumer-
8 led mass production defined management for most of the 20th
9 century.
10 Wal-Mart's model, that lower everyday price is a
11 function of lower everyday cost, and that they see themselves
12 as the largest and most efficient market makers in the world,
13 is something really worthy of study.
14 And any institution that gets 100 million Americans
15 to voluntarily show up every week is worth looking at and
16 saying, what is it they're doing right? I mean, without
17 arguing about other aspects of Wal-Mart, it seems to me that
18 they are an institution worthy of study.
19 What we're suggesting is that lowest everyday price
20 being a function of lowest everyday cost should apply to
21 health and health care, and that producing more choices of
22 higher quality at lower cost should apply to health and
23 health care, and that to the degree it doesn't, it is largely
24 a function of the mis-design of the current system.
25 Now, there are three areas where you see real proof

1 Now, our argument, both in "Saving Lives and Saving
2 Money" and at the Center for Health Transformation, is that
3 you can't succeed in reforming the current system, that the
4 current system is inherently, by design, mal-designed so that
5 a third party payment model is inherently conflict-ridden
6 because you have the person receiving goods not responsible,
7 the person paying goods confused about who they're
8 responsible to, and the person who's paying the money
9 irritated with both the provider and the patient.
10 In addition, we suggest that you want an
11 individually-centered system, not a patient-centered system,
12 because you want to use early diagnosis. You want to use
13 nutrition, attitude, and activity to extend individual
14 healthy behaviors. So we always talk about health and health
15 care. We don't start by talking about health care.
16 Interestingly, Dr. Zerhouni, the head of NIH,
17 believes that if you had a system that was refocused on
maximizing health and delngly, Dr. 5 0 in Health care.

1 independently from his perception of building expert systems
2 at Vanderbilt University believes you could also get about 40
3 percent out of the system.
4 So what we're describing is a transformation that
5 could literally be worth, if you're an optimist, 5 percent of
6 the entire economy. If you think that's too high, it could
7 be worth 3 or 4 percent, which is still fairly big money.
8 We think there are four drivers of this change that
9 the FTC ought to look at. The first is patient safety and
10 patient outcome. And the reason I start with that is health
11 is inherently moral. We called our book "Saving Lives and
12 Saving Money" in that order because saving lives is the moral
13 cause and saving money is the practical cause.
14 If you start with patient safety and patient
15 outcome -- and I used to serve as the ranking Republican on
16 the Aviation Subcommittee; this was in a distant past when we
17 were in the minority -- and I represent the Atlanta Airport.
18 We value life in commercial aviation by several orders of
19 magnitude more than we value life in the health system.
20 So when the Institute of Medicine reports that we
21 lose at least one New York to Washington shuttle a day to
22 medical error in hospitals, the country says, yes, hospitals
23 are dangerous, and we go on to the next topic. If we lose a
24 shuttle, the National Transportation Safety Board, the
25 Federal Aviation Administration, the airlines, the

1 manufacturer, all collaborate in a stunningly intense effort
2 to change the system, and when they learn what needs to be
3 changed, they retrain the pilot, the manufacturer, or the
4 maintenance people within 48 hours.
5 By contrast, the Institute of Medicine reports it
6 can take up to 17 years for a doctor to learn a new best
7 practice, and over 80 percent of doctors do not practice best
8 outcome medicine. Now, that's unacceptable in civil
9 aviation, and I simply tell every audience we should value
10 you as much in the health system as we value you in aviation
11 and you'll get to a dramatically better system.
12 The second driver should be information technology,
13 computing, and communications. The amount of information we
14 could get is stunning. I just talked with Dr. Korpman at
15 Health Trio, who runs an information system. One of their
16 major clients is Brigham & Women's.
17 As soon as they went to electronic information,
18 they reduced the number of call-backs each month by 30,000
19 phone calls a month to verify prescriptions. At $6 a call,

1 medical record in the U.S. that was sustained for around
2 $29 million a month.
3 Now, that is an absurdity not to have that. And
4 you go down the list of things IT, information technology,
5 should bring you, almost all of which are inhibited by the
6 current structure of the health system, legal structure,
7 cultural structure, and incentive structure.
8 The third thing we focus on is quality, a system
9 and culture of quality in the sense of Deming and Juran. And
10 again, if you look at manufacturing in the last 80 years,
11 essentially all of it is coming out of the Western
12 Electric/Hawthorne experiment and the rise of systems
13 analysis at AT&T's manufacturing system in the 20s, which
14 Deming actually was part of. And then you look at Deming
15 teaching 75 percent of Japanese industrial capital in 1951 in
16 a four-day course which led to the Japanese creating the
17 Deming prize for the best-run company in Japan.
18 We have had stunning explosions of productivity and
19 quality in manufacturing because we recognize it is a system
20 and we recognize you need a culture of quality. None of that
21 has happened in health. And it is -- despite the best
22 efforts of a number of people, it has simply not penetrated
23 again because the distribution of power in the health system
24 has allowed people to simply say no and walk off.
25 The fourth thing we focus on is the notion that you

1 have to re-center the health system on the individual. The
2 individual has to have the knowledge. They have to have
3 access to clear information. They have to have real power in
4 order to make real choices.
5 And they have to be held accountable. You need an
6 incentive system which says, you know, if you're diabetic and
7 you don't manage your diabetes, you have a responsibility.
8 This is not just a magic system where you can do nothing,
9 live badly, and then demand that the doctor fix you.
10 And I say this having helped author the welfare
11 reform legislation. And the direct parallel I would argue is
12 if we as a country are prepared to say to the poorest people
13 in the country, you have to go out and get a job or get an
14 education, we should have the nerve to say to every American,
15 you have a responsibility for monitoring your own health, for
16 having a health indicator system.
17 And again, one of the things that we should be
18 looking at is what is it that inhibits us from creating
19 marketing and having a system in which people could literally
20 monitor their own health on a regular basis.
21 Our goal is to consistently look for better
22 outcomes at lower cost, and we think if you aggregate those,
23 it is startling how many places there are where you can get
24 very dramatic improvements by applying better outcomes at
25 lower cost.

1 Now, there are essentially four kinds of
2 inhibitions. The first is the guilds. And here, Adam Smith
3 is very clear in the wealth of nations, for everybody who
4 believes in free markets, let me just suggest to you if you
5 think of being a doctor as a guild, you understand a great
6 deal of what I'm about to talk about. If you think about
7 being a lawyer as a guild, you understand a lot of what I'm
8 going to talk about.
9 The second thing to look at is obsolete laws which
10 are based on a different era and which is based on an era of
11 a different kind of economy, a different kind of information
12 flow, and a different kind of capability.
13 The third is the impact of bureaucracies, both
14 public and private. I mean, large corporations and large
15 insurance companies are truly as bureaucratic as large
16 governments, and bureaucracies have inherent patterns of
17 avoiding competition and avoiding change that are valid
18 whether they're public or private.
19 And the fourth is we create the wrong incentives.
20 We create incentives which are acute care-focused. We create
21 incentives which are doctor-centered rather than
22 individually-centered. And we created incentives which do an
23 immense amount once you're sick, but almost nothing to incent
24 you not to get sick.
25 Let me suggest six quick areas where I think the

1 insurance by 40 percent for the self-insured -- I mean, for
2 individuals, small businesses, and notice that under ERISA
3 we're quite cheerful about doing this for the biggest
4 companies in America.
5 So the biggest companies in America are exempted
6 from the 50 state mandates. They're exempted from the 50
7 state insurance commissioners. And if you get to be big
8 enough, you get to play in one league, but if you're not that
9 big, you're actually in an artificially -- and I want to
10 emphasize artificially -- dramatically more expensive league.
11 The second thing I want to suggest to you is to
12 look at medical rules that break America up into 50 states.
13 There's no doubt in my mind that many of the restrictions on
14 doctors are explicitly guild behavior designed to minimize
15 competition.
16 But beyond the question -- and I would argue that
17 there ought to be some kind of national registry, and if
18 you're a board-certified doctor you ought to be able to
19 practice in all 50 states. We live in a modern age. We live
20 in an age where information flows worldwide. The rules that
21 grew out of a 19th century industrial model strike me as
22 obsolete.
23 But in addition, you want to be able to move
24 medical information across state lines. The Mayo Clinic
25 exists in three states, Arizona, Minnesota, and Florida.

1 They should be able to have a control digital database, have
2 you have an MRI in one state, and if the best person in the
3 world to read that MRI is in a different state, it is
4 irrational and destructive of life and money to say that you
5 can't have access to that.
6 So second, you ought to look at the degree to which
7 state lines today artificially inhibit these things. And let
8 me point out that in terms of interstate commerce, there is
9 no constitutional reason that the health system shouldn't be
10 seen as a national system.
11 And, by the way, the minute you have a SARS threat
12 or an anthrax threat or a new model of flu, we behave like a
13 national system. So I think this is when you look at what's
14 the additional cost in inhibition, both for lives and money,
15 by the current model of state-by-state guild behavior?
16 The third is to look at what inhibits the rise of
17 the right kind of investigation systems. There's a firm
18 called Health Share which has taken the Medicare data and has
19 developed an expert system which enables you to pull up
20 hospitals based on the Medicare data.
21 And it is very interesting that consistently the
22 best hospitals tend to be the least expensive. It is the
23 inverse of the automobile business. In the health business,
24 you very often can get a Ferrari for the cost of a Subaru,
25 and if you go to a Subaru quality, you very often pay the

1 price of a Ferrari.

2 And this is a system which indicates -- and, now,

3 it's only Medicare data today; it's not all data -- but it

4 really begins to give you an ability to access what are

5 outcomes, how many medical errors are reported, how many

6 hospital-induced illnesses are there, what do they charge,

7 how many days do you spend in the hospital, et cetera.

8 There are all sorts of inhibitions against these

9 kinds of systems growing up, including -- and I'm going to

10 come to it at length -- the liability system, which inhibits

11 the development of this kind of information, but also, the

12 unwillingness of doctors and hospitals to share data.

13 And one should look at the question -- there was a

14 huge fight a number of years back about whether or not you

15 could put prices on cars. And as with all good guilds, the

16 manufacturers and the auto dealers did not want to put prices

17 on cars. And this was a big fight over the public's right to

18 know what does a car cost.

19 Well, let me suggest to you that you're in the same

20 cycle right now. Interestingly, in 1999 12 percent of the

21 country went online to find the price of a car before they

22 bought a car. In 2002, in three short years, that number

23 exploded to 58 percent of the country. And on average, they

24 save 2 percent on the cost of the car they purchase. So I

25 just want to suggest there's no inherent reason that you

1 couldn't have an accurate information system about
2 capabilities and cost.
3 The fourth change, though, is one which you only
4 have an indirect interest in but a big interest in the
5 market, and that is HIPAA will almost certainly have to be
6 modified both for research data and for price and outcome
7 data. And there's no reason you can't design it so that you
8 can have a patient confidentiality-compliant system.
9 But the way HIPAA technically is written right now,
10 for example, it's very difficult to do longitudinal research
11 under HIPAA rules. And NIH will probably be making
12 recommendations on this topic. But again we have to say, to
13 what degree does the government become self-destructive?
14 Because in the name of protecting your privacy we have
15 designed a rule which actually makes it more likely you'll
16 die.
17 And so I think we have to look at, in the age of
18 electronics, how do we both protect your privacy and enable
19 the gathering of quantitative data that we need very badly.
20 The fifth proposal I want to suggest to you is a
21 radically different way to think about purchasing drugs. The
22 current drug system -- and this is particularly timely
23 because of Medicare, but again, it goes back to the issue of
24 how do you get markets to work right.
25 The current drug system is wrong on a couple of

1 accounts. First of all, there is no pricing for drugs.
2 Drugs are almost -- particularly if you're in any kind of
3 group purchasing plan, drugs are purchased as a function of
4 rebates or kickbacks.
5 It is as though the Ford Motor Company announced
6 that they had a $600,000 truck, but for you there was a
7 $560,000 rebate so it's only a $40,000 truck for you; whereas
8 the Chrysler Company said, we have a $45,000 truck, and for
9 you we're willing to take off $5,000. Somehow,
10 psychologically, taking off 560,000 sounds better.
11 So the current system actually incents the
12 pharmaceutical manufacturers to optimize the price of the
13 drug in order to have the widest possible margin to rebate to
14 the pharmacy benefit manufacturers.
15 The second thing wrong with the current system is
16 that requiring copays up front perversely maximizes the price
17 of the drug for the person who has the choice. If I'm going
18 to put up $10 as a copay and my choice is a $40 drug or a $70
19 drug, I actually psychologically want the $70 drug because I
20 get the seven-to-one return on my money. The ideal model
21 would be to reverse that, that is, to put the subsidy up
22 front, so that every additional dollar cost came out of my
23 pocket.
24 Two other points. Historically, we couldn't handle
25 data as it related to the sheer flow of drugs. And in 1965,

1 perverse the current system is. This is a system that
2 because the doctor gets no psychological reward out of
3 prescribing a nonprescription drug -- you went to the doctor,
4 you want a prescription.
5 If the doctor said to you, you know, last year or
6 two years ago this was the second most prescribed drug in the
7 world -- I mean, for the FTC to just say, what's wrong with
8 this picture and how come the market isn't working, strikes
9 me as a very important investigation.
10 So here's how it would work. You'd have a
11 Travelocity-type page. It would list all the drugs available
12 and medically appropriate indicators. Your government, which
13 loves you, will pay 100 percent of the least expensive and
14 will give you the same dollar value for any other drug.
15 So it's an open formulary. You don't get into
16 politics. You don't get into bureaucrats picking. You don't
17 get into the kind of things we're going to see with all the
18 various closed formularies. And the drug company has to tell
19 you an honest price. It can't give you a rebated price
20 that's totally artificial because it's out in the open.
21 NDC Health believes they could provide for the
22 government every night the subsidy price for the next day
23 because they handle over ten million transactions a day.
24 Now, I just offer that as a model, but if you had a model
25 like that, the patient would have more information -- it's,

1 could report it anonymously and that no disciplinary action
2 would be taken unless there was some extraordinary
3 circumstance -- you'd been drinking or you were doing
4 something really stupid in the cockpit.
5 The result was a dramatic increase of reporting
6 near-misses and significant systems modifications that
7 ultimately saved people from running into each other and
8 killing people.
9 There ought to be some tie between quality
10 reporting, error reporting, being open about things like
11 hospital-induced illnesses and protection with a reasonable
12 framework for having participated to improve the outcome of
13 the system to save lives.
14 And again, I draw a distinction. If the doctor is
15 drunk, if the doctor is egregiously misbehaving, if there's a
16 boundary condition that clearly is what would historically
17 before 1963 have been a guilty behavior, then you ought to be
18 able to sue in a different fashion. But there ought to be
19 protections and structures.
20 The last thing I think you have to look at is the
21 degree to which -- and you see this now in Pennsylvania, West
22 Virginia, and Mississippi and Nevada -- the degree to which
23 predatory legal behavior is actually beginning to endanger
24 lives because the principles that are being established drive
25 people out of practice.

1 I was told recently that in Las Vegas, there are no
2 obstetricians willing to take any new patients. Now, there
3 has to be a public health cost here. An epidemic of lawyers
4 can be as dangerous as an epidemic of SARS, and literally
5 dangerous in the sense that by driving doctors away from
6 behavior they would otherwise engage in. We are killing
7 people. And there should be some way for this to be
8 investigated in a straightforward manner to find out to what
9 degree it is not, in fact, legal behavior but is economically
10 predatory behavior, and to recommend to the Congress ways of
11 thinking about these problems.
12 Because our interest is to have an orderly system
13 in which we optimize the activities that are productive and
14 in which we optimize the desirability to become a doctor or
15 to run a hospital or to provide good health, and in which the
16 individual citizen is guaranteed justice if they are
17 aggrieved, but we don't create classes of behavior as a
18 result of which we are economically self-destructive.
19 Thank you for letting me outline all this.
20 DR. HYMAN: Okay. Well, let me just start by
21 throwing it open to the panel generally and asking any of
22 them whether they have questions, comments. I have a whole
23 series of them, but let me defer to the panel first.
24 Warren?
25 DR. GREENBERG: I must say it was a very

1 stimulating, very thoughtful group of remarks, and I
2 appreciate hearing them myself, and I'm sure everyone else
3 did. I'd like to have a world out there, which is perhaps
4 close to yours, and just describe it just for a second. It's
5 part of my talk, but what the heck, you're here and I'll do
6 it now.

7 You talked about Wal-Mart first, Wal-Mart the
8 department store. And you talked a lot about information,
9 the lack of information that we have. How about a world, Mr.
10 Gingrich, where we would have Wal-Mart in health care,
11 competing against K-Mart, competing against Bloomingdale's,
12 competing against Nordstrom's, competing against Lord &
13 Taylor.

14 Look at the information we would have in that
15 marketplace. Look how we know, when we go into K-Mart, we're
16 going to get a particular type of good, a particular quality
17 of jewelry, perhaps, at a lower price than we would going
18 into Bloomingdale's or Nordstrom's, knowing almost nothing
19 about jewelry, perhaps knowing very little about men's
20 clothes, yet that symbol of the department store that George
21 Stigler spoke about 40 years ago, the Nobel Prize-winning
22 economist, perhaps can be applied to health care.

23 Look at all the information we would get if firms
24 of health plans -- if we could name a health plan today that
25 we know is the Nordstrom's of health care, that we know is

1 the Wal-Mart. Instead, it's ABB, blah, blah, blah, Fidelity
2 Mutual. We don't even know how good they are. But why don't
3 we have that development of brand names?
4 And this is what I'd like to address in my talk,
5 and I would ask you if you can believe that maybe this is the
6 way we ought to tie in information, and ask you and perhaps
7 other panelists, what are the imperfections that we have that
8 we don't have health plans. And it's not only the department
9 store approach. I'm talking about automobiles. I don't know
10 anything about what goes into a Lexus or who the mechanics
11 were in making that Chevrolet. But somehow, I know a Lexus
12 works better than a Chevrolet.
13 Why don't we have these brand names, from good to
14 bad, with prices, as a way to provide information to every
15 consumer in America?
16 MR. GINGRICH: Well, let me say first of all, Dr.
17 Greenberg, I agree with your core vision that -- with this
18 caveat, which I think you also agree with, because I want to
19 make this clear so we don't get some kind of attack on the
idea of marketsBut somehow, I knoo5 -blohfs'(14)Tj3rica? ake tmlenil

1 If you go back to the rise of the Food & Drug
2 Administration under Theodore Roosevelt, this was in fact an
3 appropriate response to the need to have a refereed or
4 regulated framework within which the market operates and the
5 delivery is by the market, but it's a delivery guaranteed by
6 the government in terms of quality.
7 And I say that because otherwise we're going to get
8 somebody attacks us: How can you compare health to -- within
9 that framework, you're exactly right. Now, interestingly,
10 when we first went out to begin working on "Saving Lives and
11 Saving Money" back in 1999, we started by looking for
12 branding.
13 What are the startups? What are the better
14 outcomes at lower cost, et cetera. You have some limited
15 branding. The Mayo Clinic is a world-class name. The
16 Cleveland Clinic is a very good name.
17 But what you discover early on is that the
18 inhibitions against their growing, it almost resembles
19 Lancashire cottage industries prior to the rise of the mills
20 and the degree to which you can't aggregate behavior. It's
21 very hard. So that we look at firms -- Visicu is a Johns
22 Hopkins spinoff that deals with electronic intensive care
23 units.
24 Every hospital in the country ought to have either
25 their own intensivist or they ought to be attached to an

1 electronic intensive care unit, period. I mean, this just
2 should be a minimum standard.
3 But when you go to the local intensive care doc, he
4 says, wait a second. What are you saying to me? Or you go
5 to the local group of doctors and you say, well, I don't know
6 that I want my hospital to do this, even though statistically
7 there is no question: If you go to a -- if you have
8 abdominal surgery in a hospital without an intensivist, the
9 odds are three times as high you'll die.
10 And so what I discovered, to go back to your point,
11 is it is very hard to get the rise of these branded
12 structures. Probably the Hospital Corporation of America is
13 as close as we've come to that kind of a model. But it's
14 also really hard to get to the aggregation of behavior. And
15 part of it is because of doctors and the way they're trained
16 by medical schools, which has to be redone. Part of it is by
17 legal inhibitions.
18 The other point I'd make is that historically, the
19 mistake that was made in the '80s was creating a so-called
20 health management approach, managed care approach, which
21 actually was about managed cost. There was no data for
22 managed care, and so you ended up in the wrong kind of fight
23 and you actually -- I think society was pushed back a step
24 because the design was backwards.
25 DR. HYMAN: Helen?

1 MS. DARLING: Yes. I'd like to get back to one of
2 the excellent points you made about your vision, and
3 particularly combine your history as a politician and your
4 current activities as transforming the health system, for
5 which I'm sure everybody in the room will be very grateful,
6 especially if you can do it.
7 Over-the-counter drugs and generics offer the
8 consumer much of what you're talking about. First of all,
9 the minute they become generic and over-the-counter, a lot of
10 other things happen, usually. And just generally, you know,
11 you can debate about some of the data and what it shows,
12 especially absent the competitive system -- that is, more
13 than one generic.
14 But generally, consumers and employers will save a
15 lot of money to the extent that drugs are moved to over-the-
16 counter generics. But the industry, as you know, has, shall
17 we say, kindly made it as difficult as possible for that to
18 happen even to the extent that trying to use the authority
19 that the Congress has given, both the FDA and themselves, to
20 limit either movement to generics or anything that could
21 possibly work.
22 Could you please talk a little bit about your
23 thoughts about how, number one, we move that along faster,
24 and two, if there are other barriers that we should be paying
25 attention to that keeps those kinds of changes from happening

1 in a timely way.

2 MR. GINGRICH: Thank you. I think that's a very
3 insightful question that goes to the heart of one of the
4 biggest changes that we need.

5 Let me start by saying that I think that American
6 history is filled with moments when economically very
7 powerful entities that forgot that profit is supposed to be a
8 by-product of service and began to try to rig the game for
9 themselves found that, in fact, this is a stunningly populous
10 society. I think of Robert LaFollette and the railroads as a
11 perfect example, leading to the rise of the progressive
12 movement.

13 I very much favor the branded pharmaceutical system
14 which has created two generations of therapeutic
15 breakthroughs that are extraordinary. But I think that they
16 are now trapped in exactly the same crisis that doctors are
17 trapped in.

18 Several years ago I went and spoke to the AMA when
19 I was Speaker, and I got a very nice round of applause
20 because I had followed somebody they didn't like. But when I
21 got up, I said to them, you're either going to go to Wal-Mart
22 or you're going to go to Canada. You're either going to end
23 up in a regulated, unionized, government-run bureaucracy, or
24 you're going to be in a genuine market where people have real
25 information.

