

### 3<sup>rd</sup> PANEL

SKIP: We're going to change the schedule a little bit. We're going to have two panelists now. We're going to then end that with comments and questions that you may have because we've been going straight through pretty much this morning. And then we're going to let out a little bit early for lunch. There will be a whole buffet lunch that will be appearing a few minutes before 12. So just hang loose and there will be a nice lunch here for you and then maybe just before we break from lunch I'll explain to you about how the afternoon works. We hope that all of you will be with us for the afternoon dialogue that will involve every single person in the room. So now I want to introduce to you – you've already met Tom and Tom's going to expand some comments in a few minutes. But first I'd like you to hear Patricia O'Brien, who's the Chief Operating Officer for Real Care Insurance Marketing in Sonoma.

PAT O'BRIEN: Well, I didn't get here for the early morning session but from what I've heard, you guys are a pretty savvy bunch, pretty smart. And what I do in my job is work with consumers mainly. Real Care is an insurance brokerage. We're a full service brokerage and we specialize in employee benefits. So we're working with people day in and day out who are looking for health insurance and looking for ways to finance their health care, and looking for answers as to why it's so expensive to do that.

What I have found in my experience as an agent and as a member of Health Underwriters, which is our local professional group, is that there still is a fundamental disconnect between the consumer and the cost of health care, cost of services. For so long we were covered under HMOs where we'd go in and pay a co-pay for our services and we never saw a bill and we never saw an explanation of benefits. We'd go to the pharmacy and we'd pay a co-pay for our prescription, and we have no idea how much that prescription costs. All we know is that the physician has told us we need it, it's supposed to help us, and that's what we want to have. So despite the fact that we have moved from an HMO climate back towards a PPO climate, and with that entails additional cost, deductibles and out-of-pocket expenses, people are still wondering why is it so expensive and what am I paying for. I have people ask me all the time, who's making the money around here? We talked about not having culprits and not having villains and you heard that on the prior panel and I believe that that's true. But the consumer wants to know, who's making the money? Because somebody's got to be rolling in the dough because of how much