1 And that's my message, basically, to the
2 pharmaceutical companies. I am for people paying the
3 appropriate price with knowledge in a competitive setting for
4 the drugs they get. I think a system which is dominated by
5 detail people, a system which is dominated by rebates, a
6 system in which doctors prescribe in ignorance, is a system
7 that is doomed to failure. And let me talk briefly about how
8 that will happen, I think.
9 First of all, I have talked to no audience in the
10 last six months where you describe automatic teller machines,
11 self-service gas stations with credit cards, and Travelocity,
12 and then you mention the phrase "paper prescription."
13 They don't just get it. I mean, all of their
14 common experiences every day now are that you can have
15 electronic interfaces that are stunningly accurate, and then
16 you get a paper prescription. And paper prescriptions
17 require a massive volume of call-backs. Forty percent of all
18 prescriptions require a call-back. And the doctor very often
19 doesn't even know what else you're taking. So start with
20 that.
21 At a large scale, what you want to do is simple.
22 You want to take something like Scholar, which is a Stanford
23 spinoff that has been certified by the AMA for continuing
24 medical education, and you want to have a Scholar-quality
25 page, much like Travelocity, so the doctor is an informed

1 prescriber. You can put it on a Palm. You can do -- but
2 doctors ought to know, here are the nine drugs and here's
3 what they cost.
4 By the way, in the studies that have been done,
5 when doctors do know the cost, they consistently prescribe
6 less expensive drugs. I mean, some outliers don't, but as a
7 general rule, it does have an impact.
8 Second, you want electronic prescribing. My hope
9 is that the Medicare drug bill is going to mandate electronic
10 prescribing. You want computer order entry in hospitals of
11 medications, and you want every drug that you get to have an
12 electronic indicator on it so that you automatically can
13 match up the drug and the patient.
14 And again, Pfizer has taken the lead in developing
15 that, but I think you're going to see it happen -- this has
16 been going on in grocery stores now for about 40 years. And
17 I think it's finally migrating into health. All of these
18 things have a big impact on accuracy, safety, and cost.
19 But what the country has to say, and I think the
20 Medicare drug debate may be precisely the place to start
21 saying it, is -- and this is historically how -- we
22 historically get change out of two things. We either have a
23 grievance, you know, again, Nader versus the big auto
24 companies, which whatever you may think of Ralph in terms of
25 being, from my standpoint, much too liberal, his crusade in

1 the '60s and '70s clearly changed the standard of safety in
2 America, despite the fact that the biggest companies in the
3 United States were opposed to it. But in the end, they
4 couldn't stand up to the public debate.
5 Similarly, the most successful companies in America
6 right now may well be the pharmaceutical companies, but when
7 the country decides, A, this is what I'm missing -- you know,
8 why am I paying 65 percent more than I should be paying, or
9 why is it that a detail person's ability to get the
10 receptionist to schedule ten minutes becomes an integral part
11 of which drug I get.
12 And so I think you will see a different model
13 emerge fairly rapidly, and I think it will almost certainly
14 be an internet-based model. It will almost certainly be an
15 information-rich model. And it will happen either because
16 the government shifts in the direction I'm describing or
17 because ten or fifteen large payors shift and decide that
18 they'll subsidize 100 percent of the least expensive.
19 And again, what I'm arguing for is an open
20 formulary. So none of the pharmacy benefit management
21 companies are going to like this because it takes away the
22 rebate model and the information control model which is at
23 the heart of their being an intermediary.
24 But the modern information systems take out
25 middlemen, empower you to make choices, and drive prices

1 output per dollar. So I studied under Deming as a result of
2 that experience.
3 You start with a premise: If you're really, really
4 good, you're probably less expensive. Toyota is less
5 expensive than Mercedes. In fact, there's a terrific book by
6 Womack called, "The Machine that Changed the World," which is
7 the MIT project on automobiles. They make the point that
8 Mercedes and Toyota produce about the same quality car, the
9 difference being Mercedes rebuilds one-third of their cars;
10 Toyota rebuilds 2 percent of their cars.
11 Then they make the point that if Mercedes can't
12 learn the Toyota production system, that you cannot compete
13 very long at the same price, if I have to rebuild a third of
14 my cars for quality and you're rebuilding 2 percent of yours.

1 selects out for people who want to engage in research -- so
2 you have to start with the idea that, I mean, best of class
3 very often recruit to best of class.
4 Second, they have the professional commitment to
5 force themselves to learn things they don't want to know,
6 which is very, very difficult. And it's part of the key to a
7 quality culture.
8 Third, if you in form, do it right, you don't have
9 medical errors and you don't have medication errors and you
10 don't have hospital-induced illnesses, all of which cost
11 money. There are two million hospital-induced illnesses a
12 year in the United States. If you stay in a hospital longer
13 than four days, the odds are even money the hospital will
14 give you a disease which it will then charge you to cure.
15 This goes back to perverse incentives.
16 The U.S. government ought to pay a bonus to every
17 hospital which has significantly less medical error and has
18 significantly less medication error, has significantly less
19 hospital-induced illness. One specific example: When
20 Wishard Hospital went to -- Wishard Memorial went to complete
21 order entry of drugs, they reduced the average stay by nine-
22 tenths of a day per patient. Now, seen from the standpoint
23 of the CFO, they just reduced their income. But they saved
24 nine-tenths of a day per patient by going to computer order
25 entry.

1 Visicu, according to Centera Hospital, has --
2 Visicu is the electronic intensive care system -- Centera,
3 which has it in five hospitals connected to one office for
4 electronic screening, says that they now save 20 percent of
5 the time per intensive care patient, on average, in moving
6 them through the intensive care unit because there are fewer
7 errors, fewer hospital-induced illnesses, better treatment.
8 So you actually -- true quality should actually
9 improve hospitals, not cost them more. And true quality
10 should actually improve doctors' incomes, not make them
11 poorer. But the incentive system does, in a perverse way,
12 almost incent you to have the errors and have the illnesses
13 because you get to charge for them.
14 DR. HYMAN: You get to double hit. You're having
15 them in first and then again.
16 Mike?
17 MR. YOUNG: I guess before I ask a question, I will
18 say -- you mentioned HIPAA. And HIPAA was a consulting gold
19 mine for us in the first -- for consultants for the first
20 quarter of this year.
21 But I absolutely agree with you that it has clearly
22 gone way too far, and we have a number of situations where
23 the access to data is very hard to get and seemingly, you
24 know, each holder of data makes their own determination of
25 how they use HIPAA, either as an excuse or a realistic way to

1 protect peoples' rights. So I absolutely agree that it's
2 gone too far and I think we need to come back.
3 But what I'd like to touch on is this whole issue
4 of a lot of the consulting that I do is in rural communities.
5 And I've been doing it for many years. And two of the things
6 we see are situations -- and I'll use Hot Springs, Arkansas
7 as an example. They have 30,000 people there. They have
8 three hospitals. They have eight MRIs. And so there's just
9 an incredible glut of providers, if you will, more than they
10 need.
11 And then we see other communities where there are a
12 lack of physicians, especially. And I've found with rural
13 communities especially, there are two types of physicians.
14 One are the people that tended to either grow up in those
15 communities and want to give back and go back and work in
16 those communities. And, quite frankly, another group that
17 goes there to hide from the system.
18 And so there's kind of this double-edged sword. In
19 some of these communities, there seems to be such a glut that
everybody in Hot Springs who2.k otout that

1 MR. GINGRICH: Well, you raised a couple of things.
2 Let me go through quickly.
3 First of all, rather than complaining about HIPAA,
4 people ought to start drafting the modifications. Congress
5 writes laws so Congress can meet to hold hearings so Congress
6 can write laws. I mean, instead of saying, gee, this is now
7 locked in concrete, we ought to say, okay. This was a good
8 try in the right direction. It's largely better than having
9 no law. Now, what do we have to fix?
10 And just -- I think people should say certainly by
11 early next year that Congress should be holding hearings on
12 the better patient safety, better information model of HIPAA
13 based on what we're now learning. And this will be an
14 ongoing iterative process as we get used to living in an
15 information age.
16 Second, you reminded me, there really should be a
17 nationwide database, for example, of doctors who've been
18 disbarred or of doctors who have been heavily sanctioned.
19 And it ought to be an accessible database. That is, I should
20 be able to find out whether or not I'm dealing with a doctor
21 who has lost 14 malpractice suits in 14 different states.
22 Today there are state databases, but they're not
23 accessible. They're not together. And there's no reason you
24 couldn't have a nationwide database. This is pretty easy.
25 And at a minimum, it will flush out the worst

1 doctors, which ought to be flushed out. I mean, there's no
2 reason the worst doctors should be allowed to practice. We
3 would not allow the worst airline pilots and the worst
4 airline mechanics to practice. We say there is a standard
5 above which you have to be or you kill people.
6 Third, when you have eight MRIs in a town that
7 size, as long as you know what the price is and as long as
8 that price is public, the least efficient ones are presently
9 going to go out of business unless they're self-directed,
10 which gets me to a fourth point.
11 But I think this is part of why pricing has to be
12 out in the open. Three hospitals won't survive unless they
13 can survive. I mean, I don't care how many retail stores --
14 back to your point about department stores. I don't ask you
15 how many stores there are in a town. You know, if they can
16 make a living and they're willing to do it, that's fine. You
17 could have 30 MRIs if they can do it. But what I object to
18 is that they pass the cost on and it becomes part of an
19 embedded base of what we mean by health care costs. I think
20 that's inappropriate.
21 The other thing that's wrong, where I think the FTC
22 could usefully look at, is when you have a doctor-owned
23 facility which is also self-referred. And I want to draw a
24 real distinction because I think we made a mistake in
25 designing this.

1 I have no problem with doctors investing in
2 hospitals unless they refer to the hospital they invest in.
3 But if you end up in a situation, as was described to me the
4 other day in another part of the country, where the
5 doctors -- the cardiologists are really pretty clever.
6 If it's going to be an easy cardiology problem, it
7 goes to their clinic. If it's going to be a really
8 expensive, hard cardiology problem, it ends up in the local
9 general hospital. Now, that kind of behavior strikes me as
10 absolutely wrong and unprofessional and inappropriate, and we
11 need to figure out how we monitor that.
12 The other example is places where hospitals tend
13 not to run emergency rooms so that they don't get the heart
14 attack patient until the second day when they've stabilized,
15 which again means that they have a very high likelihood of
16 success rate without having run the big risk.
17 The last point I want to make about rural America:
18 Rural America will profit more from the rise of internet
19 diagnostics and internet-based capabilities than will urban
20 America. And properly designed, you could have a Visicu for
21 an entire rural state that would literally allow you to have
22 an intensivist for all the hospitals in the state
23 simultaneously.
24 Visicu, for example, is now going to be monitoring
25 the intensive care unit in Guam for the Air Force from

1 Hawaii. And there's technically no reason not to do that.
2 So you could imagine two years from now every rural state in
3 the country could have a connectivity to an intensivist even
4 for very small rural hospitals, and the coaching improvement
5 would be dramatic.
6 I'd also say for small rural areas -- and again,
7 this is the cultural crisis -- you know, you're now talking
8 to the local doctor who's been totally in charge for all
9 their life. No one has ever questioned them. They're the
10 only doctor within 25 miles. And somebody is now going to
11 look over their shoulder?
12 I mean, this is a -- you know, and what I'm arguing
13 is, yes. For patient safety reasons, for public outcome
14 reasons, you're right. And the other example I would cite is
15 Active Health, which is a very good firm, which works for
16 large corporations. And they basically get world class
17 doctors to coach your doctor if you have an expensive
18 illness.
19 And it turns out that by getting the world class
20 doctor to work with your doctor, your doctor's quality of
21 care goes up dramatically. And again, for rural America,
22 these things are potentially doable, but they're only doable
23 from the state level down. They're not doable by small
24 hospital by small hospital because they never aggregate the
25 resources to do it.

1 DR. HYMAN: Let me ask a question about
2 information. I mean, information is an important part of a
functioning market. You've emphasized it in your remarks.

1 kind of information in insurance decisions.

2 I would argue in part that you want to have -- and
3 this may sound contradictory coming from a conservative, but
4 I think we want a country that is very close to 100 percent
5 insured. And the reason you want that is we made the
6 decision we're not going to let people die without caring for
7 them, and so to not have them insured just maximizes the
8 complexity of the delivery system.

9 I think between vouchers, tax credits, and tax
10 deductions, you can create a system in which people have
11 virtually 100 percent insurance. And then you want to make a
12 ground rule for offering insurance that you can't cherry-
13 pick.

14 And there are a variety of ways to do that by
15 having open access. You can have an open access system that
16 also incents good behavior. That is, you could have -- you
17 could say to people, if you keep your cardiovascular within
18 certain parallels, you know, we'll give you $100 back at
19 Christmastime. And you can do that without having cherry-
20 picked.

21 But I do think you want to say basically that in
22 the case of health insurance -- which is really an anomaly
23 because it's mostly not true insurance. Health insurance is
24 mostly prepaid medical care with some insurance components.

25 Now, we go a step further in "Saving Lives and

1 Saving Money." We propose that Congress should pass a law
2 creating a personal health account, which would in essence
3 mean that when you first went to work, you'd get, say, a
4 $1500 deductible and we'd put the $1500 in your account so
5 you're now spending your dollars.
6 It would be -- it could carry and have tax-free
7 interest buildup. So when you're young, you probably
8 wouldn't spend it, and within a very few years, you'd be at
9 the 20-, $30,000 deductible level with it being your own
10 money.
11 When you got above the value at which you got any
12 kind of break on the -- now you would be on a true insurance
13 system because now you would have set aside your maintenance
14 health money, which you'd be spending, and the insurance
15 company would actually be offering genuine insurance.
16 The other piece of that is probably we need,
17 whether it's designing a government-sponsored enterprise that
18 would be competitive or some other model, we probably need
19 only to go to a reinsurance system, that is, to create a
nat14onalmpbbeemdeit,whftlyou can 0 TD(12)TjoaTj1

1 million or something -- probably done by a government-

2 sponsored enterprise.

3 But I think the inability today to have that kind

4 of insurance pool means you get grotesquely expensive small

1 The information burden and the lack of integration
2 and coordination in the highly fragmented model are two big
3 problems. So one question is, how do you see the relative
4 balance between essentially bundling, creating continuity,
5 integration of services which manage, for example, chronic
6 conditions or end-of-life care, complex care, rather than a
7 highly fragmented marketplace?
8 And secondly, what do you see as the balance
9 between the regulatory function on the information
10 requirements in such a market and the self-issued information
11 opportunities?
12 And I'm probably interested in -- to the extent
13 that I've become more and more of a believer that there has
14 to be government standardization of information requirements
15 and disclosure requirements and so on and of infrastructure,
16 as you've supported for a long time, electronic
17 infrastructure to support that information capability.

t8frastructure to sace?

a9frastructure to sr thetnuity informakie,

2nd I'm probabl

1 of which are proof that you can have systematized national
2 standards.
3 There's a -- and I can't remember the name of it
4 right now; some of you will know -- there is a national
5 association founded, I believe, in 1916 for electric
6 standards during a period when the government wanted to
7 ensure things happened but didn't want to do it itself. And
8 so all electrical appliances in the United States go through
9 the same standard-setting, which is actually a private
10 association, legally empowered to do that.
11 You could -- you know, and whether you have HHS set
12 an information standard or you have the government establish
13 a freestanding commission for medical information, which may
14 be the right parallel -- but your point's exactly right.
15 I mean, jumping out five years, or no more than
16 eight but within five years, automatic electronic health
17 record -- I want to distinguish a health record from a
18 medical record. A health record is all the information that
19 you should carry with you for the next doctor. The medical
20 record is everything the doctor and the hospital need to keep
21 for the lawsuit. A very big difference in detail, in level
22 of detail.
23 Everybody ought to have an electronic health
24 record. It ought to be compatible across all the systems.
25 All the major providers of these kind of systems should be

1 part of an open systems architecture as opposed to I'm going
2 to design some cute device so once I have you, you're a
3 captive and you can't use anybody else's equipment.
4 And again, all of us who use the internet and who
5 use laptops are -- you know, everybody who uses a cell phone
6 has experienced this. And I want to draw a distinction
7 between two different points you made, and then talk briefly
8 about managed care.
9 The model that Dr. Greenberg described is a model
10 of stunning consumer choice. You know, I decide today I want
11 to go buy X. I have lots of places to go buy X. It's the
12 job of the aggregator to provide me a reputation and a price
13 and a convenience I want to go to.
14 And then you're exactly right in your analogy. You
15 know, there are all sorts of places I can go for what I want,
16 and I get signals from the system about reputation, et
17 cetera.
18 So you could have a consumer-driven system in which
19 you had a very high level of common information, more, I
20 would say, than you get today. That is, if I had an
21 electronic health record so that the next doctor knew what
22 the last doctor had prescribed, you'd already be at a quantum
23 jump above current behavior.
24 The second part, though, I think, is a misnomer
25 about what happened with managed care. It goes back again to

1 the moral cause. Health is different than buying clothing or
2 buying jewelry. There is a moral component because it's
3 about my life or my daughter's life or my granddaughter's
4 life or my mother's life.
5 And so the minute I think that a decision about
6 their life will be profit-driven as distinct from profit
7 being derived from the right decision, if it is a profit-
8 driven decision, I am very suspicious that I am now going to
9 have my granddaughter get bad care so somebody has a better
10 quarterly report.
11 I mean, the analogy -- and by the way, I'm told
12 this all the time. Insurance companies will tell you with
13 great openness, we don't do preventive care because people
14 don't stay with us long enough to justify it economically.
15 Well, that's like an airline saying, you know, we're going to
16 be as safe as our quarterly report permits. Now, we wouldn't
17 tolerate that for one minute.
18 So what the insurance company is tell you is they
19 are putting your health needs below their profit margin. And
20 it is a perfectly rational behavior in the current market.
21 And that's why people have this deep suspicion of the
22 financing of health care, that a decision will be made, I
23 won't get what I want.
24 Now, I'll give you a couple of examples. And here,
25 AARP and others are actually showing some real leadership.

1 Comorbidities are the largest single problem in Medicare.
2 Five percent of the people on Medicare use up 50 percent of
3 the money. That 5 percent has, on average, somewhere between
4 five and seven comorbidities. It's very clear they ought to
5 get managed as a complete person and not have five to seven
6 separate verticals.
7 That can be done in a system where you basically
8 say, we're going to incent the doctor to have full
9 information through an electronic health record. And we're
10 going to incent the doctor to deal with all the comorbidities
11 at one time.
12 And you can design a system that does that while
13 still allowing the patient to pick which doctor they want to
14 go to. So it's not an either/or. It's not either that we've
15 got to trap people into a system where it's controlled for
16 them, or they've got to be out here in a chaotic jungle
17 without any kind of information.
18 If you use the incentives right and you use the
19 structure of information right, you can migrate to a system
20 in which I still have choice, but it's choice among a series
21 of very high value products with much more complete knowledge
22 than we have today.
23 I would argue if you've got the right electronic
24 health records and the right kind of requirements for
25 electronic prescriptions, et cetera, you will have

1 dramatically better health almost overnight in terms of the
2 way in which we minimize medication errors and other kind of
3 mistakes.
4 DR. COMSTOCK: I do have a comment, actually. I
5 think everybody in this room, and certainly around the table,
6 agrees with a lot of what Newt has said. And whether you
7 believe that there's 30 percent waste in the system or 40
8 percent waste in the system and all of these dollars were
9 there that could be easily used to do things like create
10 access for everybody in this country or create the
11 infrastructure, improve the transparency of information, we
12 have been involved in a community project across the country.
13 And when you talk to health care leaders there,
14 fundamentally they say, well, it's all well and good to say
15 that money exists, but you can't wait to take all of that
16 efficiency and put more efficiency into the system. There
17 needs to be an investment now.
18 And what we're doing is we're talking about --
19 we're not really talking about what we really want to
20 achieve. We're talking about where the dollar is coming
21 from.
22 And I guess I'm wondering whether you have any
23 ideas of how you manage that transition from an economic
24 perspective. I mean, do we suddenly decide we're going to
25 spend X billions more money in order to squeeze the

1 year. This was some 80 years after the bubonic plague first
2 began sweeping through Europe.
3 So let's just start with the idea none of us -- and
4 we get scared by SARS, which has killed a couple hundred
5 people. I mean, none of us has seen what a real epidemic
6 would be like, and it would be horrifying.
7 So I would argue that under homeland security
8 requirements, we need about a $40 billion investment in the
9 equivalent of the interstate highway system. And in our
10 book, we quote Eisenhower, who specifically had the
11 interstate highway system as a national defense act, although
12 it's obvious from the middle class that it has been
13 enormously successful in other ways.
14 That system should also include a virtual public
15 health service which connects all 55,000 private pharmacies,
16 all retired nurses and doctors as well as currently active
17 nurses and doctors, and includes veterinarians. Because if
18 you lose a central city, one of the largest sources of health
19 resources in the surrounding countryside will turn out to be
20 veterinary hospitals.
21 Second, I want to suggest to you that here's a
22 place where there are opportunities for huge improvements.
23 We work with the people at IBM who do logistics supply system
24 modernization, where they take huge amounts of cost out of
25 logistics systems.

1 And I was talking the other night with doctors at
2 the major medical groups, who said that the paper-handling
3 transaction cost of getting paid is three or four times
4 greater in health care than it would be if you were dealing
5 again with the big department stores you were describing.
6 Imagine a -- and it's particularly stupid for the
7 self-insured. I mean, for a self-insured company to engage
8 in a long-time value of money for doctors means the doctor
9 will countervail by charging more to make up for the lost
10 value of money and will then have to add clerical staff, et
11 cetera.
12 So imagine a system where doctors filed
13 electronically with your health record and your bill
14 simultaneously, by one click, and were paid every night by
15 electronic funds transfer on a post-payment reconciliation
16 system.
17 Now, you'd have dramatically fewer clerks. There
18 was a study done, I was told, for Blue Cross -- I have not
19 seen this, but a study, I was told, was done for Blue Cross
20 of Massachusetts that they figured out if you could have
21 realtime verification of eligibility, you would eliminate
22 one-half of their clerical staff.
23 Now, this is not heavy lifting. I mean, if you
24 think about what happens worldwide when you use your Visa,
25 MasterCard, American Express, you name it, I mean, we somehow

1 are able to stand at a restaurant or at a store buying a

1 I'd like, since he's going to have to leave in the middle of
2 the presentations, a round of applause for the presentation.
3 (Applause.)
4 DR. HYMAN: I'm just going to introduce everyone on
5 the panel at once, and we can sort of go across. People can
6 either speak from where they're sitting or up at the podium.
7 The first speaker, since he's over on the far left,
8 is going to be Warren Greenberg, who's a professor of health
9 economics and health care sciences at George Washington.
10 Next will be -- he's going to speak for about ten minutes.
11 Next, David Lansky, who is sitting to Newt's left,
12 who is the president of the Foundation for Accountability,
13 has been the president since the organization was founded in
14 1995.
15 Following him will be Michael Young, who is senior
16 vice president at Aon Consulting, focusing on health and
17 welfare issues.
18 To my immediate left is Helen Darling, who wins the
19 frequent flyer award for the panel because she has spoken
20 more than anyone else on the panel, and I think probably more
21 than anyone else we've had, she's such a wonderful speaker.
22 She's the president of the Washington Business Group on
23 Health.
24 Seated to Helen's left is Dr. Marcia Comstock,
25 who's the chief operating officer and a member of the board

1 of the Wye River Group on Health care, who has done a lot of
2 work on emerging trends in health care finance and delivery
3 and is going to talk about some reports that the Wye River
4 Group has released.

1 these latter imperfections. My goal, as I believe is the
2 goal Chairman of the Federal Trade Commission as well as the
3 entire FTC, is to achieve both price and quality competition
4 in the health care sector, and I mean the entire health care
5 sector, not just the Medicare program.
6 The three imperfections I'd like to focus on are:
7 the failure to tax employer-paid health insurance premiums;
8 adverse risk selection for health plans; and U.S. and state
9 "any willing provider" laws. This is filling in the blanks,

1 There is a substantial amount of turnover in the
2 U.S. labor force. Although this differs by geographic areas,
3 location, type of job, age and gender of workers, it has been
4 estimated that job turnover is between 12 and 16 percent
5 throughout the economy. In higher turnover industries, such
6 as agriculture or construction, the turnover rate is even
7 much higher.
8 And we talk about incentives here. When job
9 turnover is high, there is little incentive by the employer
10 to invest in health plans, to invest in expensive but perhaps
11 better quality treatment and procedures, as well as superior
12 physicians and hospitals, which can improve quality of care
13 and perhaps lower cost in subsequent periods. Why? Because
14 within one or two years, those employees are going off to
15 other jobs with other health care plans.
16 In contrast, if there were an individual-based
17 health insurance system rather than an employer-based system,
18 individuals would retain their health plan whether employed
19 with the firm, self-employed, retired, or disabled.
20 Individuals would choose a health plan from a variety of
21 health plans during yearly open enrollment periods.
22 Individuals will buy health insurance in the same
23 way they purchase automobile insurance without regard to
24 employment status. Income-adjusted premiums may be needed to
25 help those with lesser incomes if universal coverage is

1 desired.
2 Individual-based health insurance is found in many
3 European countries and Israel. In an individual-based
4 system, individuals might belong to a health care plan for
5 many years or decades, providing incentives for these health
6 care plans to do disease management and to try to insure
7 quality early on.
8 There would be greater incentives for the health
9 plan to invest in a person's health and to improve quality of
10 care rather than the current system that we have in force
11 with our individual -- with our employer-based health care
12 system.
13 However, under an individual-based system, and this
14 was touched on by the Speaker, precautions will be needed,
15 however, to insure that health plans are not avoiding high
16 risk enrollees. And therefore I would suggest we also need,
17 in addition to employer-based health insurance, the idea of a
18 case mix risk adjustment system.
19 Why? Because if health plans competed on a quality
20 of care basis, and we touched on this before, the plans which
21 provided the highest quality of care, in the language that we
22 talked about before the Nordstrom's, the Lord & Taylor,
23 perhaps, would attract the highest risk employees in the
24 following opening enrollment period, increasing its cost
25 considerably.

1 Health plans would be reimbursed by a neutral party
2 according to the number and severity of the individual
3 enrolled. Those health plans with a great number of high
4 risk individuals would be reimbursed at a higher amount.
5 This would create incentives for health plans to compete on
6 quality in order to attract the higher risk individuals.
7 Those health plans which do not necessarily compete
8 on quality, and perhaps stress lower premiums, would receive
9 little or no risk-based reimbursement. Price and quality
10 competition here. Each of the health plans would be required
11 to help finance the payments to the health plans which have
12 enrolled the high risk individuals.
13 Again, I won't repeat what I said before. But
14 under these circumstances, I do believe we will see the
15 department store approach where health plans are competing
16 both on price and quality, the same way we might see a Saks
17 Fifth Avenue and Bloomingdale's approach.
18 Under this kind of competition, the difficulty in
19 determining quality of care would also be less daunting for
20 the patient. It is also possible that individuals with the
21 same price/quality tradeoffs may differ on their view of
22 particular department stores, yet with its faults, many
23 individuals are satisfied to make this one of our most
24 important buying tools.
25 Finally, in the third step, each health plan should

1 be encouraged to utilize every avenue to improve both quality
2 of care and lower price. This would include selective
3 contracting with a limited number of physicians and hospitals
4 in the geographic area to attempt to achieve the lower cost
5 or higher quality.
6 Lower cost may be achieved by playing providers off
7 one against another to achieve increased volume and lower
8 cost. Improved quality can be maintained by contracting
9 only, perhaps, with the Cleveland Clinic or Mayo or a limited
10 number of hospitals. And physicians who increase volume may
11 translate into higher quality.
12 Unfortunately, recently the Supreme Court ruled
13 that "any willing provider" laws may be enacted by state
14 governments in which a health plan must contract with all
15 providers which would like to sign a contract with the health
16 plan. "Any willing provider" laws, if enacted by state
17 governments, would eliminate the potential for contracting
18 with only a limited number of providers.
19 In order for health plans to compete based on price
20 and quality, states should no longer to attempt to enact
21 these "any willing provider" laws, and those laws which have
22 been enacted should be repealed. Thus far, in 17 states,
23 "any willing provider" laws have been enacted to prevent
24 selective contracting with physicians. Thirteen states have
25 enacted laws which prevent selective contracting in regards

1 to hospitals.
2 Health care expenditures, including studies here by
3 economists at the FTC, have been shown to be much higher in
4 those states where they have "any willing provider" laws.
5 I would sum up by saying these three steps -- an
6 individual-based health insurance, which could be achieved by
7 taxing employer-based health insurance; a risk adjustment
8 payment; and selective contracting -- are necessary to
9 achieve both price and competition in health.
10 Each of these steps is interrelated and is
11 essential to competition. Without the possibility of both
12 price and quality competition, the health care marketplace
13 will remain inefficient. There will be over-investment of
14 price competition at the expense of improved quality,
15 resulting in economic loss for those who desire improved
16 quality. Even those who put a greater emphasis on price
17 competition will be confronted with a downward spiral of
18 quality if there are no incentives to provide quality of
19 care.
20 With $1.4 trillion spent on health care in the
21 United States, it is imperative to create incentives for
22 improved quality as well as reduced costs and to eliminate
23 these three market imperfections to compliment the antitrust
24 efforts of the FTC and the Department of Justice.
25 DR. HYMAN: Dr. Lansky, your PowerPoint is up on

1 the screen. So you can run it from up there if you like.

2 DR. LANSKY: Thank you, David and the Commission,

3 for letting me join you. I appreciate it.

4 My particular area of interest is in the

5 information requirements of consumers to be successful in

6 this health care system and market. And you had a marvelous

7 set of witnesses in the last few months covering much of what

8 I would normally have wanted to say.

9 So given that, I thought I would take a particular

10 slant on a theme, I think, that has not been adequately

11 addressed, which is the genuine experience of patients

12 seeking and getting health care, and what information is

13 needed in the course of our real lives, leaving a little bit

14 aside the legal and technical requirements that I think are

15 vital but I do think have been fairly well addressed.

16 So I'll introduce the term person-centered. And

17 the Speaker has certainly emphasized that throughout his

1 support competitive purchasing.

2 We developed about fifteen different sets of

3 measures addressing a number of chronic illnesses, end-of-

4 life care. We've done a great deal of work the last five

5 years on child and adolescent health, particularly to support

6 the CHIP and Medicaid purchasing requirements.

7 In the course of doing that, we quickly learned

8 that measures and data per se were not sufficient to support

9 a successful market, and we had to think about a framework

for presenting and communicating information. We developed

1 interoperable, it's transportable, and it is lifelong. And
2 we are just now working on a project with the maternal and
3 child health bureau here to develop what we call a data
4 resource center, which allows the consumer or a policy-maker
5 to access all the knowledge there is that may help them
6 understand and advocate for health improvements.
7 We've done about a hundred focus groups in the last
8 few years. We've done very large surveys. We do a lot of
9 interviewing. And we spend a lot of time working with
10 patients, veterans, labor organizations, to understand what
11 their constituency may be concerned about.
12 So that is context. I think the main theme I want
13 to mention today in terms of the quality, information, and
14 field that we work in is that the history of the last ten
15 years or so in this field -- and the Speaker spoke about the
16 idea of guilds influencing the behavior of the delivery of
17 care.
18 It's equally true in the information field, that
19 the information constructs that are often used to communicate
20 to the public are actually driven from above, not from the
21 experience of the person who needs to make a decision.
22 So the categories we use to fund health care and
23 the categories of specialty training tend to be the
24 categories we use to collect and disseminate information. I
25 don't think those always serve the needs of a real family

1 removal of the section of the lung to remove this tumor.
2 Obviously, my mother-in-law and my wife were
3 paralyzed with fear and anxiety, and immediately wanted to
4 pursue the doctor's recommendations. But my wife, on the far
5 right of this picture, being at least interested in the web,
6 got online. And this is her weekend's work, between the time
7 of the recommended scheduled surgery and the end of the
8 weekend.
9 She found a lot of resources to try to assess what
10 was going on in this case. You'll see the one on the left
11 there says "Probability of malignancy in solitary pulmonary
12 nodules," which is actually an online calculator that allows
13 you to enter the information that you may have from the film
14 and get a prediction of whether or not this is in fact a
15 malignancy or benign.
16 And my mother-in-law's data said it was 24 percent
17 chance of being malignant. So whether it was appropriate
18 with a 24 percent probability of malignancy to do this
19 radical surgery was certainly something needing a little more
20 discussion than we'd had the first time around. You also see
21 information from the cancer support groups, and a quick
22 education on imaging.
23 It turns out that one of the articles my wife found
24 has an NCBI study that she found in 1999 when this occurred
25 of a three-year-old study which talks about the evaluation of

1 fourfold difference in mortality if you go to a place that
2 does a lot of them versus a place that does only a few of
3 them.
4 And if you look at this New York City data, one of
5 our concentrations of medical excellence in America, only one
6 hospital in the entire central area of New York City performs
7 above the threshold number of lobe resection surgeries in a
8 year. A huge number of hospitals perform one, two, seven
9 operations a year in this very complex and very invasive
10 procedure.
11 My mother-in-law again had no information
12 whatsoever provided to her to guide her decision. And as I
13 suggested earlier, even in this one story, there are maybe
14 ten, fifteen important consumer decisions to be made: the
15 primary care doctor, the first imaging center, the second
16 opinion, the second imaging center, the facility to have the
17 operation done in, the surgeon to have conducted the
18 operation, in a moment of enormous anxiety, pressure, and
19 fear. It's a very complex set of consumer decisions to
20 unravel in the real world.
21 A second example I want to give is our development
22 of a set of quality measures for HIV and AIDS care. And this
23 would -- we had a wonderful commission or advisors, the
24 chairman of the President's Commission on AIDS, and a great
25 group of experts.

1 And they listed, as you see here, about eighteen
2 things which they think are important to measure to describe
3 the quality of HIV and AIDS care. And if you're a patient or
4 if you're in an oversight position and you want to evaluate
5 the quality of care in this arena, here are the things you
6 might want to look at.
7 We asked the experts to rank order which of these
8 eighteen things are the most important to use to assess the
9 quality of care for HIV and AIDS. And you see the rank
10 ordering they have here. The first was that the patients
11 receive anti-retroviral therapy, the second that they be

1 was actually given to the doctors, not to the patients.
2 But the thing I found most interesting in talking
3 to many patients -- these are parents of sick children -- was
4 that what they said was, I don't want to choose a new doctor.
5 I don't want to be told my doctor is poor. I want to make my
6 doctor better. I've been using this doctor for four years,
7 ten years, whatever. It's a place I'm comfortable getting
8 care. I want to know what they're doing poorly so that I can
9 basically beat them over the head with it and I can work with
10 them to improve the quality of care they receive.
11 So I think the ah-hah for us who had done an awful
12 lot of worn on exit, on choice, was that a lot of patients
13 really want voice and they want tools to improve their
14 interaction with their providers. So it's a much more
15 complex use of information than we had previously discussed.
16 Just to tie this all together and again reveal the
17 complexity of it, this is a map we did with the General
18 Electric workforce to identify all the information patients
19 want to know in real life -- these are people who've been
20 diagnosed with breast cancer. We asked them, what do you
21 want to know to get the best possible health care?
22 And as you look at a spectrum from the far left,
23 where people are at risk of breast cancer but not diagnosed,
24 to the far right, where they have had successful intervention
25 and are now living with the disease as a survivor, there's a

1 lot of information.

2 And it's very contextual, not surprisingly. The

3 information a young woman who may feel at risk for cancer

4 because of her relatives' experience wants to know is

5 dramatically different than someone who's about to have an

6 operation to remove a vital part of their body or deciding on

7 a form of therapy postoperatively.

8 So the sensitivity, the specificity, the

9 personalization of information is in some ways self-evident,

10 but most of our discussions about making the market work have

11 not been very finely attuned to where patients are in their

12 experience of seeking care.

13 And one other footnote on this particular example.

14 This is a study done in comparing care in Massachusetts and

15 Minnesota for breast cancer. And I think there are two

16 astonishing numerical figures on this slide.

17 One is that twice as many people in Massachusetts

18 as Minnesota are even seeing an oncologist as part of their

19 decision-making, let along deciding which oncologist to see

20 or evaluating those oncologists. And ultimately, then, twice

21 as many women, almost, are not told that they have an option

22 of breast-conserving surgery, having been given a diagnosis

23 of early-stage breast cancer. And these are in two,

24 nominally speaking, excellent states for medical care and for

25 the dispersion of medical knowledge.

1 So my conclusion, much like the Speaker's, is that
2 we need a modern information strategy which is sensitive to
3 these complexities of real life, and one which understands
4 that in a democratic consumer culture, people can and must be
5 capable of using information.
6 Let me just tick off some of the dimensions I think
7 we have to address in building such a modern information
8 system. First, medical care is very complex. My wife,
9 knowing nothing about medicine, is suddenly an expert on PET
10 scanning and solitary pulmonary nodules. And she had to be.
11 There was nobody else in the entire enterprise of medical
12 care in the Seattle area who stepped up and made the
13 investigations and decisions to support her decision-making.
14 Secondly, we have many, many sub-specialities and
15 many, many layered organizations. We have doctors, nursing
16 homes, home health agencies, and so on, all of which play a
17 part in achieving successful care.
18 Thirdly, care is multi-dimensional. There is
19 technical care, guidelines-based care, humanistic care,
20 patient education care, care in dealing successfully with
21 daily living, and simply the service aspects of care, all of
22 which have to be addressed by consumer information strategy.
23 Fourth, I am increasingly aware, as I mentioned in
24 my Vermont pediatric story, that what people are seeking in
25 health care are relationships, not transactions. So to treat

1 medical care as a bundle of transactions underestimates the
2 complexity of the human exchange of information and decision-
3 making, let alone therapy, that goes on.
4 Fifth, the population is not uniform. Not only do
5 we vary where we are in the course of an illness, but each of
6 us in this room has a different way of processing information
7 and using it. And in a vital area like health care decision-
8 making, this is a very subtle and complex problem.
9 We did a segmentation model that identifies four
10 types of American health care consumers. And we
11 differentiate them partly by their level of independent
12 action and partly by how much they listen to their doctors.
13 And depending on which type of these four groups you see at
14 the top of the slide a person may be, that will affect the
15 kind of information they want and how they will use it.
16 Next is the issue of transparency or, actually,
17 lack of transparency. But there simply isn't the information
18 available, period. Not only does the patient not know the
19 information they would use to make good marketplace
20 decisions, neither do the providers. Neither does the
21 government. The information does not exist. It's not known.
22 Next, the issue of third party payment all of us
23 have talked about for quite a while creates a barrier between
24 the purchaser, the financial transaction source, and the
25 person who actually needs to receive the superior care.

1 We have mediating decision-makers. In my mother-
2 in-law's case, there was a primary care doctor referring to a
3 surgeon, and a surgeon referring to a hospital. The actual
4 locus of control had been taken away from the patient. We
5 differ in where we are on the trajectory of illness, as my
6 breast cancer slide suggested, and we have to target
7 information to where a person really is in their decision-
8 making.
9 Therefore, just as we in getting medical care
10 expect personalization -- we want someone to hear our
11 history, understand our allergies, understand our values, and
12 help us make a good decision -- so in the information arena
13 we have to personalize the support of marketplace information
14 to the specific needs of each person.
15 Now, fortunately, as the speaker suggested, the web
16 and related technologies enable us to do that. But we
17 haven't really put our effort behind that so far. We've
18 tended to have very blanket strategies for public
19 information.
20 Finally, as I mentioned in my family's case, there
21 is nobody else out there who will do this for you. We may
22 not be confident that every American can step up, master all
23 this information, and make successful decisions. But there
24 really isn't an alternative.
25 There are some mediating organizations who will

1 certainly help. There are information advisors. There are
2 ombudsmen. There are a variety of other sources. But for
3 the vast majority of us, there's no one else you can rely on
4 to take your illness as seriously as you do.
5 So what can be done about it, and what can the FTC
6 and other agencies do? A couple of focal points I want to
7 suggest. First is we need to do more work on outcomes, not
8 process. As I suggested in my question earlier, the more
9 that we try to have a process measure for every fragment of
10 the American health care system, the more crazy we will
11 become. We have an enormously rich and technically complex
12 system, and we can't possibly cover the landscape with
13 everything.
14 And unfortunately, most of our research and others'
15 shows that there are not good correlations between being good
16 at A and being good at B. A clinic may be great at heart
17 disease care, and the same group of doctors, nurses,
18 technicians, could be terrible as asthma care. And they're
19 sitting in the same offices. You can't say because they're
20 good at heart disease, I'll go there for my asthma. There's
21 no correlation in any evidence we've seen so far.
22 So what do you do? Do you expect to have a set of
23 quality measures for every conceivable health problem?
24 That's not very practical. So the benefit of focusing on
25 outcome measures is it drives innovation because people

1 not only to help individuals make personal choices, but to

1 between a patient and doctor. We've been working on
2 something we call the ASK, the Agreement to Share Knowledge,
3 which is actually an agreement between a patient and their
4 doctor about the way they will each play their parts in the
5 care relationship and the way they will share information
6 with each other.
7 Using information intermediaries, whether it's AARP
8 or senior centers, to distribute information and make it
9 usable to people.
10 Providing interactive coaching of information on
11 the web. And I don't mean just simply portraying a table of
12 numbers on the web, but providing interactive decision
13 support tools.
14 And then finally, personalized choice aids using
15 the patient's own values and preferences as a way to help
16 them make decisions with this information.
17 I just wanted to illustrate a couple of ways on the
18 web that we've been approaching that, but let me just
19 conclude. Where I think there's a regulatory role per se:
20 In particular, I think it's the information infrastructure.
21 That does include what to measure and what must be disclosed,
22 but I think it goes further than that, and it goes back to
23 the Speaker's example of the interstate highway system.
24 There has to be a massive commitment and a public
25 awareness that we will not be able to improve this health

1 system short of centrally managing it in a way that the
2 National Health Service or perhaps the VA or Kaiser might do,
3 short of a central management system working off a centrally
4 allocated budget. Otherwise, there's no way to improve this
5 health system short of building an information
6 infrastructure.

7 So that requires information standards. It
8 requires requiring every player in the health system to
9 collect and disclose the relevant information. It requires
10 that the content be patient-driven and patient-centered. It
11 requires that we integrate that information infrastructure.

12 It's not enough to say to every doctor, you must
13 buy a personal electronic medical record. Those medical
14 records, if they can't talk to each other and talk to the
15 pharmacy system and talk to the nursing home system and talk
16 to the patient in their living room, that's not going to add
17 value to the system. So there has to be an integrated
18 electronic information infrastructure.

19 And I would encourage the regulatory approach to be
20 wary of commoditization. That is, if you try to treat every
21 health care interaction as a commodity, as a discrete,
22 individually-priced transaction, which by itself has a flow
23 of information and set of requirements around information,
24 that will actually undermine the ability of us to improve the
25 health system through what I'll broadly call relationship-

1 based care.
2 And finally, as public agencies, I hope that these
3 groups will realize that there is no one else out there
4 representing the patient and family. Everyone else has a
5 legitimate but primarily self-directed interest in the health
6 care system.
7 The public sector, part of why we use public funds
8 and why we have election is that someone has to say, we
9 represent the interests and the will, and we have means of
10 listening to the voice of, the American public in its breadth
11 and diversity. That's a very daunting challenge, and I'm
12 very concerned that some major initiatives going on at
13 present in the government don't fully make the effort to
14 listen to the public will.
15 Thank you.

1 for 25 years I've been working with employer groups of all
2 sizes, from 50 employees all the way up to 50,000. And
3 invariably, each year it gets tougher and tougher to get
4 through this process that we go through this time of year,
5 which is helping companies strategize about how to deliver
6 health care benefits to their employees for the next year.
7 So I was really excited to be able to come down and
8 share some of the thoughts. And what I did was I actually
9 took the questions from the hearing and threw them at some of
10 my clients of all sizes to get their perspective. Because
11 what I'd like to do today is be one of the panelists that
12 kind of shares with you, you know, what the specific employer
13 problems are and what their issues are when it comes to some
14 of the things we've been discussing today.
15 And the Speaker was right. Being from
16 Pennsylvania, I will say that not a week goes by that my wife
17 or another family member or a neighbor or somebody tells me
18 about somebody whose doctor has left the state. It is a very
19 serious problem in all of Pennsylvania, more so in Pittsburgh
20 and Philadelphia but just in the state in general. So
21 clearly, a significant issue.
22 What I did is actually -- because I work with
23 actuaries, although I'm not one. I'm somewhat anal about
24 this, so I actually put the questions into the overhead so I
25 knew what they were.

1 the standpoint of being covered for a traumatic, large-cost
2 situation, employees tend to get that coverage.
3 They also get typically some sort of preventive
4 benefit covered -- we'll talk a little bit in a minute about
5 the move from HMOs to PPOs -- but the Speaker was right.
6 It's kind of a mixed bag. What we find is what one company,
7 what one client of ours or what their insurance company might
8 define as good preventive care benefits versus another could
9 vary drastically.
10 We have some with very -- schedules of benefits
11 based on peoples' ages and the types of tests they have, and
12 then we have other clients who basically say, well, we'll
13 give you $300 each year towards preventive benefits. You
14 decide how you want to spend them. So although preventive
15 benefits seem to make sense to a lot of employers, they don't
16 know how to deliver the right kind of preventive benefits.
17 What employees would like beyond those is lower
18 cost. And I would say clearly the vast majority of our
19 clients each year, and certainly this year, are going to be
20 passing along larger cost increases for health care coverage
21 than they're going to be passing along salary increases.
22 So at the end of the day, a lot of our clients will
23 have employees whose payroll deduction for health care will
24 be greater than their increase in their salary. And what
25 happens is their take-home pay becomes less.

1 They also would like coverage for alternative
2 treatments. As you all know, there are more and more types
3 of treatments out there -- you know, acupuncture,
4 biofeedback, and all kinds of things that are on the horizon.
5 And employees are becoming more savvy. They are reading
6 the -- you know, they are going to the internet. They are
7 finding some of these kinds of treatments. They are making
8 suggestions that they would like to get those treatments
9 done.
10 Typically, though, the clients we have, the
11 companies we have, tend to rely on the insurance company, the
12 Blue Crosses, to set the standard as to what's covered and
13 what's not covered, what's considered valuable and reasonable
14 treatment and what's not. And that tends to lag from where
15 the marketplace is. So we have kind of a lag period, and as
16 employees find these kinds of information, they tend to get
17 pushed back from the plan still not covering them.
18 Administrative ease: Yes, we are getting close to
19 a world of having all this data pass electronically, but we
20 are not there yet. And it still does vary by each of the
21 claim intermediaries that exist. Some are better than
22 others. Some have spent more on technology and IT than
23 others. So it's still -- there are certainly still a lot of
24 employees out there who find, you know, working through the
25 health care system to still be an administrative nightmare.

1 And then finally, coverage after retirement. I
2 think the latest study showed that there's only 23 percent of
3 large employer who provide a retiree medical benefit for
4 retirees after the age of 65, which is a continuing and fast-
5 dwindling percentage of employers.
6 Employees recognize, I think, at this point that
7 that trend is not going to change or reverse. What we see
8 now from employers, though, is at least the understanding
9 that they've got to educate their employees that even though
10 they're not going to provide a benefit, that you're going to
11 need to save significant amounts of money during your active
12 life to have that money to supplement Medicare, even with the
13 possibility of prescription drug coverage, when you do
14 retire.
15 There's a great article in Fortune, I think it's
16 this week or last week, suggesting huge amounts of money that
17 need to be put away prior to age 65 that you would need to
18 have to cover those expenses as you go forward.
19 I also had some other statistics. This is from the
20 Robert Wood Johnson Foundation. Again, 43 -- I thought this
21 was interesting -- 43 percent of people that were polled said
22 they feared that their employer or their spouse's employer
23 might eliminate some health benefits within one year, some of
24 their benefits.
25 Twenty-one percent said they feared that out-of-

1 pocket expenses will increase to an unaffordable level, and
2 8 percent said that they fear that the company plan may just
3 go away in one year. So there's continued fear, there's
4 continued uncertainty, as to the role of whether the employer
5 is even going to provide a benefit in the near future.
6 I don't want to -- we can talk a little bit about
7 distortions. Again, I was very intrigued by what the Speaker
8 said. I think that there is a role for employers in this
9 process, although it does -- today, the way it's set up,
10 small employers clearly do not have the same size, the same
11 leverage in the marketplace as large employers to get the
12 kind of coverage they need.

And benefit levels, types of plans, those things,

1 We're hearing more and more of that from employers every day.
2 And again, I just wanted to put up this statistic
3 because I think it shows that the key problems that smaller
4 employers had -- and the Speaker made mention of this --
5 because of the risk pools and the abilities for these small
6 employers, employers that have 24 employees or less, you
7 know, what kind of health coverage can they get?
8 And you can see that if you take employers with
9 less than 25 lives, 40 percent of those employers do not
10 provide health coverage today. And what that means is that
11 the spouse's plan has to pay or these people may be going
12 uninsured, you know. But in any way, it exacerbates the
13 problem in the system.
14 What changes have there been? Clearly, there's
15 been a move away from the more tightly managed HMOs -- and
16 again, the Speaker was absolutely right, it wasn't managed
17 care, it was managed cost -- to more loosely managed PPOs,
18 which the employees embraced, getting away from the referral
19 mechanism and all the paperwork with that, was just something
20 that they were very much in favor of.
21 But what that led to is, it's led to more cost as
22 it's become a more unmanaged system. So what employers have
23 done, what our clients have done, is basically used -- you
24 know, the good message is, we're getting rid of your HMO and
25 we're putting in a PPO, which is less managed. The bad news

1 philosophically believe it's the right thing, but quite
2 frankly because they have no other option and they're
3 desperate. Okay?
4 They probably wouldn't know the underpinnings of
5 why consumer-driven plans actually work, but their CFO has
6 said, we have to cut cost. It is a new thing to try and they
7 don't have many other strategies. So I think you'll see a
8 great proliferation of consumer-driven plans.
9 Is it going? No, it's not. Okay. Here we go.
10 Actually, this is from the Washington Business Group on
11 Health and I just wanted to touch on some of the access to
12 health care information. Again, because we're running low on
13 time, I'm going to skip that. Helen can certainly talk about
14 that. I think they do a wonderful job.
15 The Speaker did talk a little bit about group
16 underwriting, about the fact that when you're in an
17 employment-based situation you're able to take all risk --
18 good risk, bad risk, whatever. Certainly, in the individual
19 market we've seen all kinds of issues with employees trying
20 to get coverage, questionnaires, you know, being selected
21 against, paying higher rates if they have certain medical
22 conditions, and then seeing the rates go up maybe on a
23 quarterly basis versus an annual basis. So clearly, the
24 individual market, unlike life insurance, is not anywhere
25 near as competitive as the group market.

1 And I think what I would do to summarize this,
2 because I don't want to -- I'd like to save time for some
3 questions and things -- is just to leave you with the fact
4 that employers out there are questioning their roles today.
5 They're not ready to give up the ship yet, but they recognize
6 that they can't continue to maintain the structure the way it
7 is.
8 And I think the structure today has a lot of
9 inherent problems with it. And if we don't do something
10 soon, I think you're going to see employers start to take
11 more drastic actions. Thank you.
12 DR. HYMAN: Next is Helen Darling from the
13 Washington Business Group on Health.
14 MS. DARLING: Thank you. Thank you for the
15 opportunity for the FTC and the Department of Justice taking
16 on these complex issues that have burdened the system since
[illegible] I'll sk2.92.92 with thts,

1 fact is very true, and especially what Michael was talking
2 about. Not just our data but his experience as well sounds
3 very familiar.
4 Also, you have researchers. Our very own David
5 Hyman and others like Judith Lave have done research. And
6 for those of us who are real benefits managers at heart or
7 have been at some other time, I think we are pleasantly
8 surprised to see repeated data of how much employees value
9 their benefits.
10 Because if you actually manage them, all you hear
11 about are the problems. Nobody says, yes, we really think
12 this is great. But interestingly, in the last five years,
13 thanks to the work of some really great health economists and
14 some survey researchers, we have seen evidence that employees
15 really do greatly value their health benefit. And we see
16 evidence, which again we didn't see till this past five
17 years, that employees actually are making decisions about
18 where they work, you know, relative to the benefits.
19 So if the economy turns around, health benefits
20 again could become a competitive advantage, which is one of
21 the things that had kind of gotten lost in the shuffle in the
22 last two years. I mean, things are just generally so bad out
23 there that, in fact, it's hard to sort out what's happening.
24 But if what we saw up until about two years ago is
25 true and the economy begins to pick up, then the companies

1 that offer these better -- as the Speaker said, better
2 quality and more choice at a lower cost, those initiatives
3 will become far more important.
4 What I would like to say is that employers are

1 obvious. And so people will say, well, I'd rather have the
2 $5 copay.
3 So we've got a lot of confusion out there. But
4 employers are trying to move us to more cost-sharing, and not
5 just in symbolic terms but real cost-sharing.
6 We did a survey of our own members recently about
7 what they had been doing in the last few years, and this
8 won't surprise anybody here. They are doing more cost-
9 sharing and generally feel that enough cost-sharing for the
10 consumer to have a financial stake is really essential, and
11 that coinsurance, not copayments -- many people that I talk
12 to and work with and our own members feel that going to
13 copayments to encourage people to join managed care
14 organizations, where the delivery system did the management,
15 was one thing. But copayments have really become the kiss of
16 death for much of what we're trying to do in this system now.
17 Once you have a wide-open system, which we
18 essentially have now -- I mean, even the PPOs are --
19 everything is wide open and the data show that -- then
20 copayments become truly absurd. So we're moving to
21 coinsurance across the board.
22 The second thing is that all of our members, our
23 large employers, believe and are working hard that consumer
24 involvement is essential. And if you've heard some -- and I
25 thought David's presentation was just superb on that point.

1 that's there, but we also have to make sure that people can
2 access it and know it's there, and you don't have to know the
3 system.
4 Again, David's point and others about transparency,
5 we believe that's essential. And we have a report out on the
6 table -- I hope you all have picked it up -- about
7 transparency and accountability. It's essential.
8 We also believe that in the short term, that it
9 would be very easy to require that all currently publicly
10 reported information, which is already -- all the battles
11 have been fought about whether these are the right measures
12 and all those, and they're imperfect, to be sure.
13 But they're already in the public domain because
14 they have to be reported to somebody, whether it's Medicare
15 or the state health department or, like in Texas, the
16 commission. If that information just has to be required to
17 be available on the website of every hospital, and in
18 libraries and things like that, so that people can get to it.
19 One of the things that we've found is it's very
20 difficult to measure or to get information on cost and
21 benefits because the data are limited. We also found that
22 disease and health management programs are growing and
23 there's a lot of reliance on those, but that's also another
24 area where we don't have a lot of information about what
25 works and what doesn't and what's effective. And are these

1 the money in, and that can go into retirement, if you want.
2 Essentially, it becomes the 401(k) of health accounts, with
3 portability and lot more flexibility.
4 These are times of great challenge. We are
5 struggling with health care cost increases five years in a
6 row, 50 percent, this year 14 percent. They say next year
7 it's probably another 14 percent on top of that.
8 Some people have raised a question about whether or
9 not employers will stay in this business. And we would say
10 that the likelihood is that they will stay in the business,
11 but the account and the allowance and the amount of money
12 they pay will grow more slowly than the cost of health care
13 will, and therefore the employees and their retirees will be
14 spending a lot more money.
15 There was a story in today's New York Times, if you
16 haven't seen it, an excellent story. It starts on the front
17 page, Milt Freudenheim, about how the coinsurance is, in
18 fact, beginning to have an effect. So maybe we'll see some
19 changes soon. Thank you.
20 DR. HYMAN: Dr. Comstock?
21 DR. COMSTOCK: Yes. Good morning. When you come
22 at this point in the panel, you have to throw out everything
23 you were already going to say because it's already been said.
24 But I'm not ever at a loss for words, so I'm going to pick up
25 a little bit on some of the things that David said. But

1 obviously, on your philosophy.

2 Another issue that's been talked about a great deal
3 this morning is information needs. There just is not enough
4 information out there for consumers. And I want to also
5 point out that we have to remember that at least 25 percent
6 of people in this country are medically illiterate, and they
7 are going to need a great deal of help, and that information
8 that is relevant and useful to a 45-year-old college
9 graduate, woman college graduate, may not be at all useful to
10 a 20-year-old Hispanic mother of three who doesn't speak
11 English. And so we have to remember that there's got to be
12 ways of getting information to people that is useful and
13 meaningful.

14 I really want to -- what I would like to talk about
15 a little bit is a project that is related to this in the
16 sense that we have had strong validation that this is a real
17 movement that is not the final form of health care, but it is
18 a major move in the right direction.

19 Wye River has been involved in the past year in a
project where we have gone around the country to ten

1 Institute, Senator Lieberman's office, and so on. So it's a,
2 you know, bipartisan, multi-stakeholder initiative to talk
3 about the values and principles that should drive health
4 policy. David Lansky participated in our Portland meeting.
5 The first thing I want to -- the first comment I
6 want to make about that is that there's much more agreement
7 than difference when you get out of Washington and you get
8 into communities. These leaders really want to roll their
9 sleeves up and work together to move this health care system
10 in the right direction.
11 There is broad support from liberals and
12 conservatives toward a patient-directed health care system.
13 But there are some caveats. From the perspective of the
14 liberal, they'll say, that's all well and good to talk about
15 personal responsibility. But remember that 25 percent who
16 need extra help. And also, it only is going to work if it
17 comes with system accountability, telling the patient you've
18 got to take care of yourself and you've got to be responsible
19 for your health behaviors. So that's very, very important.
20 The other thing that's very, very heartening to me
21 is that the most conservative elements in the meetings are
22 saying that the world's richest country cannot afford to have
23 40 million people in this country who do not have access to
24 health care. And, of course, we all know insurance doesn't
25 equal access, and getting care in the emergency room doesn't

1 equal coverage. So this has to be balanced.

2 We also have heard in our meetings at every single

3 community across the country that if there's one thing that

4 we need to do, we need to start a dialogue that we've never

5 had in this country. And that is, what is it we want from

6 our health and health care system? We haven't even defined

7 health and health care. And how do we talk about whether

8 we're spending too much or too little or what kind of system

9 we should have when we don't know what we want out of the

10 system? So that's something that they feel very strongly.

And as we move forward into phase twoe

1 take responsibility, for providers to educate patients, and
2 to provide preventive care services? Because all of the
3 dollars being spent on end-of-life care or unnecessary
technology could do an awful lot. And that's why I

1 these rural areas, whether it's through community health
2 workers or lay educators. And this is kind of like, it's
3 very low tech but it's high touch, and people love it. And
we need to build that into wor Tuwe're29eat il8025

1 coverage. And so the focus of where I'm going to be looking
2 at is the federal and state regulations in the small group
3 and individual market.
4 The individual market, which accounts for about 10
5 percent of private coverage, is primarily regulated by the
6 states, while the small group market, which accounts for
7 about 25 percent of private coverage, is regulated by both
8 the state and the federal government.
9 Given these different regulatory environments, we
10 have guaranteed issue imposed by the states in certain
11 individual markets while guaranteed issue is opposed across
12 the board by the federal government on the entire small group
13 market?
14 First of all, what is guaranteed issue? Guaranteed
15 issue is a law that requires insurers to accept everyone who
16 applies for health insurance, regardless of their health
17 condition. Under guaranteed issue, an individual who has no
18 health insurance and becomes ill may apply for private
19 insurance coverage and must be accepted. This is comparable
20 to allowing a person to purchase auto insurance for their
21 accident after being involved in a car wreck.
22 When people know they can get insurance when
23 they're sick, they'll forego it when they're healthy.
24 Younger and healthier people cancel their policies. The
25 health insurance pool gets smaller and sicker. Escalating

1 premiums occur, and eventually the pool is left with just the
2 sickest and most -- and people with the most expensive health
3 care needs.
4 We eventually reach a point where many insurers are
5 no longer able to offer a product under such chaotic
6 conditions. The end results are: inordinately high prices
7 for insurance; considerably reduced choices for coverage; a
8 greater number of uninsured; and ultimately, a health
9 insurance market where few, if any, insurers are offering
10 coverage.
11 I want to look at both the states' individual

1 carriers are exiting the market in droves. The General
2 Accounting Office recently completed a study that showed a
3 disturbing market concentration in the small group market,
4 with the top five carriers controlling more than 75 percent
5 of the market share in the majority of the states that the
6 GAO studied.
7 Healthier groups are dropping coverage because of
8 escalating prices. For example, in Colorado, the state
9 division of insurance has reported a loss of 14,663 small
10 groups, covering more than 125,000 individuals, in just the
11 last two years. The state attributes much of this problem
12 due to the guaranteed issue requirements in the small group
13 market. Healthier groups are just leaving.
14 While the increases in health insurance costs and
15 the loss observe coverage options do not occur in a vacuum,
16 guaranteed issue is the one regulation where you can see the
17 distinct impact on the cost and availability of coverage.
18 Given that guaranteed issue is nationwide in the
19 small group market and limited only to certain states in the
20 individual market, guaranteed issue is one of the
21 contributing reasons why the small group market is more
22 expensive than the individual market.
23 Contrary to popular conception, the small group
24 market is, on average, much more expensive than the
25 individual market. For example, even though coverage is not

1 quite as comprehensive always in the individual market as it
2 is in the employer-based market, policies sold through e-
3 health insurance are on average 25 percent higher for small
4 business members than they are for individual members, and
5 this is done in a state-by-state comparison.
6 So we get into a tricky situation. Results show
7 that if you make insurance available to everyone, it's simply
8 not going to be affordable. And if you make it widely
9 affordable, it's not going to be available to absolutely
10 everyone.
11 So if we want affordable and accessible policies,
12 instead of regulating 100 percent of the market, regulations
13 or programs should be designed to address the 1 to 2 percent
14 that cannot obtain coverage. For example, high risk pools
15 are such programs that allow the market to work for the 98
16 percent of the population who can obtain coverage while
17 providing a strong and viable safety net to cover the sick.
18 States with the least regulatory burden
19 successfully rely on high risk pools to cover their
20 uninsurables, and have affordable health insurance for the
21 rest of the population.
22 Since the effects of guaranteed issue, regulations
23 on the cost and availability of coverage can be pronounced
24 and identified. These regulations can often be repealed.
25 For example, on the state level, Kentucky, Washington, and

1 New Hampshire repealed their guaranteed issue laws recently
2 after these laws caused a complete dearth of health insurance
3 options in their states.
4 With the deteriorating state of the small group
5 market, Congressman Mike Pence is planning on introducing
6 legislation to repeal guaranteed issue in the small group
7 market.
8 The clearcut effects of guaranteed issue on
9 competition, price, and availability of coverage should be
10 helpful to policy-makers as they revise these laws, and I
11 hope that this examination is helpful to the participants in
12 this room as we look at the effects of regulation and
13 competition in our health care marketplace. Thank you.
14 DR. HYMAN: Thank you. Well, everybody has done a
15 great job of staying on time. You're all very public
16 spirited. And so we've got about 20 to 25 minutes left to
17 have a panel discussion about these various presentations.
18 Let me just start, and people can feel free to ask
19 questions themselves of other panelists if they want. But
20 I'll exercise the speaker's privilege of filling the
21 uncomfortable silence that might otherwise result if I just
22 threw it out at the start and just ask the following
23 question.
24 There's been a lot of discussion today and in past
25 hearings about the extraordinary saliency when it's time to

1 actually receive health care of the need for information, of
2 picking the right provider, of deciding whether the
3 recommendations that you're getting are sensible ones, and
4 the difficulties of obtaining information about that.
5 But the options that you have and who you get to
6 see are tremendously influenced by the nature of your
7 coverage. And the saliency of the coverage tradeoffs, it
8 seems to me, is a different matter entirely.
9 So I guess the question I would ask is how do you
10 make the coverage tradeoffs more salient to people? Is
11 consumer-directed health care a way of finessing that by
12 putting the burden on the patient to make those decisions at
13 the time they receive care? And is it really realistic to
14 expect people to pay close attention to their health
15 insurance when they only get to choose once a year and it's
16 aggregated for them, for many people, by employers? So
17 that's, I think, a range of questions we can start with.
18 Helen?
19 MS. DARLING: Well, I'd like to take that one on.
20 Actually, I'd like to take on your assumption.
21 DR. HYMAN: Go right ahead. Then it's a really
22 good question.
23 MS. DARLING: Yes. Because actually, most people
24 have choice. I mean, if you look at the numbers of -- you
25 know, you look at visits by coverage, between the fact that

1 decisions actually at the very time. Same thing in the
2 pharmaceutical business. I mean, if at the point of
3 purchasing something you have coinsurance and you make that
4 decision, as opposed to later on getting a bill for whatever
5 it is, you're not really going to drive good decision-making.
6 A couple thoughts. One, when people are really
7 sick, that is the great equalizer of everything. They
8 want -- they're not in a position, really, to make major
9 decisions. But assuming that you have some kind of a
10 consumer-directed plan where you have a high deductible
11 policy that's pretty broad and that you can basically go to
12 whomever you really want, the decision-making, as you say,
13 it's really around -- you're trying to drive the decision-
14 making toward that discretionary kind of care, not toward
15 those critical kinds of things.
16 And the other thing that I find quite interesting
17 is that almost by definition, quality is incompatible with

1 of care.
2 MR. YOUNG: No, I agree. I mean, I think we have
3 to be careful, though, and make sure we understand that there
4 are kind of exceptions to every situation.
5 And just as we have exceptions to the fact that not
6 everybody is going to be able to use the same level of health
7 care information, the other exception is that under the
8 current system, there is a need for, in the employer
9 marketplace, a claim intermediary, whether it's a Blue Cross
10 or an insurance company, but some sort of claim intermediary,
11 whether it's an insured plan or a self-insured plan.
12 And most employees -- most employers are relying on
13 that claim intermediary to not just process claims, but to
14 contract with providers and to provide information to the
15 employees and do all those things. And what happens is then
16 the employee is kind of held to whatever that claim
17 intermediary can provide.
18 And we have -- and I know you talked about this in
19 prior sessions -- but we have areas of this country, fairly
20 large areas of this country, where one claim intermediary has
21 a stranglehold on that geographic market because the network
22 discounts they have with their providers are so great
23 compared to everyone else that it precludes any type of --
24 any other claim intermediary or any managed care
25 organization, whatever you want to call them, coming into the

1 marketplace.

2 And if that claim intermediary says, I don't
3 believe in consumer-driven plans; I don't believe, you know,
4 in providing quality health care information to employees,
5 then you're stuck unless the employer circumvents the whole
6 system and overlays something on top of it, which large
7 employers may be inclined to do but small employers won't.

8 So, you know, there are a number of claim
9 intermediaries, without taking shots, that really have a lot
10 vested in keeping the status quo, you know. And so you can
11 talk all -- you know, consumer-driven will work for 60, 70
12 percent of the market, but 30 or 40 percent of the market
13 will not have access to it for a number of years, not from
14 their own choosing.

15 DR. HYMAN: Well, you'll be pleased to know that
16 the claim intermediaries were in here complaining about the
17 providers insisting that the status quo is preferable. So
18 there's a high degree of finger-pointing, certainly, in this
19 industry.

20 MS. DARLING: Everybody is a vested interest,
21 almost, I think.

22 DR. HYMAN: David?

23 DR. LANSKY: Another angle on the same issue. I
24 think this transition, the bridge between the coverage and
25 the care, that creates this tension.

1 I think an interesting thing is going on where
2 those who are -- whether it's the intermediary or the payor
3 is creating transparency around the criteria of network
4 participation. So Leapfrog, I think, was an example where
5 they were trying to say you -- in theory, Leapfrog said, we,
6 the purchaser, will continue to do business with you, the
7 plan, if you in turn prefer -- do preferential business with
8 high safety institutions that adopt certain practices.
9 And they supported that, with an employee education
10 program to help the employee recognize, here's where care is
11 superior. And I'm part of a chain of relationships with my
12 employer, with the plan, and in a sense with Leapfrog as a
13 policy organization, that is trying to help me seek out and
14 get the safer quality care.
15 I think there's a series of initiatives in which
16 the payor or the intermediary can either give visibility to
17 or money to entities which adopt elements of superior care.
18 And so whether it's transparency or pay for performance,
19 either way it's a way to try to make the system work better
20 without directly managing care with a heavy hand.
21 DR. COMSTOCK: Actually, that just reminded me of
22 something I wanted to say earlier that the Speaker talked
23 about, and that is, whose job is it and on whom should we
24 rely to make certain that data are standardized and things
25 like that?

1 And I would be very concerned if that became a
2 governmental role, except as a purchaser. And to the extent
3 that CMS and other powerful buyers in the system as a
4 purchaser, as a condition of participation, insist on
5 information being collected and analyzed and everything done
6 in a standardized way, that's terrific.
7 But the organization or organizations that decide
8 what those measures are going to be, I believe, has to be
9 outside of government, and for a couple of reasons. First,
10 there's no evidence that the government -- the government has
11 actually essentially owned the health system about 40 to 50
12 percent since 1965. They have enormous power. They have
13 never used it for those purposes. So counting on them at
14 this point to be our guide in that regard is not a good idea.
15 It's certainly not going to get us anything before I'm dead
16 in my grave, I'm sure.
17 The second thing is that a lot of these things, as
18 David knows because his foundation has done a lot of work and
19 I've been involved with NCQA's committee on performance
20 measurement, that you need a lot of people sitting around a
21 table working as fast as possible with a nimble approach to
22 it to get these things right and to keep making them better
23 and better.
24 And when you have new information, you do a pilot.
25 You can -- you know, FACCT and other organizations can

1 decide, okay, it's not going to be this. We just found this
2 doesn't work out in Colorado, and so we're not going to do
3 it.
4 So having the organizations, whatever -- you know,
5 the private sector arm and how they're put together is less
6 important than there are people who have that as their
7 responsibility, organizations. They know what they're doing.
8 They're able and willing to test. They're able and willing
9 to bring from the best and the brightest whatever the issue
10 might be, come up with the best measures, pilot them, test
11 them, fine-tune them, and then they can be picked up by the
12 larger purchasers, including the government and be driven
13 that way. But if we try to put it in the government, it just
14 won't happen with the kind of speed. The other thing is that
15 once it gets in the government, it is so vulnerable to
16 pressures from narrow special interests who have no interest
17 in seeing progress in these areas.
18 DR. HYMAN: David?
19 DR. GREENBERG: All right. Let's take the
20 government out of that for a little bit and put it in the
21 third party payor. And I remember when we used to have HMOs,
22 and I remember when women on normal deliveries used to be in
23 the hospital for four and five days, and people having
24 surgery used to come one or two nights before, and stayed for
25 much longer than they are now.

1 That wasn't my doing as a consumer or patient, or
2 the person next door's doing as a consumer or patient. I
3 don't really know how long a person has to be in the hospital
4 after a normal delivery, after a certain kind of surgery.
5 How many days, really, does that person have to be there
6 before the actual surgery?
7 That was done by a third party payor who has
8 thousands and thousands of patients, perhaps experts on the
9 team, who could make such decisions, provide information to
10 that patient. Gee, a normal delivery, two days may be
11 enough.
12 Okay. We can always debate that the managed care
13 firms overstep their bounds, that they have other incentives
14 to contain cost and only those incentives. But I would
15 maintain that I just can't do it. I can't do it as a patient
16 right there before the surgery in the hospital, even a couple
17 days before the surgery.
18 And we have these experts as managed care firms. I
19 still come back to perhaps my earlier point: Without the
20 government interference, Helen, let's have those third
21 parties -- when we pick them on a yearly basis, we decide
22 ourselves, based on a variety of information, brand name,
23 signaling, however you want to deal with it, the same way we
24 pick automobiles and other difficult -- we have so many
25 difficult products that we buy today, cell phones, whatever.

1 Somehow, the market works, a little bit imperfectly, but the
2 market works.
3 In the comfort of our living room, picking a health
4 care plan based on price, quality, brand name, signaling --
5 and I think that's the best we could do. I mean, you could
6 find things on the Web that says, this cures cancer, and go
7 another website and it says, this does not cure cancer.
8 DR. HYMAN: And we do enforcement on some of the
9 first category for fraud.
10 DR. GREENBERG: But anyway, I go back to the
11 comfort of the living room, deciding on the third party plan,
12 and creating incentives for those third parties to provide
13 health care cost containment as well as quality of care.
14 DR. HYMAN: Let me follow up on a point that got
15 made earlier and see if we can push this in a slightly
16 different direction because we could use all of our time just
17 to talk on this one.
18 On the issue of quality, David asked the Speaker a
19 question that I thought was quite insightful, which was, you
20 know, there's -- basically, do you fragment or do you
21 aggregate? And there are virtues and costs with both of
22 those strategies.
23 Aggregation allows you to sort of leverage your
24 purchasing power for both price and quality, if you choose.
25 And I guess the challenge is how do we think about these new

1 arrangements for benefit design in the context of trying to
2 deal with the problems of integration and quality? And given
3 the information that we have, how confident can we be that
4 this is going to head off in the right direction?
5 MS. DARLING: I'm not sure I understand the
6 question.
7 DR. HYMAN: All right. I didn't ask it very well,
8 then. Do we -- when we disaggregate purchasing pools by
9 essentially open-ended choice and by allowing people to make
10 their own decisions as to who they go to and how much to pay,
11 it makes it much harder for employers to do things like
12 Leapfrog because they can't selectively contract, okay,
13 unless you're going to do it with everyone, and to impose
14 minimum quality standards.
15 So I guess I'm really just trying to put a sharper
16 point on David's question.
17 MS. DARLING: Well, but they could -- you can do it
18 two ways. You can give people lots of choice at the point of
19 care but still have a plan who administers.
20 The other thing is that you could provide
21 information that's especially penetrating and useful about
22 the providers. And you are allowing the employee or their
23 dependents or their retirees to choose, but with information,
24 just as they do now -- again, David's example. They suddenly
25 have information about different hospitals.

1 Your pressure comes from -- and by the way, I've
2 actually seen this happen. The pressure comes from the fact
3 that the hospital goes on whatever it is, the website or
whatever's pubc, therr3ebsite or

1 better providers, which in most cases probably has very
2 little to do with quality and has a lot more to do with the
3 contracting, you know, possibility of contracting between
4 that provider and that claim intermediary.
5 So you have to be very careful. I mean, there are
6 many times -- and this is where I think we have to have
7 pressure on -- and I keep coming back to these claim
8 intermediaries -- to if they're going to contract, if we're
9 going to have a structure where somebody is buying services
10 at a unit price discount, that some of -- that the criteria
11 for making the decisions of who those networks are has to
12 much more involve quality.
13 DR. COMSTOCK: I mean, that's all true. Just a
14 couple issues. One is we all know that the vast majority of
15 health care has not definitive best practice. I mean, so
16 much of what is done in health care does not have an
17 absolute, this is the right thing and the wrong thing.
18 Yes, if you have colon cancer, you need surgery,
19 whether to cure it or to keep you from being obstructed. But
20 for many other things, there is no definitive answer. The
21 real issue is: is the physician engaging with the patient in
22 a shared decision-making process around their values and
23 what's important for them?
24 But I wanted to make the comment -- you know, you
25 said the hospitals will respond to information. I know one

1 of our supporting organizations is Jack Wennburg's group up
2 at Dartmouth. And they've done some wonderful work that
3 showed that, you know, physicians don't like to be measured a
4 whole lot. But they have a way of doing it that's
5 collaborative and collegial.
6 And what they do, for example, in the northern New
7 England cardiovascular disease project is physicians looked
8 at each others' processes of care and they began talking
9 about what did they do and what results did they get. And
10 they immediately responded. Nobody had to hit them over the
11 head with it.
12 So I think that getting back to the importance of
13 culture when it comes to any of these things related, you
14 know, to delivery changes. You've got to recognize the
15 culture. The hammer over the head doesn't work well with
16 physicians but other kinds of methodologies do work well with
17 physicians. So it's just a little bit of a flip side.
18 And then I just think we just have to remember that
19 quality metrics are great, but there's only so many things
20 that you can measure definitively.
21 I thought your question to Newt was different. I
22 thought -- was it different? Was your question --
23 MR. LANSKY: It was a very subtle question. Go
24 ahead. I'd like to her your interpretation.
25 DR. COMSTOCK: I thought you were asking a very,

1 very different question about is it more appropriate when

2 you're looking at quality: to look at quality of the entire

1 talking about today may go in a different direction and also
2 create a technical problem that measurement becomes very
3 difficult if we fragment. And then access to information
4 becomes very difficult if we have a high fragmented system.
5 So I was concerned about both impulses.
6 I wanted to answer your question as well, David, or
7 start a piece of it. I think most of us in this field have
8 been fairly naive about thinking about the solutions, and we
9 need a new way of thinking that is more subtle.
10 We've got a system we're talking about here in a
11 room among ourselves that accounts for a sixth of the
12 national economy, millions and millions of peoples'
13 livelihoods, enormously complex. It's not a -- we use words
14 like system and managed care and chronic diseases if we're
15 talking about a thing that we can implement to address. And
16 we just can't.
17 So we have to -- we need some other way of
18 recognizing that it's a very layered problem. I think it is
19 more achievable for federal agencies, the regulatory process,
20 the legislative process, to deal with what we would call
21 infrastructure, making sure that the highways are there and
22 the railroad tracks are the right gauge and that the
23 underlying structure is in place that would permit us to do
24 all the things we've talked about today, without yet saying
25 what those things are.

1 And we've gotten all of us a little bit ahead of
2 ourselves in some of the work we've done the last ten years,
3 fifteen years, in thinking we knew what some of the solutions
4 were rather than building pipes and paving roads that would
5 let us at least drive around a little bit without saying
6 where we drive or what kind of cars we drive in.
7 So I would encourage you -- and I think the
8 SEC/FASB model that was talked about a lot ten years ago and
9 underlay the President's advisory commission report but was
10 never implemented remains a very important model to think
11 about carefully.
12 In Helen's point, you know, what does the FASB part
13 of that need to look like, in which you have an open dialogue
14 with private sector interests, very involved? And what does
15 the heavy hand of government need to look like, which asserts
specific requirements upon the entire regulated industry,

1 system.

2 FEHB, for example, still has 70 percent of the
3 employees in fee-for-service models. Therefore, in a sense,
4 those who choose the managed care models or the managed care
5 plans are punished for participating in NCQA and in doing the
6 right things.

7 So I think there has to be some government
8 standard-setting to ensure full participation and that the
9 public really has meaningful information to make decisions.
10 But where to draw that line is just a very difficult problem.

11 DR. HYMAN: Let me follow up on that point because
12 so far we've talked about information at great length. We've
13 talked about government purchasing a little bit. But we
14 haven't talked about what David nicely called the heavy hand
15 of government, the regulation, direct regulation. And to the
16 extent we have, it's been concerns expressed about guaranteed
17 issue, concerns expressed about the tax treatment.

18 And let me use as a springboard David's slide that
19 you showed about the number of institutions in New York state
20 that performed more than a minimum number of a particular
21 procedure. And it really doesn't matter which procedure; you
22 see the same patterns in every state and for every procedure.

23 So the question is, is there a role for government
24 directly in dealing with that? Is that a health planning
25 sort of thing? Is that, you can't do this procedure unless

1 you have a minimum amount? Or do we want to instead
2 designate centers of excellence? And how do we guard against
3 the kinds of risks that Greg has talked about in the context
4 of guaranteed issue?
5 MS. DARLING: Well, I'll be happy to jump in on
6 that. A couple of things. The first study I did at the
7 Institute of Medicine was of the health planning certificate
8 of need program some years ago, and I can tell you that when
9 we were done, that even the most liberal people on the
10 committee that love that stuff and believe in it in their
11 souls concluded that it will never work in this country for a
12 whole bunch of reasons, which I could do a whole session on.
13 DR. HYMAN: We'll have you back.
14 MS. DARLING: Yes. Okay. But that was actually
15 when it was a lot easier. I mean, we were smaller by quite a
16 bit. We had a lot fewer hospitals. We had relatively few
17 surgery centers. And even at that, it just was -- and
18 actually, there was more of a belief in those days that the
19 government had a role.
20 We had PRSO programs developed. You know, there
21 was a lot going on. A lot of people even thought we had
22 national health insurance around the corner. So it was a
23 very different era. But even then, with everything much more
24 compatible with the concept, it was generally an utter
25 failure, and actually left a lot of people really turned off

1 at the idea for the next 20 years.

2 Somehow, the government can play a role that is
3 both a combination of a carrot and standard-setting at a
4 minimum, but the concern is that it will always be the least
5 common denominator. If you look at every other program like
6 it and everything that's been done -- and I was a senate
7 staffer for a while, and among other things, I dealt with all
8 these issues from a senator's office.

9 And there's just nothing like getting 500 letters
10 from all the old ladies in a small town about a doctor who
11 has been demonstrated to have been absolutely fraudulent,
12 doing terrible things like, you know, charging Medicare for
13 30 colonoscopies a day or something like that -- I mean,
14 blatant, blatant, blatant fraud and errors, and yet the town
15 loved him.

16 So that's when you've got all the evidence.
17 Ninety-nine percent of the time, you don't have that much
18 evidence, and there are all these grey areas. And the second
19 you have grey areas, then as long as the government is doing
20 it, there will be somebody who says, you can't have the heavy
21 hand of government doing this, so a lot of really bad things
22 happen.

23 DR. GREENBERG: At the same time, David, I think
24 there may be a role, a continued role, for the FTC, is when
25 the private sector tries to regulate itself. The AMA in the

1 early '70s and prior to that refused to allow physicians to
2 advertise or disseminate information, and in fact the FTC did
3 bring a case against the AMA, went to the Supreme Court, and
4 the FTC won that case, which submitted that the physicians
5 should be able to advertise.

6 We have something called the Joint Commission on
7 Accreditation of Health care Organizations. I submit this
8 would be another avenue for the FTC to go into. This Joint
9 Commission has acted like a cartel against hospital
10 dissemination of real information on hospitals for as long as
11 its existence, and should go after these people.

12 There have been other sorts of professional groups
13 that perhaps the FTC ought to do something as far as its
14 Section 5, Federal Trade Commission Act. So this might be a
15 role for government because those -- maybe some of these
16 accrediting medical schools or whatever might be examined by
17 the FTC.

18 DR. HYMAN: Greg, you haven't spoken yet.

19 MR. KELLY: Yes. Just that separately on what you
20 were mentioning a little bit earlier, as the Speaker brought
21 up, regulation sometimes is needed. When he goes into
22 McDonald's, he wants to make sure that he is ordering beef.
23 And it's up to the private market to decide how best to
24 deliver that. So some regulation is, of course, needed.

25 And going back to guaranteed issue, if you actually

1 standards, they are far too low, and frequently the voluntary
2 are higher -- you need both. I'm not saying you shouldn't
have government doing a certain thing. You need the

1 taken us past our authorized time.
2 We're going to reconvene at 2:00, when we'll be
3 discussing information and advertising.
4 (Whereupon, at 12:30 p.m., the hearing was
5 concluded.)
6 * * * * *
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

1 consumers. And we'd like to see how that information is used
2 by consumers and how it's interpreted.
3 We've already had some hearings on how consumers
4 receive and evaluate the information, and I would commend
5 that testimony to you. It's available on the FTC's website,
6 which is www.ftc.gov.
7 So after that incredibly long setup, I'd like to
8 introduce the panel very briefly and encourage you to pick up
9 the more complete booklet that has the bios of all of the
10 panelists. I'm going to keep this very, very short in the
11 interest of moving things along so that we'll have sufficient
12 time to have a really ample discussion of these issues.
13 I'd like to also ask you all if you would please
14 turn off your cell phones because I'm sure someone is going
15 to be saying something incredibly brilliant and I don't want
16 them to be distracted by anybody's cell phone ringing.
17 I'll introduce the speakers in the order of their
18 presentations. After the presentations go on, we'll take a
19 short break and then at the conclusion of the testimony will
20 have a panel discussion. Everyone will come to the front and
21 we'll be able to have a little bit of a dialogue.
22 First of all, we're going to have Bernie Dana, who
23 has come all the way in from Ohio. I think he's one of the
24 farthest fliers in today. He's an assistant professor of
25 business at Evangel University in Springfield -- I'm sorry,

1 Springfield, Missouri. Sorry about that.

2 Second of all, we'll have Laura Carabello, who is

3 with CPRi Communications.

4 Following that will be Dr. Thomas Henry Lee of

5 Partners Health care.

6 Following that will be Dr. Douglas Koch, who's come

7 up from Baylor College of Medicine.

8 After that, the shortest trip was made by Richard

1 MR. DANA: Well, as was mentioned, my name is
2 Bernie Dana. I chair the American Health Care Association's
3 quality improvement subcommittee. And I'm representing AHCA
4 today.
5 I'm also, as was stated, an assistant professor of
6 business at Evangel University in Springfield, Missouri. And
7 prior to joining the faculty there two years ago, I spent 28
8 years as a corporate leader and consultant in all segments of
9 the long-term care industry, both nonprofit and for-profit
10 organizations.
11 Equally important to me, and I hope to others, is
12 the fact that I am also a consumer of long-term care
13 services. And I'll be explaining that a little bit later.
14 When we talk about long-term care, we're talking
15 about a dynamic, diverse, and evolving sector of our nation's
16 health care system that refers to many settings, not just
17 institutional settings like nursing homes and assisted living
18 facilities. Yesterday you heard from our sister
19 organization, the National Center for Assisted Living. Today
20 I will focus our nation's system on skilled nursing services.
21 The American Health Care Association represents
22 approximately 11,000 long-term care facilities of both
23 nonprofit and for-profit ownership. Many of these facilities
24 are providing multiple types of services, from post-acute
25 services to special care units for those suffering from

1 Alzheimer's disease and related dementia.
2 Also, our membership includes a very specialized
3 area of long-term care that provides services to persons with
4 mental retardation and developmental disabilities, called
5 immediate care facilities and group residences.
6 Let's talk a little bit about our customers.
7 Nursing home care is something that most of us are likely to
8 deal with at some point in our lives, but is not a service
9 that very many of us are actively seeking either for
10 ourselves or for any of our loved ones. As a result, many
11 consumers end up not being very educated about the complex
12 issues of long-term care until they actually or suddenly need
13 that service.
14 Now, this was the case for my siblings and me when
15 we were advised that our mother, at age 89, was going to be
16 needing to transfer to a nursing home after a short stay in
17 the hospital. I was miles away in Nebraska at that time, and
18 my sister and my father in Ohio went through two days of
19 unbelievable pressure trying to navigate all of the admission
20 process and choose an appropriate nursing facility.
21 Our consumers do expect long-term care services to
22 continue to evolve and diversify. And we can look forward to
23 even more segmentation of the long-term care marketplace than
24 has already happened simply because our primary customers,
25 the residents and their families, want and demand more

1 spectrum.

2 Even though many states have continued policies
3 that limit the growth of nursing home services, the growth in
4 alternatives over the past ten years has reduced the demand
5 for nursing home services. And that lower demand for nursing
6 home services has reduced occupancy rates, and in many cases,
7 prompting nursing home providers to actively compete for
8 residents.

9 Even within the prevailing paradigm of regulatory
10 compliance, the increased competition has brought a renewed
11 interest in the expectations of the customers and in
12 providing value-added services to them. The lower occupancy
13 rates are once again giving consumers a choice in selecting
14 where they will receive nursing home services when they need
15 it.

16 Another important factor in consumer choice for
17 nursing homes relates to their ability to pay. Medicare and
18 Medicaid programs have become important resources to assist
19 nursing home residents with payment for their care. Medicaid
20 is a state-administered and federally-supplemented program
21 for the poor who can't pay for their own care and have very
22 limited resources. Medicare is a federal health insurance
23 program for people age 65 and over.

24 It's important to note that in both of these
25 programs, they determine the rate that they will pay the

1 nursing home for the services being provided. The Medicaid
2 rate is usually significantly less than the rates charged to
3 people who pay from their own resources, and in some cases
4 even less than the cost of providing the care.
5 At any one time, approximately 65 percent of the
6 nursing home residents in the United States qualify for
7 Medicaid assistance, and approximately 10 percent of nursing
8 home residents are receiving Medicare assistance. The
9 remaining residents pay from their own financial resources,
10 and a small percentage of residents -- and it's growing --
11 are covered by long-term care insurance.
12 Now, even though the Medicaid and Medicare programs
13 provide payment assistance to many residents, and they also
14 set extensive standards for providers' participation, it is
15 the customers -- again, the families and the resident, both
16 prospective and current, who choose where to receive those
17 services.
18 How are consumers informed about these services?
19 In addition to having a choice of where to go, consumers need
20 appropriate information to make the best choice related to
21 their wants and needs. Nursing home consumers rely on a
22 variety of sources of information.
23 Most nursing facilities do not spend large amounts
24 of resources to mass promote their services. Many rely on a
25 simple brochure, a Yellow Page advertisement, limited media

1 advertising, a website, and a direct mail newsletter to
2 supplement their efforts to reach potential customers through
3 staff visits with referral agents such as physicians,
4 hospital discharge planners, and social workers for
5 congregate living facilities. They also rely on positive
6 interaction with staff, residents, and families to promote
7 word-of-mouth advertising.
8 Most potential customers will visit a facility or
9 personally observe and learn about the environment of
10 services from a facility staff. Many states severely limit
11 the amount of advertising costs that can be included in a
12 Medicaid cost report from which Medicaid rates are
13 determined. Because of that, many will only allow
14 informational advertisements.
15 Print or media ads usually include the facility's
16 licensure level and may list some of the services or special
17 features of the facility. Few if any facilities make quality
18 claims other than to announce the winning of a quality award
19 or perhaps provide a testimonial from a resident or family
20 member.
21 The American Health Care Association provides free
22 pamphlets for consumers through a toll-free call-in line and
23 the web. And many nursing facilities provide these or
24 similar tools to help educate and clear up common
25 misconceptions.

1 decision-making. As a component of the Nursing Home Quality
2 initiative, which was launched this last year, the site now
3 includes the quarterly reporting of eight standardized
4 quality measures that are intended to provide meaningful
5 insight into nursing care outcomes.
6 Unfortunately, many of the quality measures are
7 flawed in their construction or they simply report
8 demographic characteristics of a nursing home's residents.
9 The measures do little to reflect the respect,
10 responsiveness, living environment, and quality of life that
11 really make a difference in the satisfaction level of nursing
12 home residents and their families. As a result, the
13 information has dubious value in enabling consumers to
14 actually compare and choose a nursing home.
15 I know this to be true from personal experience.
16 There are three nursing homes in the community where my
17 mother needed care six years ago before she passed away. We
18 picked the nursing home that had the fewest deficiencies at
19 their last inspection. In fact, they had zero deficiencies.
20 After Mom was in the nursing home for a week, my
21 sister called me in Nebraska and asked me to come to Ohio
22 because she was upset with the way Mom was being treated. I
23 flew to Ohio immediately, and after all, I, being the
24 executive vice president of a company that owned and operated
25 32 nursing homes in a five-state region, was the expert in

1 nursing home care for our family.

2 I was appalled and frustrated at the lack of
3 consideration of my mother's needs and preferences simply
4 because of the operating policies. This facility was
5 compliant with the regulations but they didn't listen to the
6 customer very well.

7 What are the solutions? Most consumers don't want
8 confusing clinical statistics or deficiency information.
9 They simply want to know which facilities have the most
10 satisfied residents and families. Until recently, this kind
11 of information has only been available anecdotally.

12 In the last six years, several long-term care
13 provider associations have taken the initiative to
14 quantitatively measure, compile, and publish satisfaction-
15 based information. For example, the three trade associations
16 that represent nursing homes in Michigan have collaborated to
17 both publish and present on the internet a consumer guide to
18 nursing homes.

19 This consumer guide is published every two years
20 and reports the number of inspection citations for each
21 facility, but most importantly, it presents the percentage of
22 families that are satisfied with the facility's services and
23 the percentage that are willing to recommend the facility to
24 others.

25 The American Health Care Association affiliate in

1 West Virginia publishes a similar consumer guide annually,
2 with the same kind of issues addressed. But they have also
3 added to the report, to the consumer guide, the percentage of
4 staff members who are satisfied with the facility as a good
5 place to work.
6 The various trade associations in Ohio have
7 collaborated with the state health department there to
8 require nursing homes to participate in collecting and
9 reporting on a state-funded website the results of family and
10 resident satisfaction surveys that measure all aspects of the
11 services in addition to overall satisfaction.
12 My dad's nursing home is in Ohio. Of the three
13 facilities in his community, his nursing home has the worst
14 record on the Nursing Home Compare website, but by far the
15 highest family satisfaction rating in Ohio's new consumer
16 guide web report. Interestingly, the nursing home that my
17 mom was in had the lowest family satisfaction rating, despite
18 having the fewest inspection issues.
19 When given a choice, consumers clearly prefer the
20 satisfaction results because they understand them. Nursing
21 home residents are not merely users of services. The nursing

1 only be on the nursing care outcomes, it must also include
2 quality of life issues such as respect, dignity, and resident
3 choice.
4 Research conducted by Dr. Vivian Tellis-Nayak in
5 1999 analyzed satisfaction survey results of 11,715 families
6 of residents in 504 nursing homes across 26 states. The
7 research shows that family and staff satisfaction are
8 compelling measures of a nursing home's overall quality and
9 performance.
10 Family satisfaction is a window to that quality of
11 care that residents receive, to the stability and devotion of
12 the staff, to the way state surveys turn out, and to the
13 nursing home's overall operation.
14 For this reason, AHCA has developed a model to
15 encourage its state affiliates to begin developing a
16 satisfaction-based consumer guide. The model focuses on
17 reporting a nursing home's three-year trend of family
18 satisfaction, family willingness to recommend, and staff
19 willingness to recommend, as well as the inspection data, but
20 presented as a percentage of the 495 standards that each
21 nursing home must meet.
22 Our profession is committed to quality and is
23 further -- our commitment to quality is further demonstrated
24 by the launching of the Quality First initiative in July
25 2002. This is a proactive, profession-wide partnership of

1 AHCA, the American Association of Homes and Services for the
2 Aging, and the Alliance for Quality Nursing Home Care.
3 The Quality First initiative declares that we are
4 collectively and individually committed to healthy,
5 affordable and ethical long-term care services that are
6 rooted in continuous quality improvement, openness and
7 leadership. An independent national commission is being
8 formed to assess the report to the public -- and report to
9 the public our collective improvement on six important
10 outcomes.
11 So where does all of this take us? Nursing homes
12 are facing tremendous challenges. We have 52,000 vacancies
13 for certified nursing assistants, the true backbone of the
14 long-term care system and the key to customer satisfaction.
15 The GAO predicts that the overall demand for nurse aide
16 positions in all areas of health care will grow by 38 percent
17 between 1998 and 2008.
18 Current challenges are compounded by knowing that
19 the number of individuals 85 and older are double from the
20 current -- will double from 3.5 million to 7 million in 2020,
21 and the number will again double to 14 million by 2040.
22 We are also facing a crisis in funding for Medicare
23 and Medicaid assistance. An analysis by the national
24 accounting firm of BDO Seidman found that Medicaid has
25 underfunded nursing care nationally by nearly $3.5 billion

1 annually. Many nursing homes are experiencing extensive and
2 significant financial strength.
3 Long-term care providers are proactively working
4 with the federal and state governments to find solutions to
5 these critical problems. At the same time, we are also
6 actively pursuing ways to provide consumers with the
7 reliable, valid and timely information they need to make
8 informed choices about the type and quality of care of
9 services they need when they need it.
10 We are intent on hearing the voice of our customers
11 as we continuously improve and design long-term care services
12 for the future. Thank you.
13 MS. KOHRS: Thank you, Mr. Dana.
14 Next will be Laura Carabello.
15 MS. CARABELLO: Good afternoon. I am Laura
16 Carabello, founder and principal owner of CPRi
17 Communications. And I'm located in New Jersey. And when I
18 gave this presentation about a year ago in Texas, the doctors
19 in the audience wanted to know if I was related to the
20 Sopranos. And I am not.

20

20r thewholearest

20r theWr cufprin. aur Ang

1 online marketing, interactive communications including web
2 and multimedia development, direct mail programs and market
3 research.
4 We are headquartered in Teterborough, New Jersey.
5 We have a large airport there that serves the DEA
6 extensively. And we have an office in Scottsdale, Arizona.
7 We have clients in 35 states and strategic partners located
8 in London, and we have a global presence and a continuous
9 focus on generating results for our customer base.
10 I want to commend the Federal Trade Commission on

1 advertise their services.
2 And several key factors have influenced these
3 changes: obviously, regulatory oversight; guidance and
4 censure from professional trade associations and
5 organizations; increased competition, which is now fierce,
6 particularly for non-covered services classified as out-of-
7 pocket expenditures; the advent of the internet and website
8 communications; the commercialization of medicine; and
9 consumer empowerment.
10 And I think that all of these areas have had an
11 impact on the way physicians approach the marketplace and the
12 way that their advisors help them to structure their
13 advertising and marketing campaigns.
14 If you take a look at Yellow Page advertising, for
15 example, and you look back, how many of you in the audience
16 can look back to prior to the 1980s when Yellow Pages, for
17 example, in the Manhattan Yellow Page book revealed doctor
18 listings, including addresses and telephone numbers.
19 And if you jump ahead from 1980 to 1990, that same
20 section provides small space advertising and full-page
21 promotions in black and white promoting specific services.
22 And by the way, Yellow Page advertising is not inexpensive.
23 The listings became aggrandized with boxed
24 information as an upcharge, as well as detailed information
25 on practice offerings. And I can tell you that Yellow Page

1 advertising gets more expensive because the Yellow Pages
2 tells you that you have to be in every single Yellow Page for
3 a particular community, and then they narrow those areas down
4 so that they have to spend more money.
5 And if you fast forward to the present, not only
6 did the Yellow Pages triple in size with the sheer number of
7 doctors listed, but also the number of color display ads has
8 grown exponentially. And if you look in any Yellow Pages in
9 any city or states, you will see that doctors advertise
10 extensively. And, by the way, the return on investment for
11 Yellow Page advertising is high.
12 I guesstimate, and I say guesstimate because
13 there's nobody really tracking the number of physicians, but
14 I would say that 95 percent of all physicians engage in some
15 form of paid advertising or marketing. And I will go into
16 that in a few moments because I think that the scope of the
17 opportunity is far greater than we realize.
18 And about 25 percent -- actually, that's an
19 approximation; it might even be less -- of all physicians opt
20 for public relations activities. When you look at public
21 relations versus advertising, public relations is considered
22 earned media. Advertising is paid media.
23 And consultants are usually offering a range of
24 both. They're paying for it. They are consulting with them.
25 They are helping them to work with their practices to

1 generate coverage in local, regional, national print and
2 electronic media, whether it's press releases complimented by
3 outreach to editors, reporters, and producers.
4 And the results are mentioned in newspaper and
5 magazine articles, appearances on TV and radio, speaking
6 engagements and other venues where the physician is
7 positioned as an authority or thought leader in his or her
8 given field. Many physicians opt for this coverage since it
9 offers an opportunity to share quality information and may be
10 perceived as a third party endorsement. The credibility of
11 public relations versus paid advertising cannot be disputed.
12 Many physicians seek both.
13 The advent and growth of web-based communications
14 has clearly changed the marketplace. And this is taken from
15 the AMA. Approximately three out of ten, or 29 percent of
16 physicians using the web, currently have a website. And this
17 has been increasing every year and has remained constant over
18 the past few years.
19 Websites are greatest among physicians in solo or
20 two-physician practices, and lowest among physicians in a
21 hospital-based practice, as you would imagine. And the
22 primary reasons that physicians offer why they have a site on
23 the web is: 43 percent to promote and advertise their
24 practice; 35 percent to provide patient education and
25 information; and 11 percent increase in physicians using the

1 of fact that is likely to mislead consumers acting reasonably
2 under the circumstances.
3 I put this ad up because -- and this is not a real
4 ad; obviously, the numbers are made up -- but I happened to
5 see this in the paper a couple of days before I came to this
6 hearing. And is it good taste? Does it give you good
7 information? One of the things that sort of turned me off
8 was the $499 for the first 1,000 eyes. You know, how do you
9 ascertain that you're one of the first 1,000 eyes? That sort
10 of set up a red flag. But the question comes to mind: Is it
11 bad taste? A lot of ophthalmologists I know would say yes,
12 it is in very bad taste and we wouldn't have any part of it.
13 Obviously, there were people that liked it and wanted to use
14 it as their ad.
15 The AMA also offers policies governing advertising
16 and publicity, offering no restrictions on advertising by
17 physicians except those that can be specifically justified to
18 protect the public from deceptive practices. And it goes on
19 to say a physician may publicize him- or herself as a
20 physician through any commercial publicity or other form of
21 public communication -- newspapers, magazines, telephone
22 directories, radio, television, direct mail. I could go on
23 and on how physicians market their practices.
24 They do direct mail. They announce when their
25 office is changing. They announce when somebody is joining

1 the practice. There are lots of ways that they go about it,
2 lots of opportunities to advertise.
3 When I called the AMA to see how they were tracking
4 physician advertising, the quote from their spokesperson
5 said, "The AMA is a membership organization, not a regulatory
6 body. The FTC put us out of that business in 1980," and had
7 very, very little information to offer, in fact, cut me
8 short.
9 It is evident, however, from their policies that
10 the organization is concerned about the quality of physician
11 advertising, and throughout the profession, most responsible
12 physicians endeavor to adhere to the guidelines cited.
13 If you go on the web and you look at all the
14 different states, every state has their own little quirks and
15 their own little tweaks on what is allowed and what is not
16 allowed. So I'll just give you an example here.
17 North Carolina, Maryland, Virginia, District of
18 Columbia, Illinois. Illinois doesn't allow testimonials or
19 claims of superior quality. A lot of states do not allow
20 testimonials. New York and Texas also preclude the use of
21 testimonials by physicians, but you can see that the trend is
22 that they all agree that you cannot use deceptive practices.
23 However, advertising is advertising, and they're
24 allowed to do so. And what is the purpose of advertising?
25 It's designed to spark the interest of the health care

1 consumer and prompt the buyer, the patient, to access or
2 purchase services. In some instances, consumer expectations
3 are elevated, leading to liability for physicians who cannot
4 deliver what they promise.
5 How do consumers get this access to this
6 information? For those consumers who are employed,
7 information regarding health care financing and doctors is
8 usually provided by their employers. This is a hit-or-miss
9 opportunity at best, depending on the individual employer and
10 its concern to deliver good information.
11 For employers that are bearing the majority
12 of costs, particularly in the current economic environment,
13 plan selection may largely be a function of price. Large
14 employers usually distribute brochures, which are provided by
15 the plans, and often sponsor health fairs, offering plans the
16 opportunity to provide more information not only about the
17 plan but about the doctors.
18 Employees have come to count on the fact that their
19 employers have reviewed quality aspects of the plan. I'm an
20 employer, and employees just guess or have enough faith in
21 our power to review these plans, especially since we're in
22 the health care business.
23 In fact, it's interesting: Because we're in the
24 health care business, I think all of our employers think that
25 we know everything about health care. I can tell you that

1 people call us all the time for doctor referrals, and I keep
2 saying, we are not a doctor referral agency. We can't give
3 you information. But we must get probably, I would think, 20
4 to 25 calls a week from consumers.
5 For small employers, which we are a small employer,
6 this information can be scant, leaving the consumer more

1 friends or colleagues.

2 When they select a health plan, when the price is
3 the determining factor, the provision of quality information
4 means little to the consumer. And consumers often select
5 plans based upon the participation of doctors that they know,
6 that their friends know, and not necessarily quality
7 benchmarks.

8 For those who are unemployed and do not have
9 coverage, the options to access information are even
10 narrower. These consumers must turn to advertising or web
11 messaging, and their reliance on personal recommendations is
12 heightened.

13 We can also look at web messaging, though. If you
14 think about the number of doctors that have websites now and
15 the number of people that are actually web connected,
16 internet connected, there is a disparity. Not everybody has
17 access to the web, although we all are electronically
18 connected today, here.

19 The growth of consumerism, including consumer-
20 driven health care plans, medical savings accounts, flex
21 spending accounts and other offerings may drive the need for
22 more quality information.

23 As consumers spend their own money -- and as my
24 kids always said to me, "This is my money I'm spending" -- to
25 pay for their own health care services, they may be seeking

1 better information regarding quality. This will put more
2 emphasis on the advertising and marketing and further burden
3 on the providers themselves to establish credibility and
4 substitute claims.
5 Consumers can access select information regarding
6 provider quality. As noted earlier -- and that should be
7 NCQA; I'm going to have to smack somebody -- URAC, JCAHO
8 accreditations for plans and networks offer benchmarks.
9 Many, not all, employers utilize accreditation as
10 criteria for offering the plans to their workforce and tout
11 these achievements in a variety of advertising venues.
12 However, employees and consumers do not really have a clue.
13 They really don't understand accreditation, and may not
14 regard this as important to the selection process.
15 I always am tickled when I ride along the highway
16 and see those kinds of JCAHO accreditations and say, do
17 people really understand what they're talking about?
18 Furthermore, the economics of achieving accreditation or
19 issuing report cards often forces plans to forego the
20 process.
21 Condition-specific advertising dominates physician
22 advertising and often includes information about the nature
23 of the underlying condition, whether it's chronic or acute.
24 Many advertisers play upon the emotional aspects of the
25 condition, particularly those that represent life-threatening

1 conditions such as cancer or heart disease.
2 There is usually a strong call to action with a
3 toll-free number or opportunity to respond. Many physicians
4 who advertise track the overall response and attempt to gauge
5 the return on investment of a particular venue.
6 Ads may target the impact on a spouse or loved one,
7 or the impact on patient quality of life or appearance. The
8 more responsible physicians do not claim to offer a cure, but
9 may offer diagnostic, treatment, or management options which
10 may be surgical or medical.
11 How do you communicate quality? The quality and
12 quantity may depend upon the advertising venue. For example,
13 billboards offer up to a two-second opportunity to deliver
14 the message, two to three seconds at the most, leaving little
15 room for information or quality communication. Radio spots
16 usually run 30 to 60 seconds, hardly enough time to cover
17 details. Here we go. That's the end of the billboard.
18 That's as much time as you probably had to get that message.
19 And what are the effects on the behavior of health
20 care providers? Physicians who advertise often adopt their
21 own marketing persona. For every patient generated -- this
22 is a rule of thumb -- through advertising, four additional
23 patients will be referred by that patient. So they look at
it as an opportunity to really drive their practices.

1 must also follow through during the patient encounter to
2 ensure a pleasant experience regardless of the diagnosis.
3 And marketing-oriented physicians often undergo training, not
4 only to prepare them for media interviews but also to deal
5 with patients.
6 Practice management and public relations counselors
7 advise on a variety of issues impacting multiple aspects of
8 interpersonal relations, from developing appropriate body
9 language to eliminating bad breath.
10 Physician marketers may encounter some push-back
11 from their colleagues or a drop off in referrals. There's
12 professional jealousy. Their colleagues who do not engage in
13 advertising express disdain by minimizing referrals. For
14 successful marketers, however, these issues are no loner of
15 grave concern.
16 Physicians who run advertising for elective, out-
17 of-pocket procedures not covered by insurance usually tout
18 benefits, substantiated or otherwise, along with cost-
19 competitive positioning and opportunities to charge your
20 services to a credit card. Plastic surgery, corrective
21 vision procedures, laser hair removal, fertility, and diet
22 plans are among those conditions which fall into this
23 category.
24 The quality or credentials of the physicians are
25 not a key selling feature. In some of these instances, the

1 volume of procedures performed or the number of pounds lost
2 are cited. Before and after photos are often featured as the
3 incentive. This hard-sell approach extolls the volume of
4 procedures, not the quality of the outcomes.
5 Is advertising driving up the cost of care or
6 simply fueling the competitive spirit? Physician
7 reimbursement is established by the government, Medicare and
8 Medicaid, or set by individual health plans. The fees do not
9 change for physicians who advertise. In the area of non-
10 covered benefits, however, physicians can use pricing as a
11 sales tool.
12 The competition for patients remain fierce and
13 competitive market forces come into play. What forms of
14 advertising are good? Quality pays off in the long term.
15 As the competitive climate escalates, there is
16 likely to be surge in comparative advertising. And one of
17 the things I want to point out is that a lot of physicians
18 are dying to be featured as the leading doctor, the best
19 doctor, New Jersey Monthly or New York Magazine, U.S. News.
20 But they realize this is a popularity contest unrelated to
21 performance, not a real litmus of quality. Hospitals and
22 health plans also use these ratings.
23 Marketing quality services and actually delivering
24 quality services are two distinct issues. There are no
25 restrictions, which limit the quality of -- limit the

1 advertising of health care goods and services based on
2 quality, but there are regulations articulating standards for
3 avoiding advertising claims that are misleading. These
4 standards are widely respected and adhered to by most
5 physician marketers, and coupled with guidelines, they know
6 what to say.
7 The ability to advertise and market health care
8 services supports a competitive climate and should ultimately
9 drive improved quality. Competition is healthy, even in this
10 delicate market niche. And for those that stray from
11 restrictions and guidelines, however, there should be
12 enforcement that protects consumers. And obviously, selling
13 health care services is different than selling vacuum
14 cleaners.
15 My final thoughts: When developing and
16 implementing a marketing campaign, it is incumbent upon
17 physicians and their advisors to know and play by the rules?
18 Advertising that is in bad taste is simply distasteful.
19 Advertising that is false or misleading is illegal.
20 Guarantees are simply not allowed. The objective
21 is to elevate quality of care goals to the same level as
22 financial goals. And advertising that adheres to standards
23 set forth by government and others is mandatory. Advertising
24 that communicates quality and provides information should be
25 the end result. Thank you.

1 MS. KOHRS: Thanks very much. We'll have Dr. Lee
2 speak.
3 DR. LEE: I'm Tom Lee. I'm an internist and a
4 cardiologist and the chief medical officer for the network of
5 Partners Health care System in Boston. And I'm speaking
6 today about direct-to-consumer marketing of high-cost
7 radiology tests, at least I will if we can get in slide show
8 mode.
9 The issue that I'm speaking about are high-cost
10 radiology tests that are being directly marketing to
11 consumers. And I'm really going to focus on two of them, the
12 two most common ones, which are general screening for
13 malignancies, the most common being lung cancer screening
14 with chest CT versus whole body CT, and then a coronary
15 artery disease screening with electron beam CT, EBCT, as it's
16 called. It's technology that I'll talk a little about more
17 on the next slide.
18 To summarize, you know, these technologies are
19 marvelous. Technologically, they are really incredible if
20 you understand what they're doing, particularly with the
21 EBCT. But just because they're marvelous doesn't mean they
22 actually help anyone, or at least given our current state of
23 medicine. So their value is unproven. They have not been
24 shown to make people live longer or live healthier lives.
25 In fact, there's concern. There's concern about

1 the impact of false positive rates, the economic consequences
2 of false positive rates as well as the anxiety, and even the
3 medical consequences of false positive rates.
4 And there's also concern about whether the
5 advertising is misleading regarding the false negative rates.
6 That is to say, if you have a negative CT of your body
7 looking for cancer, do you really have -- should you really
8 have peace of mind? And as you can probably guess, my answer
9 is no. And as I said, there's no evidence that they improve
10 patient outcome.
11 The insurance companies are completely correct in
12 not paying for these tests. The evidence doesn't support it,
13 and where there are many things that are supported by
14 evidence that need to be paid for.
15 As a result, consumers are being asked to pay for
16 these tests out of their pocket. A lot of people would say,
17 well, if they want to pay for it out of their pocket, that's
18 fine. One of my arguments is that we are all paying,
19 however, for the sequelae of these tests being performed.
20 The sequelae are real, and as evidence I would cite
21 the fact that the tests are sometimes offered at very lost
22 cost or even free by health care organizations, physician
23 groups and other kinds of organizations, with the
24 expectations that the follow-up tests are going to be covered
25 by insurance, and that is where the health care providers

1 will make their money.

2 I want to talk first about electron beam CT. I'm

3 not going to give you a lecture. I'm just going to try to

4 give you the bare minimum. It is an incredible technology

5 that was very promising when it was first developed. It can

6 detect calcium deposits in coronary arteries.

7 And what's remarkable about it is that it takes

8 such a quick image that the heart is essentially holding

9 still. And the heart is always moving, of course, but the

10 image is done so quickly that you can get a picture that

11 allows you to figure out whether or not there are calcium

12 deposits in the walls of the coronary artery.

13 It's not so sophisticated they can look inside the

14 coronary arteries and tell you whether the artery is

15 narrowed. But it can tell you whether there's calcification.

16 And such calcifications are present in virtually all patients

17 with coronary disease. And there are very good studies

18 showing that the higher your calcium score, the higher your

15 fnd td uauoaemcour5Taf coursugo muheugo muheugs5 0 vingain virtsw

1 the next year is very, very low, like in the 1, 2, 3 percent,
2 even if they have coronary artery disease.
3 And no study has shown that the treatment of high
4 calcium scores improves outcome. There have been studies
5 where they take people who feel fine but have high calcium
6 scores and randomize them to statin therapy versus placebo,
7 and there is no difference in outcome because all of them
8 tend to do very, very well.
9 There is, however, a very high false alarm rate.
10 Let me give you -- this is what the scans look like. This
11 is, you know, cut through horizontally the top of your heart,
12 and that is like the main artery going down the front of the
13 heart, a little segment of it, the left anterior descending
14 artery. And you see those bright white shadows are
15 calcifications in the wall of the left anterior descending
16 artery. And you would rather not have calcification than
17 have calcification.
18 This is the kind of image that gets people -- there
19 are some very good people who are very interested in the
20 technology, and this is why they're so interested. You can
21 get an image like that, and you would like to think that
22 would help you take better care of those patients.
23 However, it hasn't worked out that way, but
24 nevertheless, these are being advertised. You know, Father's
25 Day is Sunday, and you can get both the heart and lung scan

1 rolled together for early disease detection. And this is a
2 New York Times ad, so it didn't reproduce too well on my
3 slide. And there are ads like this all over the country, for
4 $499. My children haven't gotten me one. I don't know what
5 that means.

6 So what do these results mean? Well, first, if you
7 have a low score, there's a 99 percent chance of no cardiac
8 events over the next year. If you have a high score, there's
9 a 1 to 5 percent risk over the next year. As I said, the
10 problem is that no one has shown that you can change that
11 risk, because it really is pretty low to begin with, by
12 giving people medications.

13 But here's what really bothers me most about these
14 tests. If you don't have obstruction in your coronary
15 arteries and you're over the age of 65 and you're an American
16 who's been eating an American diet, what are the chances that
17 you have a worrisome calcium score? It's 50 to 70 percent.
18 There's a very, very high false positive rate. It really is
19 calcium in the walls, but it isn't atherosclerosis that's
20 going to cause a heart attack.

1 they're hoping for.

1 science. There is no evidence indicating that it is helpful.
2 That doesn't stop other websites from telling you a different
3 story. And, you know, you don't need to read all this, but
4 this is from an organization that's trying to hook people up

1 millimeters in diameter. That's the tip of a pencil point.
2 The tip of a pencil point is millions of lung cancer cells.
3 And there's plenty of good research -- not some,
4 plenty of research -- that indicates that genetic factors
5 have programmed those cells so that the ones who are
6 programmed to metastasize have already metastasized by the
7 time that there's a one- or two-millimeter mass, and the ones
8 that are not going to spread very easily are not going to
9 spread. And they may reach golf ball size, and you can take
10 them out then, and the patient will still have a good
11 prognosis.
12 So that by the time you can find them on a CT scan,
13 it's -- probably the game is going to be over one way or
14 another anyway. But it's an unanswered question, and at this
15 point I would say somewhere by saying proponents, the
16 optimists, say it would be unethical to ask people to wait
17 while the big studies are done. The opponents say it's
18 unethical to ask people to pay for an unproven technology.
19 Again, my problem here is the false reassurance
20 issue. A negative CT can easily miss small tumors, and some
21 tumors are just not visible by routine CT unless contrast
22 agents are given. So anyone who's a clinician here knows
23 that you can't find adrenal tumors and renal tumors and many
24 other tumors unless you infuse intravenous contrast, but
25 those contrast agents carry a small, about 1 percent, risk of

1 reactions and they're also very expensive.

2 Fortunately, no one out there is doing screening

3 CTs with contrast. They're not that irresponsible. That

4 said, people walk out thinking that they've got a clean bill

5 of health. They may continue smoking because they believe

6 that they are getting away with it.

So, I mean, this -- I put this slide in here just

1 you didn't know about before has disproportionate value in
2 your mind, so that you have people smoking cigarettes while
3 worrying about SARS or worrying about, you know, other things
4 that are just not, you know, important.
5 And, you know, for me the epitome was a car that
6 someone pointed out to me in Boston the other day, a sports
7 car with a bumper sticker saying, "Ban nuclear power," and
8 there was a radar detector in the front. So the chance this
9 person will die from a car accident, of course, is much, much
10 greater than from a nuclear accident. But the prospect of a
11 nuclear accident was much more worrisome. There is this
12 whole line of thinking. The bottom line of it is that we're
13 not rational animals and it's very difficult for us to put
14 risks in perspective.
15 Well, what do physicians do? These are my last two
16 slides. I did, after being invited to come down here, do an
17 e-mail poll of the internists and the cardiologists of Mass
18 General Hospital and Brigham & Women's Hospital. And I
19 actually got responses from 141 internists, and I asked them,
20 have you undergone a CT to screen yourself for cancer? And
21 then the follow-up question -- and I asked the cardiologists,
22 have you had an EBCT to screen yourself for coronary disease?
23 And then the follow-up question was, if so, did you pay with
24 your own money? And third question was going to be, did you
25 pay with post-tax dollars?

1 But I never got to the third question because not
2 one internist at the Brigham or Mass General has had a CT
3 scan to screen themselves for lung cancer or other cancers.
4 Two out of the 26 cardiologists have had electron beam CT,
5 but neither paid. One of them indicated that he would have
6 paid, but as my wife said, she'd believe it when she saw it.
7 So these were some of the comments I got back in
8 the e-mail from the cardiologists on electron beam CT. You
9 know, "I would not have done it even if it was covered by
10 insurance. It's hype. I discourage my patients from having
11 it done if they ask."
12 "No. I was asked by my wife's rich uncle in
13 Argentina whether he should invest, and I told him if it was
14 a good plan to get in and then make sure there as a good exit
15 strategy once people figured out the limitations."
16 "No. I can't see use for it save to generate
17 anxiety and more business for the ETT lab" -- exercise test
18 lab -- "which would be good from a purely commercial
19 standpoint."
20 And the last one is, "Absolutely not. This test is
21 not ready for prime time."
22 The last comment I'd make is that I wish the
23 medical profession was effective enough in trying to regulate
24 it. When the leaders of cardiology and general medicine
25 don't believe these tests have value, I wish our profession

1 was effective in keeping physicians from marketing things.
2 But it's not, and I don't have realistic
3 expectations it will be in the near future. So I'm hoping
4 that these hearings will lead to some other kinds of
5 interventions. Thanks very much.
6 MS. KOHRS: Thank you, Dr. Lee.
7 We're going to have Dr. Koch speak next, if I don't
8 have the computer shut down one more time.
9 DR. KOCH: Thank you very much. It's a pleasure to
10 be here. I was asked to speak because of the notoriety of
11 good and probably a lot bad that ophthalmology has with
12 regard to LASIK advertising and how it tends to dominate the
13 marketplace in terms of the amount of -- proportion of
14 medical ads. And I think that was shown or reflected in Ms.
15 Carabello's talk as well.
16 I'm from Baylor College of Medicine. I also would
17 like to acknowledge that I've been discussing this with my
18 colleagues at the American Society of Cataract and Refractive
19 Surgery, and as a society, we have a lot of interest in this

1 results, as you might logically feel.

2 It's a big business. In 2002, there were over one
3 million LASIK procedures, with a total cost of $1.9 billion.
4 And a marketing cost at about $140 an eye is about $160
5 million, so there's a lot involved here.

6 Now, where do our patients learn about LASIK? The
7 American Society of Cataract and Refractive Surgery just
8 worked with the Harris Interactive to do a poll, and you can
9 see that they learn about it from their eye physicians,
10 opthalmologists/optometrists; family and friends; internet;
11 other media; and then advertising. And of course,
12 advertising -- really, these things probably also are part of
13 the advertising, and then less so from the medical
14 associations.

15 As physicians, obviously, our first role is to do
16 no harm, to be the caretaker. And we have a pact with our
17 patients as ophthalmologists who are entrusting their vision
18 to us. And so cannot advertising be consistent with this
19 goal?

20 Absolutely. If it honestly informs the patients of
21 availabilities of practices and procedures, describes them,
22 and even fair comparisons are doing -- probably are
23 beneficial to our patients. They drive costs down. They
24 inform patients. We're not opposed to any of that.
25 Obviously, there must be no deception, stated or implied.

1 The fundamental problem is this whole thing about
2 health care and commodities and is LASIK truly a commodity in
3 a free market? Clearly not in the traditional sense, and
4 again, this was alluded to earlier.
5 You can't test-drive your surgical result. You
6 can't try to remove one spot and see if this cleaner works
7 better than the other cleaner. You have one crack at having
8 surgery on your eyes. And it's difficult to get data
9 regarding quality of surgeons and outcomes.
10 The ads kind of run the spectrum. There are those
11 that are legal and ethical, those that are legal but we would
12 consider unethical, and then clearly illegal ads. So an ad
13 can be legal but not in the best interests of patients. And
14 we're also worried about the profession and about not only
15 the image of the profession to the public, but about what we
16 try to instill in our colleagues as physicians.
17 So the advertising can deceive patients in a
18 variety of ways. These are at least four ways that
19 advertising in LASIK surgery can deceive patients, the first
20 one being price.
21 The classic one was already really shown, the
22 asterisk, which is a bait and switch: 499 for your eye, and
23 all of a sudden you end up using -- the patient realizes
24 that's not the laser they want to have used. There's a
25 limited refractive range, up to myopia, up to minus 2, for

1 Here's one: "LASIK eye surgery for free. I can
2 see clearly now." Their website is seeclearly.com. And
3 again, the implication that everything is clear. "Win a free
4 laser vision correction." These kinds of inducements that
5 are misleading about price. Two-for-one pricing.
6 This is one of my favorites: "Guess what I won,
7 hon?" And, you know, which media? And you can see, there's
8 your fine print. You'd need LASIK surgery just to read the
9 fine print.
10 And my favorite of all time, and I want to
11 acknowledge Dr. Terry O'Brien, who sent me some of these:
12 "Kiss a pig and you can win free LASIK vision correction."
13 You know, it's a trivialization. It's a kind of -- the humor
14 in these kinds of approaches kind of minimize the seriousness
15 of the decision that patients make in contemplating this type
16 of surgery.
17 Well, what about the eligibility criteria? There's
18 the implication that the procedure is for everybody. And
19 I'll give you one example of that. Here's one -- let's
20 see -- "Get rid of your glasses. Cataracts. Nearsigned.
21 Farsightedness." So it doesn't matter what you've got, we
22 can fix you.
23 And again, it draws patients in. It makes them
24 think that, gee, I must be eligible for this, and makes them
25 less critical in thinking about the applicability of this

1 procedure for themselves.

2 Outcome: There's implications of the perfect

3 result, of the permanent results, of no complications.

4 "20/20 for 2995." You can get rid of your contacts for life.

5 "The only laser vision correction facility offering a 20/20

6 promise." Refund the final fee. "To the best." How do they

7 define "best"? There are the glasses. No more glasses. No

8 more contacts. Things that are clearly not accurate or

9 correct.

10 "Participate in our free LASIK" -- dah dah dah dah

11 dah -- "seminar." The "get-rid-of-your-reading-glasses"

12 seminar. And learn how it uses -- for the best results. And

13 again, no data to substantiate these claims.

14 Other claims from recent ads: "Quick and pain-free

15 way to eliminate your way for corrective lenses." "The

16 world's most advanced ophthalmic lasers." "The only 3-D eye

1 poor patient decisions regarding undergoing a procedure. It
2 demeans the profession, and is a violation of the implied
3 pact between physician and patient.
4 As part of this survey, we found that dissatisfied
5 patients after LASIK surgery were less likely to know what
6 procedure they had -- they didn't even know if they had LASIK
7 or another procedure -- or to be knowledgeable about the
8 benefits, risks, and expected amount of visual improvement
9 that could occur with the surgery. And they were more likely
10 to note advertising as a source of information about LASIK
11 surgery.
12 So how can we better protect our patients? We have
13 to provide better information. That falls upon the medical
14 profession to do that. And I think tighter scrutiny in
15 advertising is important.
16 Now, at the American Society of Cataract and
17 Refractive Surgery, we've developed the Eye Surgery Education
18 Council, and that has a website that has a range of
19 materials, including very detailed LASIK patient-screening

1 combined with the American Academy of Ophthalmology and the
2 American Society of Cataract and Refractive Surgery, they
3 were approved by the FTC. They provide a legal framework for
4 those issues as you see. And they talk about the kinds of
5 claims, and they give good examples about efficacy,
6 comparative efficacy, safety, permanence and predictability,
and success rates.

1 be -- sorry. It's going to be Richard Kelly from the Federal
2 Trade Commission.
3 MR. KELLY: Good afternoon. I think the
4 presentations so far have really been excellent. Given me a
5 lot to think about even before I walked up here.
6 It reminds me of the story of why lab technicians
7 prefer lawyers to white rats for their laboratory
8 experiments. And maybe you've heard this story before, but I
9 think it's an interesting one.
10 One of them, of course, is there are just much more
11 lawyers than white rats. And the second reason is that the
12 lab technicians don't get attached to those lawyers. And the
13 third one, of course, is that there are just some things you
14 can't get a white rat to do.
15 So, you know, here I am today, listening to these
16 presentations and desires for the agency to do more. And
17 certainly we're listening and we want to respond.
18 And what I wanted to do today was to talk a little
19 bit about the FTC's experience with LASIK, but also to give
20 you a little background in case you don't know a little bit
21 about what this agency is about and the kinds of things we
22 do.
23 It's probably useful for this slide to be up there
24 in terms of the value, the positive value, of advertising.
25 Because inherently, we're going to hear about some negative

1 things. These ads are deceptive. These ads have
2 misrepresented this or that. These ads lead people down the
3 wrong path.
4 And I think Laura had mentioned the Supreme Court's
5 intervention in the area to open up the doors to advertising
6 by health care professionals several decades ago. And that
7 was certainly over First Amendment concerns, but it's also a
8 recognition that advertising, if done well and right, can
9 help the marketplace.
10 Obviously, it can do all of those things that are
11 on that slide. You yourselves can think of experiences where
12 advertising has helped you make a choice or a selection or
13 become aware of something new that you just didn't know was
14 out in the marketplace. But that last point, that last point
15 on that slide, is of course essential. But of course it must
16 be truthful and non-misleading.
17 You know, it's interesting: When I hear the
18 discussions about the FTC, I mean, and all the things that we
19 might do or could do, today, right now, we're in court today,
20 not on a case involving physician advertising, but we're in a
21 court today, right now, seeking a temporary restraining order
22 against a marketer of a product called coral calcium.
23 And coral calcium was being marketed as to treat or
24 cure cancer and other diseases such as multiple sclerosis and
25 heart disease. Very widely promoted on television. So we're

1 in court today challenging that.

2 Just last week we went into court, got a temporary
3 restraining order against a marketer of the Q-ray. Q-ray,
4 which is being marketed as something to relieve muscular and
5 joint pain, even though a very recent Mayo Clinic study
6 showed that it was no better than a placebo.

7 So there is much to do, and many areas for us at
8 the FTC on the consumer protection side to be focused on.
9 And that basic mission, as is set out in that slide, is to
10 prohibit unfair or deceptive acts or practices, and to go
11 against false advertisements for food, drugs, devices, and
12 services.

13 A practice is deceptive if it's likely to mislead
14 consumers acting reasonably under the circumstances, and is
15 material to a consumer's decision to buy or use a product.
16 And a practice is unfair if it is likely to cause injury to
17 consumers, injury as such that cannot be avoided by consumers
18 themselves and is not outweighed by some benefit.

19 One of my handouts was some pictures of some ads.
20 And the first one was for this, this amazing Gutbuster. The
21 ad says, "Turns ordinary sit-ups into tummy-tightening power
22 stretches." It's an old case from the FTC, old, I guess by
23 most standards, 1990. But what was interesting about that
24 case, it's a combination of both that unfairness and
25 deception concept.

1 It turned out that Gutbuster really didn't do
2 anything to tighten your stomach. So those claims were
3 deceptive. But the other concern -- and this is a
4 Gutbuster -- the other concern about the Gutbuster was that
5 it could break upon use and maybe actually bust that gut by
6 piercing it or hurting some other part of the body. That
7 part of the advertising was unfair because it would cause
8 injury that consumers could not reasonably expect or avoid,
9 simply by using the product.
10 Core advertising principles: I don't think anybody
11 could disagree with any of these. Obviously, tell the truth.
12 But that's an important point, too: Tell all the truth.
13 Don't omit information that's needed to keep what's being
14 said in an ad from being deceptive. And, of course, to make
15 sure it's the truth, which is a core, very significant
16 approach that the Commission takes, and is certainly very
17 vital for any health care advertising.
18 The concept is, is before an advertiser makes a
19 claim in their ads, they'd better have a basis, a reason, to
20 believe that in fact that product or service will do what's
21 being said. And this standard, which we call the
22 substantiation standard as it says here, is flexible. It
23 depends on the claim.
24 So if you say in an ad, four clinical studies show
25 that this does this, well, then, you'd better have four

1 clinical studies that show that. If you say in an ad that 98
2 percent of our customers or our patients or the consumers
3 taking this product achieve this result, that certainly is an
4 implication that you've done some kind of study or follow-up
5 with your patients to demonstrate that that's true.
6 But the point is that the standard is also flexible
7 so that if something new has been developed, some new
8 technology is being developed that information can get out in
9 an advertising about this technology so that there isn't some
10 absolute bar that you must have at this point this amount of
11 evidence before you can say anything, but still if you do
12 choose to do that you've got to present it in a fair and
13 reasonable way that consumers would understand what that
14 evidence means and what it doesn't mean. And of course, it
15 requires competent and reliable, and in the health care area
16 scientific, evidence, evidence that an expert would say is
17 needed.
18 A little concept here about ad meaning. When you
19 look at those ads that were being put up on the board before,
20 advertisers are certainly responsible for any express
21 statement they make in the ad, but also for ones that are
22 reasonably implied by the express statements they make.
The net d bm7 ex525mho.925 0 TD(5Te ex52d-o.9aers are cert
22

1 testimonials. It's worth pointing out that you can't say --
2 basic rule: An advertiser cannot say in a testimonial what
3 they couldn't otherwise say in an ad. So just because
4 someone who has gone through a particular procedure or bought
5 the product had this particular result, if the advertiser
6 felt, I couldn't say that because I don't have substantiation
7 for that, I don't think that's true, just because some
8 consumer says it is, you couldn't use it in the ad.
9 And testimonials can often contain claims that are
10 basically statements of efficacy. We can see it in the area
11 of LASIK. We see it in many, many other areas, where that
12 testimonial is making some kind of statement that, you know,
13 basically says, this product will do this. It did it for me
14 and it will do it for you. And, of course, such claims need
15 to be supported.
16 Let's talk a little bit about LASIK. We've been
17 interested, involved, working with others in this area for a
18 number of years. And it seems like some of the issues
19 continue to be the issues that have been from day one: Throw
20 away, eliminate the need for glasses or contacts, has
21 certainly been a major question, a major issue.
22 Misrepresentations being made about the safety of the
23 procedure are certainly of issue. And concerns raised about
24 making comparisons.
25 And what our approach has been to date has sort of

1 been this multi-faceted approach combining not just one area
2 exclusively, but looking at others. So we're going to do
3 education, we're going to encourage self-regulation, and
4 where needed, going to do law enforcement.
5 So we have over the years been working with a
6 number of groups, and again trying to come together.
7 Absolutely right, we did help and assist in the development
8 of guidelines. We have been in discussions and had meetings
9 with the various professional groups. We've talked with the
10 state medical boards. Again, where we have found examples of
11 advertising that have been questionable, we have tried to get
12 someone interested in going after it.
13 That last point: Bring cases where necessary.
14 And -- did I jump ahead? Well, let's go right there. Recent
15 Commission cases: We just announced two cases in March
16 against national advertisers, and they focus again on some of
17 these claims that people have been concerned about for a
18 number of years.
19 Eliminate glasses and contacts for life. Eliminate
20 the need for reading glasses. Risk of glare and halo.
21 Significantly less risk than contacts or glasses. It really
22 seemed to be an inappropriate thing to be comparing the risks
23 of going through a LASIK procedure with what might happen if
24 you put a contact on your eye or a pair of glasses on your
25 nose. They were really speaking to very different issues,

1 and so we challenged that.

2 This false claim of free consultation: The problem
3 wasn't that the consultation wasn't free. The problem was,
4 the consultation didn't have anything to do with your
5 suitability for the procedure. Even though the ad expressly
6 said, come in for a free consultation to see if you qualify
7 for this procedure, when you showed up what you saw was
8 someone who basically told you what the price would be.

9 And then you had to pay over $300 if you wanted to
10 go to the next stage. At the next stage you would find out,
11 in fact, whether you were suitable, and you'd find out about
12 the risks. Those cases, again, were put out for comment in
13 March, and we're awaiting final action by the Commission.

14 Let me finish up here with some key points, and
15 look forward to the discussion that will occur later today.
16 Truthful and non-misleading advertising: Of course this can
17 be of great assistance too consumers. But deceptive
18 advertising, misleading advertising, will certainly distort
19 consumer choice.

20 So what we need, what we think we need here at the
21 FTC, is reasonable industry self-policing, informative
22 education efforts, and targeted government action, working
23 together to protect consumers and encourage fair competition.
24 Thank you very much.

25 MS. KOHRS: Thanks, Dick.

1 Now, I'd like to give you a little bit of
2 background, and then I will try to answer some of the
3 questions that appeared on the FTC website relating to
4 quality advertising.
5 Quality advertising is considered by many
6 inherently deceptive because it cannot be verified and it
7 cannot be precisely measured. The rationale for this
8 statement is the striking disparity between the knowledge on

1 as a result of what the health care professional did to the
2 patient.
3 Many economists in this area and other experts have
4 come to the conclusion that the lay public is totally
5 incapable of evaluating the quality of medical services. A
6 patient's loyalty to his or her dentist also complicates the
7 effectiveness of quality advertising.
8 In other words, there are bonds between patients
9 and dentists and patients and various physicians so that
10 irrespective of how you might rate that physician or dentist,
11 they will continue to go to that dentist because they have a
12 relationship with the dentist or the other health care
13 professional.
14 Now, as a result, the Supreme Court determined that
15 these various significant challenges to informed decision-
16 making by the customers for professional services suggest
17 that advertising restrictions arguably protecting the
18 patient -- this is the requirement for verification of the
19 quality advertising -- could not be looked upon in the rather
20 cursory manner that the Federal Trade Commission had in
21 determining that there was an antitrust violation.
22 The Bates case has been mentioned by a couple of
23 speakers now, and that was the case that first introduced
24 advertising to the professions. But even in the Bates case,
25 although it said advertising for routine services was fine --

1 Now, how are the ways that Jane Jones can show that
2 she is the best dentist in the West? I suppose if something
3 like a magazine like Consumers Union did a study and
4 determined that she was the best dentist or among the very
5 best dentists, that would probably satisfy the fact that this
6 advertisement had been verifiable.
7 What are the problems that might arise if this type
8 of advertising is permitted? Well, a patient may go to Jane
9 Jones, believing that she is the best dentist in the State of
10 California, and Jane Jones may not be the best dentist in the
11 state and may, as a result, leave the patient with lips that
12 are sore and a mouth that is sore as a result of this. Well,
13 certainly this patient will not return to Jane Jones. She
14 will go on and look at other dentists, and it may be trial
15 and error before she finds a dentist who she considers is
16 best for her.
17 Well, that trial and error constitutes search
18 costs, which would therefore interfere with the delivery of
19 services. And one of the arguments in the California Dental
20 Association case was that the elimination of those search
21 costs meant that this type of advertising would be pro-
22 competitive and, in fact, the Ninth Circuit Court of Appeals
23 found that to be the case.
24 What is the difference -- here's another
25 question -- what is the difference between dentists who

1 advertise and those who do not advertise quality services?
2 Well, there may be no difference between them in terms of
3 training and skill. It's simply one is advertising that she
4 is the best, and the other is not advertising. So it would
5 appear as if the advertisement might give the dentist who was
6 advertising sort of the ability to say that they are superior
7 to the other dentists in the community.
8 What role does comparative advertising play in
9 dental advertising? There is almost no comparative
10 advertising; at least, I've never come across comparative
11 advertising in dentistry.
12 Are there governmental and association limitations
13 on advertising? And yes, as you saw with Mr. Kelly speaking,
14 the advertisement does have to be truthful. And in the case
15 of the California Dental Association, it also has to be
16 verifiable.
17 And the question then is, is that -- what effect is
18 that on the marketplace? In my judgment, that's a salutary
19 effect on the marketplace because consumers in California,
20 for example, can rely on the fact that the professional
21 association of dentists in that state verify the
22 advertisements that are being run in the Yellow Pages or in
23 newspaper columns or newspapers in general.
24 There's another question: What empirical evidence
25 supports this justification? Well, I'm really not aware of

1 any empirical evidence that supports this. However, I
2 suppose one way that you could determine that is to run a
3 study and see whether or not -- let's take California again
4 as the illustration -- whether dentists in California who are
5 not members of the California Dental Association run more
6 quality advertisements than members of the California Dental
7 Association, who cannot run quality advertising unless
8 they're ready to verify those.
9 As a matter of fact, just as others have said here
10 with various physician-type advertising, advertising among
11 dentists is flourishing. The last time the ADA survey center
12 took a survey on advertising was in 1996 and I'm sure the
13 numbers would be much higher today. But in 1996, 65 percent
14 of all dentists were advertising. Now, that's not to say
15 they were advertising quality, but they were advertising in
16 general.
17 And the survey further asked those dentists, did
18 they believe that their advertising was worthwhile? And 70
19 percent of the dentists of that 65 percent stated that the
20 advertising was in fact worthwhile.
21 Now, the aftermath of the CDA litigation indicates
22 that probably the California victory was a pyrrhic victory
23 because what has happened because of the expense of that
24 litigation, none of the state associations are enforcing
25 advertising principles of ethics.

1 But it's even more significant: They are so
2 concerned about anything, any enforcement, any disciplinary
3 actions, under the ADA principles of ethics that they are not
4 moving forward to try to obtain discipline for any violation
5 of the principles of ethics.
6 Now, I'd like to make one other statement for the
7 record. There was a dentist here yesterday, I guess during
8 the Noerr Pennington discussions, whose name -- I'll leave
9 his name out. But he made a statement which I would like to
10 challenge.
11 His statement was that a dentist may not advertise
12 that he is a mercury-free dentist. And although the ADA
13 Judicial Council has never been called upon to resolve that
14 issue, nor am I aware of any state association ever being
15 called upon to make a determination with reference to this
16 ad, the likelihood is that that ad, without more -- mercury-
17 free dentist, John Smith is a mercury-free dentist -- that
18 would not violate the principles of ethics.
19 On the other hand, if that dentist went further and
20 stated that he or she were mercury-free dentists because of
21 the toxicity of a certain type of restorative material, that
22 very likely would violate the principles of ethics because
23 that claim is untruthful and it's not verifiable.
24 In fact, the Food & Drug Administration, Health and
25 Human Services, has an extraordinarily large body of

1 literature, that supports the notion that that form of
2 restorative is not harmful to patients and, in fact, except
3 for a very small element of the population who may be
4 allergic to that restorative.
5 But with reference to history, that restorative has
6 been used for 150 years. All the governmental agencies, the
7 scientific bodies, all conclude that it does not harm
8 patients. And therefore, if this dentist were to go further
9 and say he is a mercury-free dentist because of the toxicity
10 of a certain restorative, that probably would violate the
11 principles of ethics.
12 Let me conclude by telling you a joke that I used
13 to tell all of the dentists when I litigated with the Federal
14 Trade Commission. And that litigation lasted for a number of
15 years. And that was, how many lawyers does it take to screw
16 in a light bulb? And the answer is, as many as you can
17 afford.
18 And I would tell the dentist that the United States
19 government has many, many lawyers that it affords who work
20 for them in litigation with the FTC. Thank you very much
21 for permitting me to speak to you today about this subject
22 matter.
23 MS. KOHRS: Thanks, Mr. Sfikas. I think we're just
24 going to take about a ten-minute break to give everybody just
25 a chance to get up and stretch your legs and think a little

1 bit before we come back for the final speakers. So we'll
2 reconvene, actually, at about 4:00 by this clock here on our
3 wall.

1 Earlier this year as well, I had the opportunity to
2 serve on a panel at the NCQA that dealt with the issues of
3 provider referral and what kind of directory information
4 should be available to consumers. So hopefully I have some
5 insights onto some of the issues we're dealing with today.
6 I'm also going to talk a little bit about the
7 company. We provide a couple services, one of which I think
8 is directly germane to today's discussions. And I would
9 submit the other one is as well, but perhaps not as obvious.
10 And we're going to focus primarily on my Quality Coach, which
11 is a provider service -- or a service that we provide to
12 health plans and large self-insured employers.
13 DoctorQuality was founded in 1999 during what I'd
14 like to refer to as the apex of the dotcom toga party. I
15 actually represent the second generation of management. The
16 academic physicians who founded the company are back in
17 academic medicine, and doing so, they were able to double
18 their salaries and they now have 401(k) matching, to which I
19 say God bless America.
20 Even though we have a very -- we're very young and
21 very new on the scene, we do have a very strong customer base
made up of some reputable clients who have really helped us

1 One is a gentleman named Chuck Buck, who actually is a member
2 of the Institute of Medicine, who published the frame-
3 breaking report in 1999, "To Err Is Human," which really kind
4 of blew the covers off of medical errors. And the other is
5 Dr. David Nash. Dr. Nash heads up the Center for Health
6 Policy and Outcomes Research at Thomas Jefferson University,
7 nationally known as one of the experts in quality and patient
8 safety.
9 We are a company that uses health care technology
10 to improve quality and safety. We believe in the transparent
11 marketplace. We believe that there's an opportunity to get
12 more information into the right hands as people try to either
13 monitor performance or make critical decisions.
14 To that end, we have a hospital and physician
15 selection tool that helps consumers choose resources based on
16 performance and quality. We also have a hospital incident
17 and adverse event reporting tool which is used for quality
18 assurance purposes, and from that activity we today house the
19 largest database that we know of -- we've looked everywhere
20 to find anything comparable, and we haven't been able to --
21 we've got the largest database in existence for medical
22 errors and near-misses. And I'll talk a little bit about
23 that.
24 The two products that we offer are Risk Prevention
25 and Management, or RPM -- this is the hospital error

1 collection tool. It's used for quality assurance purposes.
2 And we also have My Quality Coach, and that's the physician
3 and hospital selection tool.
4 I'd like to emphasize, it's very important as we're
5 trying to provide information to consumers to make informed
6 decisions. You must know that there is an impermeable wall
7 between these two platforms. The information that we collect
8 in the conduct of the RPM program is private, confidential
9 information for quality assurance purposes only.
10 Frequently I get the question, so you collect
11 hospital error information and tell consumers who makes the
12 most mistakes? That's not the objective of the program, nor
13 will it ever be.
14 I want to start by talking about the hospital error
15 reduction program. I think it's important -- maybe not
16 directly in the context of today's discussions, but I think
17 it's important in the context of: at some or another every
18 one of us here is going to be a patient or has been a
19 patient.
20 Between 44,000 and 98,000 people are killed
21 annually in the United States as a result of an unnecessary
22 medical error. Let's put that into context because 98,000 a
23 year is a big number. It's hard to really figure out what
24 that means. I've been given 15 minutes today. Three people
25 will die while I'm up here. And that's a pretty sobering

1 fact. So it's a very significant problem.
2 The other thing that's very interesting is of the
3 numerous medical errors that are made, it's been estimated
4 that only about 5 percent are actually reported, reported in
5 the context of trying to analyze why the mistakes happened so
6 preventive measures can be taken.
7 Not only is it a tragedy, but it costs a lot of
8 money, too. Medical errors cost this country about $140
9 billion a year, both in terms of repeated procedures and the
10 costs for those procedures, and there's also a growing
11 concern, a crisis in many states, with respect to malpractice
12 insurance. And this is a piece of it.
13 Now, it's very encouraging to see that many of the
14 states in this country are now requiring some form of
15 mandatory medical error reporting. About 20 states today
16 actually have some legislation on the books requiring error
17 reporting.
18 I think two in particular are, I think, very near
19 and dear to DoctorQuality's heart. In New York, there's a
20 program called NYPORTS, and it might not be generally known,
21 but every single hospital in New York has a dedicated NYPORTS
22 terminal at which the hospital employees are required to
23 report certain errors to New York State.
24 Also, in Pennsylvania, I'm very proud to say that
25 yesterday our company submitted the bid to provide error

1 reporting across the state to a new regulatory agency in
2 Pennsylvania known as the Patient Safety Authority. And
3 Pennsylvania is really going to be the first state of its
4 kind that is going to encourage not only what's known as
5 serious events -- in other words, the things that harm
6 patients -- but Pennsylvania wants to know about the near-
7 misses as well. And I think it's a big step forward in terms
8 of really being able to find ways to be proactive about some
9 of these problems.
10 The problems that we see here are not necessarily
11 individual acts of negligence or incompetence. The problems
12 that we see, we believe, most often are the result of a
13 system of care.
14 Here's a very startling statistic: From the time
15 that an individual is admitted to a hospital for what's
16 become a fairly routine procedure, coronary artery bypass --
17 from the time that person is admitted to the time they're
18 discharged, about 400 people are going to be involved in
19 delivering care to that individual, 400.
20 Not all of these are going to be hands-on. Some of
21 these people are going to work in the lab, some in the
22 pharmacy, some in the kitchen. Some are going to work in
23 maintenance, and they're going to clean up the operating room
24 after the fact.
25 But 400 employees of the hospital are involved in

1 to change that, help our clients change that, and start to
2 gather the information to help them figure out where the
3 problems are.
4 So we start with culture. We move to data capture.
5 Once we know -- once we have the data, we can start to
6 analyze the data to figure out what the solutions are,
7 implement the solutions. And we find among a lot of our
8 clients, once we've nailed down one solution, another one
9 pops up. Health care technology changes constantly. Or once
10 you've solved a problem on the surface, it might expose
11 several other problems underneath.
12 So we believe that it's important at every level,
13 and I think in particular with respect to health care policy,
14 legislative policy, something has to be done to really evolve
15 the culture of health care.
16 I mentioned a little bit earlier the database that
17 we have. Earlier this week we crossed the line. We now have
18 a little more than 80,000 medical errors. Next week, it will
19 be more than 81,000, collected from more than 150 health care
20 facilities across the country.
21 You'll see that about two-thirds fall into either
22 the adverse clinical or medication areas. And I think the
23 statistics on the right-hand side are pretty telling as well.
24 The one I like the most is that of all the items that are
25 reported to us, 43 percent involve a near-miss.

1 You know, this might be a situation where in the
2 middle of the night you see the nurse come into your hospital
3 room and say, "It's time for your pill," and she hands you a
4 yellow pill. And maybe you're going to be awake enough to
5 say, "Wait a second. Mine is blue." That's a near-miss. It
6 was caught in time. And there could be about 15 people
7 someplace in the chain that somehow put a yellow pill on that
8 tray for you instead of your blue one.
9 We've seen numerous cases where our clients being
10 able to quantify the recurrence of near-misses has led to
11 some very significant improvements in their procedures. And
12 we were able to prevent similar recurrences in the future.
13 I'm just going to say one more thing about the
14 medical error situation before we roll into the physician and
15 provider selection tool that we provide. But I get a lot of
16 questions very frequently about why should anyone really want
17 to report a medical error?
18 The first one, you know, why should you want to do
19 it? Well, I believe that doctors went to medical school to
20 learn how to do a good job. And there's a little bit of a
21 Pollyanna in me about that. I don't believe doctors go to
22 medical school so they can golf on Wednesday. There are
23 cheaper ways to golf on Wednesday.
24 I think that health care professionals try very
25 hard to do a good job, and I think it's harder and harder to

1 do a good job. And what we provide is an improvement tool
2 that helps people understand where their weaknesses are and
3 be able to react to them.
4 Next question: Won't error reporting lead to
5 lawsuits? A very, very common misperception. And the answer
6 is, in 49 states, no. In 49 states, any information that's
7 collected as part of a quality improvement is protected by
8 the peer review statutes, which means you cannot subpoena it.
9 I'm sure that will be challenged, and it's probably a
10 question that we're going to have to wrestle for a long time.
11 But I'm very pleased to say that at a policy level, in 49
12 states the answer is no. This does not lead to lawsuits.
13 This leads to better health care.
14 Who would want to report on a coworker? Well, let
15 me tell you about one of the programs that one of our clients
16 has in place, which I think is just the perfect embrace of
17 the kind of culture that we hope our clients are promoting.
18 We have a client who has a program called the Plant a Flag
19 program, and what happens is the hospital gives lapel pins
20 and collar pins to the doctors and nurses that report an
21 error.
22 They take the attitude that the errors are like
23 potholes in the road. If you stepped in the pothole, please
24 plant a flag so that your coworkers don't step into the same
25 pothole. And we see hospitals give out gift certificates for

1 cookies in the cafeteria, movie tickets, anything to promote
2 a culture of blame-free reporting.
3 And does this offend doctors? Well, it doesn't
4 offend doctors if they've embraced this culture of blame-free
5 reporting. It's very important that we look at error
6 collection data in a non-punitive fashion. And I go back to
7 my first point: 98,000 people die because of medical errors.
8 It seems pretty apparent to me that blame has not worked. We
9 need to try something else.
10 Let me turn to our second product, My Quality
11 Coach, which is an online consumer decision support system
12 whereby consumers can choose physicians and hospitals based
13 on quality and satisfaction data. With this program, we
14 encourage consumers to log on and prepare ratings on their
15 doctors. And we also invite doctors and hospitals to present
16 certain information about themselves.
17 Now, this information, we think, is pretty
18 important in the context of how resources are chosen, VHA
19 did -- the Voluntary Hospital Association, that is, did a
20 study last year and it seems pretty clear that health care is
21 becoming more consumer-centric. I won't go ahead and read
22 all those, but you can probably them.
23 But in other words, this slide makes the point that
24 consumers are interested in finding out quality information.
25 They would be very pleased to make decisions based on the

1 standards of performance and the quality of care that's
2 delivered.
3 It's also becoming an increasing trend that
4 employers are very interested in this as well. It doesn't
5 cost more -- in fact, it actually costs less -- for the
6 employees to go to better quality doctors and better quality
7 hospitals. And to the extent that this both is a way to
8 reduce health care cost and to bolster employee satisfaction,
9 this is something that large employers in particular are
10 increasingly becoming very interested in.
11 This last point on the slide: Network size is
12 taking a back seat to network quality. Actually, that's
13 backwards, and the person who drafted that is going to be in
14 big trouble tomorrow morning when I get back to the office.
15 Network quality -- no. I'm sorry. I'm backwards.
16 Start again. Network size is taking a back seat to network
17 quality. It used to be that when you'd get into a health
18 plan, you'd look at the book and say, is my doctor in here?
19 Well, now people are increasingly trying to figure out, is
20 the good doctor in here?
21 Just a snippet from the Philadelphia Business
22 Journal, where last year the Blue Cross organization in town
23 has actually developed an incentive program based on quality.
24 If institutions are delivering certain quality metrics,
25 they're paying bonuses, cash from a health plan, for doing a

1 good job.

2 We have a number of prominent clients -- I see the
3 two-minute sign is up, so -- we have big clients and we're
4 proud of them. I do want to point out that Patient Choice,
5 Luminos, and Destiny Health are all in the defined
6 contribution, defined consumer choice plans.

1 this performance data has had a very positive impact on the
2 actual performance of the physicians themselves.
3 And I'll end with the last one from a fellow you
4 might know of, Dan Rather. "When it comes to choosing a
5 heart surgeon, Pennsylvania is on the cutting edge in helping
6 consumers pick the right one."
7 So we like the idea of making information
8 available. We think it has a good impact on the institutions
9 themselves. And we think it's a trend that consumers are
10 continuing to demand. Thank you very much.
11 MS. KOHRS: Thank you, John.
12 I'll ask all of the panelists to come up. Helen,
13 you're going to speak. You don't have a PowerPoint, but
14 everyone else can come up and have a seat. You can choose to
15 speak from your seat or from the podium, whichever you would
16 prefer. Helen has been here all day.
17 MS. DARLING: I just -- obviously, the satisfaction
18 of what I have to say will be inversely related to how long
19 it takes me to say it. So I will try to make it as fast as I
20 can.
21 I'd like to mention that two of our Washington
22 Business Group on Health public policy goals, two of our
23 highest, are to increase transparency in the system -- and
24 there is a report out there; if you haven't gotten it, I hope
25 you will read it. It talks a lot about what's now available.

1 I think for anybody who hasn't worked in this field
2 recently doesn't really appreciate how much incredible
3 information, DoctorQuality.com being one of the best
4 examples, is available to especially companies. I know one
5 of the companies that uses them is G.E. And they are a very
6 demanding purchaser and very sophisticated purchasers.
7 So they have a product. Others have products. The
8 interesting thing is how many are emerging, how all of them
9 are getting better, how -- I mean, they have data and tools
10 that would just make us salivate even as recently as five
11 years ago.
12 And the ability -- it's probably one of ours,
13 too -- but the ability to put in something like your personal
14 zip code, and say you want a hospital within ten or fifteen
15 miles, and these are the things you care about, like
16 complication rates and things like that, it will create its
17 own report for you, ranking all the hospitals in your
18 immediate area.
19 And again, if you're not familiar with that, what's
20 amazing is what's available and how critical it is that we
21 keep moving. They're now using data that I hear now, but
22 we're not going to have more data unless we have more
23 pressure to have more data.
24 We certainly think as an organization that
25 advertising can be fine, and we certainly wouldn't want to

1 squelch that, whether it's First Amendment or not. But we do
2 think that the role of FTC -- and the FDA, by the way, and we
3 met with the Commissioner the other day about the role they
4 can play from where they have authority to try to drive the
5 system to more fact-based information, and also, obviously,
6 certainly no deceptive advertising.
7 If anybody has -- you should see Tom Lee's letter

1 So one of the things we'd like to see in every
2 piece of legislation that goes through any time in the next
3 two years are requirements around reporting. At a minimum,
4 of all currently publicly reported information, that such
5 reporting would be easily accessible to consumers. But we'd
6 like to go further and eventually have even better
7 information.
8 There is evidence, as we just heard from John a
9 minute ago, that public disclosure of provider performance is
10 resulting in clinical quality improvement, in Pennsylvania
11 but also in New York. In fact, in every state that has such
12 information available, we are seeing improvements and people
13 do pay attention. The interesting thing is that providers
pay attention because they don't like looking bad, and for

1 protecting the consumer, especially in these complex areas,
2 at a time when consumers, employees will have much more of a
3 role to play, whether they want it or not; they will be
4 playing a much bigger role, and they're going to have to have
5 information. And the only way they're going to have it is if
6 we keep the pressure on. Thank you.
7 MS. KOHRS: Thank you very much, Helen.
8 It's sort of the policy here to give the first half
9 of the panel an opportunity to respond to some of the things
10 that were said after they spoke. To make things a little bit
11 easier for me and to move these things a little bit easier,
12 if you're interested in speaking, just tilt your name tent on
13 its side so that I can see. If it's tilted like that, I'll
14 know that you want to participate and ask a question.
15 So we'll go ahead and just start down the line, if
16 you want to just make a comment briefly. Bernie Dana had to
17 leave, so we have a fill-in. Ms. Condeelis?
18 CHRIS CONDEELIS: Thank you. I guess one of the
19 things that I'd just like to share, a couple points, is that
20 I think with the panelists today, we do in long-term care
21 share some things in common, in that our residents, our
22 consumers, come to us with a very critical need. We are not
23 an elective care service.
24 The fact that 75 percent of our customers are
25 coming to our homes and their payments are capped does have a

1 very specific influence on the way we provide our services
2 that is -- you know, it kind of caps competitiveness. And I
3 think that's different from the other panelists.
4 We do for our consumers have quality measures.
5 There is difference in the marketplace about how good those
6 measures are, but I think that as a profession, we have
7 pioneered the consumer satisfaction data that is then
8 allowing us to give yet another indicator of quality to those
9 that are seeking our services.
10 MS. KOHRS: Great. Laura?
11 MS. CARABELLO: If we are to insist upon getting
12 quality information out to the consumer, what is going to be
13 the best way to get it out there? Whose responsibility is it
to do so? Is it incumbent upon the physician himself? Is itbility

1 generally. Helen, you look like you're --
2 MS. DARLING: Well, I can always answer a question.
3 I think on that one, it's a good example of where the complex
4 system that we have will govern. That is, all purchasers
5 should make certain that it's available to the people they
6 purchase for -- Medicare to its beneficiaries, the states for
7 their Medicaid beneficiaries, and private purchaser employers
8 for their employees.
9 And many of the companies, as you saw, some of the
10 insurance companies that provide coverage for lots of middle-
11 sized and small employers, provide these tools as well. So
12 that is who's paying should pay for it.

1 DR. LEE: You know, I would actually add that I
2 think the professional societies, they should be challenged
3 more by the business community and by others to pick up the
4 role and really show some leadership in this area about
5 making even stronger statements about what is and isn't
6 supported by evidence.
7 And I actually think they're ready for it. I mean,
8 I do a lot of stuff with the American College of Cardiology,
9 and I think they're primed. They're actively discussing
10 having -- you know, taking stands on -- you know, to try to
11 reduce waste. Because frankly, they know they need to. You
12 know, providers need to show that they are also trying to
13 make the system work because they haven't been doing that
14 much thus far.
15 I'd also that, you know, people don't usually think
16 of physicians being in synch with the business community.
17 But I would say that in general, our physician -- at least
18 our leadership is very much in synch with what Helen said on
19 both counts, in that first, we would be very supportive of
20 strong action to try to reduce, you know, misleading
21 advertising that generates demand where there isn't really
22 need, and we'd do everything we could to try to support that
23 with our, you know, experts and so on.
24 And then the second half, which is that how do
25 physicians feel about public disclosure of data related to

1 quality, and there's certainly a bit more neurosis and
2 ambivalence about that. But I would say that times have
3 changed, and that many of our physician leaders accept it and
4 are for it. They think that it's -- you know, it's like
5 having your teeth cleaned. It's, you know, uncomfortable, it
6 draws some blood, but it's good for you.
7 And then there are others who just understand that
8 it's going to be this way, and they're not going to resist it
9 any more. So I actually think that there's enough people who
10 understand that it's a tremendous driver for improvement, and
11 that wherever something isn't -- wherever we are against data
12 being made public, we'd better have a good internal sense of
13 accountability. And that's sort of where we've arrived in
14 our system.
15 So I actually think the providers are in synch on
16 both counts: better quality data being released to the --
17 made available to the public, while a reduction in the poor,
18 misleading information that makes up a lot of advertising.

tion that makes u2f where we've arrivetng 5c, becauseD(12)'

our sy0 TDso falseDeading info, p0 Trtt6

1 its perspective, whether those types of claims would be
2 allowed now.
3 And you said that there was a reticence on the part
4 of the California Dental Association, or indeed any dental
5 association, to pursue any types of claims. How do we
6 encourage them to get involved in the process, as Drs. Lee
7 and Koch would want an association to be involved, without
8 causing anticompetitive problems?
9 MR. SFIKAS: Well, it's a real irony because, of
10 course, we prevailed in the California Dental Association
11 case. We won. The Court said that it was not an antitrust
12 violation.
13 I think you've heard that in the case of
14 guarantees, that they're really not a solution. If someone
15 is injured, the mere fact that they get the cost of the
16 dental services back is not really anything that's extremely
17 helpful.
18 How do you encourage the associations to get
19 involved? I think if the FTC -- I think from the standpoint
20 of the dental profession, it would be very helpful -- and
21 there's really no way to do this, I mean, because the
22 principles of ethics are already out there. But it would be
23 very helpful if we could present the principles of ethics to
24 the FTC where they would say, excluding the advertising -- we
25 wouldn't give those to you because we've already won that, in

1 our opinion -- but if we gave everything else to you and you
2 said, you know, none of these would raise antitrust
3 concerns -- and many of these certainly would not raise
4 antitrust concerns.
5 For example, some of the things that are not being
6 done today, in the case of peer review, peer review was
7 always used as an alternative dispute resolution mechanism.
8 A patient comes forward, says they're unhappy with what the
9 dentist did. They don't like the procedure that was done.
10 The association hears it, often agrees with the patient,
11 would make the dentist reimburse the patient.
12 Now, because it's no longer obligatory since it's
13 not being enforced, the patient is left to file a lawsuit,
14 which is not a good way out of that. Consultation and
15 referral, when it is in the best interests of the patient,
16 certainly that doesn't raise any antitrust issues. This is
17 the dentist determining that the dentist ought to refer, more
18 likely than not, to a specialist. That's not being enforced.
19 And even a very recent one, the dentist should
20 avoid interpersonal relations that could impair personal
21 judgment, sort of something on the order of sexual
22 harassment. None of those are being enforced, and I'm sure
23 that we could agree that none of those would raise antitrust
24 issues.
25 So it's a real irony. It's the expense of the

1 California Dental Association having to litigate that case,
2 first before the administrative law judge, then before the
3 Federal Trade Commission, then in the Ninth Circuit Court of
4 Appeals; then, because the first time, as you know, the Ninth
5 Circuit Court of Appeals ruled for the Commission, a two-to-
6 one decision, then the Supreme Court takes the case. The
7 Supreme Court reverses, and then sends it back down to the
8 Ninth Circuit Court of Appeals before that litigation came to
9 an end.
10 Well, the other state associations, not as large as
11 the California Dental Association, are saying, we just don't
12 want to get into that. So there is a great reluctance to
13 enforcing not only the advertising restrictions in the
14 principles of ethics, but other provisions as well.
15 MS. KOHRS: Go ahead. Dick?
16 MR. KELLY: Yes. I'm not an antitrust lawyer. I'm
17 not in the Bureau of Competition. So to directly respond to
18 some of those issues would be foolhardy on my part.
19 Clearly, in the California Dental case, there was a
20 debate as well as to what kind of record needed to be in
21 evidence to justify or not justify those restrictions. And
22 ultimately, that case, at least, turned in significant part
23 on what approach was being used. There's something called a
24 per se approach to evaluating restrictions, and then there's
25 a truncated rule of reason. And the Court was saying the

1 where do you draw the line? What do you focus on? And we
2 try to focus on claims that are making representations about
3 curing dread diseases, for example. And that's where our
4 focus is.
5 So it requires consumers, it requires the groups,
6 it requires government, in some sense working together to try
7 to address some of these problems as best as possible. And,
8 you know, I remain hopeful.
9 In the coral calcium case I mentioned today, one of
10 the things we're doing at the same time we were going into
11 court seeking this temporary restraining order, the FTC and
12 the FDA were together sending out letters to marketers on the
13 web, trying to get them to stop making similar claims for
14 coral calcium products.
15 So, you know, there is hope. There is approaches
16 that can be taken. And, you know, hopefully we're all
17 willing to try to work together to achieve that.
18 MS. KOHRS: And speaking of things going on on the
19 web, John, you have dealt with the gamut of physicians and
20 consumers and various entities. Can you talk a little bit
21 about what that experience has been like? Do you have a
22 minimum pool of doctors? If I wanted to look up my doctor,
23 John Smith, and I see that 100 percent of the comments have
24 been negative and I click on it, does it tell me that there's
25 only been one comment made, something like that? How do you

1 assess -- how does a consumer assess the data?

2 MR. GEBHART: We try to make everything as

3 transparent as possible. So if one person has submitted the

4 rating, it will say one. You know, whatever the number of

5 ratings have been, that's obvious to the consumer when

6 they're using our site.

7 Some of our clients have actually asked us to

8 suppress any rating information until 30 ratings are

9 submitted, so at least there can be some semblance of an

10 average. Now, of course, you get into a little bit of a

11 Catch-22 game when that happens because if you submit a

12 rating but you can't see the results right away, then it's

1 So you're at risk. We keep our own data, for
2 example, and for a while we used to put it up on the website.
3 But no matter whatever number we put up, the next person down
4 the street somehow had a number that was a little bit better.
5 And so unless you have some kind of an external, objective
6 measure of quality, either in terms of results or risks or
7 incidence of complications, it's a difficult problem. And
8 it's particularly difficult when you're not in a hospital or
9 other type of setting where you have other people overseeing
10 and monitoring your outcomes.
11 DR. LEE: You know, it's a very tough area and I
12 think you have to have realistic expectations about what you
13 can do. I mean, another area where a lot of numbers get
14 thrown around is prostate surgery for prostate cancer, and

10

Ank ydon'foreaeryoread a tie usat billboardstal or13

thrown arolem. hp, s. 13111213

10

1 not an area where investment in energy and time is going to
2 have a great return. I mean, I'm not against going in there,
3 but I would be realistic.
4 One thing that ran through my mind that I -- you
5 know, this is going to sound like a, you know, like a
6 physician-like, Taliban-like perspective on things. But I
7 think that in the interests of promoting fair competition in
8 the health care marketplace, I think a number of my
9 colleagues would be -- they would support a ban of
10 advertising of anything which required a physician decision,
11 that is to say, a prescription being written, a test being
12 ordered, with the logic being that if the decision-making is
13 supposed to be restricted to a physician, then the lay public
14 doesn't have the expertise to judge their need for it. And
15 this obviously would limit all direct-to-consumer advertising
16 in pharmacy.
17 And I think that that kind of thing does provide --
18 have some small benefit. I think it creates much more demand
19 where there isn't much need. You know, the ratio, you know,

1 billboard that they may be able to read or not because it
2 wasn't in their language?
3 Are they going to get it from, you know, the health
4 club? Are they going to get it from some other source? Or
5 have they lost total confidence in the quality components of
6 advertising?
7 MS. KOHRS: Dr. Lee?
8 DR. LEE: My response is that I'm not really
9 worrying that much, actually, whether the consumer really
10 understands it. I think that if solid quality measures get
11 put out there, it produces the desired effect, which is it
12 makes consumers like, you know, me in my day job, you know,
13 sweat bullets and try to create systems to make it better.
14 So that it will be great if the consumers
15 understand it, but to me it doesn't really matter if your
16 goal is to actually improve care.
17 MS. KOHRS: Well, going back again to that Cal
18 Dental decision, when "gentle dentistry in a caring
19 environment" was seen as a quality assessment that Cal Dental
20 was not willing to allow dentists to advertise, how would you
21 assess what quality advertisement really is? Do you have
22 a -- can you give us a sense of what that might be?
23 MS. CARABELLO: Well, in my mind, anything that
24 flies in the face of the regulations is not quality. So that
25 has to be the first benchmark, whether it's the state

1 regulation or it's the FTC or it's your association or some
2 guideline that you're following, as long as you're in the
3 guidelines.
4 It's a question of good taste versus bad taste. I
5 mean, there are doctors who are advertising regularly who are
6 advertising in good taste and promoting quality. And I think
7 quality wins no matter what. That's the bottom line.
8 And I somewhat take issue with the fact that, do we
9 care whether the consumer gets it? I think we have to care
10 whether the consumer gets it because ultimately, when they
11 get the right information, they take better care of
12 themselves, the outcomes are better, and it costs the system
13 less money.

1 behind giving that information.

2 How expensive that is becomes a different story,
3 and I think as far as the employers go, they sort of, from
4 what I hear, have had it up to here as far as assuming more
5 cost. So I think there's got to be a buy-in from other
6 sources as well as far as getting the information across.

7 MR. SFIKAS: I think quality is very important in
8 the hospital, in the physician's office, in the dentist's
9 laboratory. But quality advertising, it's pretty clear that
10 the difference between what a physician or dentist or other
11 health care professional knows and what the consumer knows,
12 there is a striking dissimilarity in their ability to
13 understand that.

14 So I think it's very, very difficult to use quality
15 advertising as you would some of the other types of
16 advertising, like price and other things, because of the
17 difficulty in consumers understanding it.

18 MS. KOHRS: Helen?

19 MS. DARLING: Well, I think we have a lot more
20 positive experience than the tone of this conversation is
21 headed. A number of people have been working on HEDIS

1 interesting -- because we've got about seven years'
2 experience now -- is that the health plans that allowed their
3 information to be reported publicly initially got better and
4 better; that the ones who were doing -- basically, people who
5 did a good job and made it available did better in lots of
6 ways. They got better.
7 The plans themselves in many instances, we know
8 from reports that if they didn't do well one year on
9 something inside the plan, then a lot of things happened. A
10 lot of steps were taken to improve it.
11 We do know that there are companies that pay a
12 differential and provide information. When I managed health
13 care at Xerox, we actually provided data from the HEDIS
report, and we had an allowance, and our employees had

1 decisions and interactions with the system, they're very
2 personal, very intimate interactions. And I think to the
3 extent that different age groups and different cultures have
4 different needs, we think one expression of quality is that
5 the services are appropriate for the individual
6 circumstances, not just their diagnosis.
7 So I think it's a very important component of it.
8 It hasn't been demanded of us yet at DoctorQuality, but, you
9 know, sure enough, it will be coming.
10 MS. KOHRS: Helen?
11 MS. DARLING: Actually, it's become the hot topic.
12 And cultural competence is the current language on this.
13 It's actually a big issue and very important, and large
employers who especially -- like the hotsl2smfs cy theg'r theike tr1

1 the HR material is done in Spanish or -- you know, they are
2 particularly good on, if you will, the easier languages for
3 us now as a country, where we have a lot of people speaking
4 that language in a lot of different places. It's easy to get
5 the resources.
6 But they're recognizing that there are many, many
7 categories of people from different cultures. It's going to
8 be very expensive, though, to deal with it. But employers
9 really think this is extremely important.
10 MS. KOHRS: Dr. Koch?
11 DR. KOCH: I want to just touch base again on this
12 issue of doctor quality and quality health care provision.
13 And I'm very intrigued by your website and what's occurring,
14 and also a little concerned about the possibility that, you
15 know, unhappy patients can try to get in multiple ways. And
16 certainly in the LASIK world, there are whole websites
17 devoted to complications, and then certain physicians will be
18 spoken of, you know, based on one case.
19 And when we try to think about who is best capable
20 of evaluating quality of care, it's really our peers, our
21 peers in our specialty and, to a certain extent, peers not in
22 our specialty.
23 And I guess maybe my request for your next project
24 is, why not have doctors evaluate doctors? Don't do it
25 through the best doctors of America, which is one way to do

1 it, but why not have doctors evaluate doctors and have those
2 ratings become available? I know that's all the competitive
3 and all that sort of issues, but who else better than those
4 in their own peer group?
5 MR. GEBHART: I think that's a very valid
6 observation. And let me respond to that a couple of ways.
7 And I failed to mention this earlier.
8 It's interesting: We do not have enough ratings to
9 really see what the true pattern is going to be yet. But the
10 overwhelming majority of ratings that we have are quite
11 favorable. So we find there's probably a greater propensity
12 for people to get online and help their doctor out with, you
13 know, thank you for a good experience.
14 Having any kind of a peer review function, it would
15 be great to be able to present it. My immediate reaction was
16 to try to figure out how to organize it, and that would take
17 a little bit of work. But what we do provide is a survey
18 that both the doctor and the patient can use that for any
19 given condition displays what the evidence-based standard of
20 care is. And an evidence-based standard of care is prepared
21 by peers.
22 The doctor is able to get online and indicate
23 whether or not they follow that standard, and then that
24 standard is displayed to the member, to the user, so they can
25 determine if what's happening in the process is indeed in

1 accordance with that standard.

2 So, you know, whether or not your doctor has a nice

3 office staff and free parking and things like that, that's

4 good to know. Whether or not you're actually going to get

5 the treatment you need and they're going to follow a pattern

6 that's been proven to be effective in the past, that's really

7 where the rubber meets the road. And we try to help people

8 with that as well.

9 MS. KOHRS: Well, I'm afraid that that's going to

10 have to be our last word on the topic today. I'd like to

11 thank everyone who was able to come and be a part of this

12 panel, and I'd like to ask everybody to join in a round of

13 applause at this point. Thanks very much.

14 (Whereupon, at 5:02 p.m., the hearing was

15 concluded.)

16 * * * * *

17

18

19

20

21

22

23

24

25

1 **C E R T I F I C A T I O N O F R E P O R T E R**

2

3 DOCKET/FILE NUMBER: P022106

4 CASE TITLE: HEALTH CARE AND COMPETITION LAW AND POLICY

5 DATE: JUNE 12, 2003

6

7 I HEREBY CERTIFY that the transcript contained herein is

8 a full and accurate transcript of the tapes transcribed by me

9 on the above cause before the FEDERAL TRADE COMMISSION to the

10 best of my knowledge and belief.

11

12 DATED: JUNE 11, 2003

13

14 ________________________________

15 LISA SIRARD

16

17 **C E R T I F I C A T I O N O F P R O O F R E A D E R**

18

19 I HEREBY CERTIFY that I proofread the transcript for

20 accuracy in spelling, hyphenation, punctuation and format.

21

22 ________________________________

23 SARA J. VANCE

24

25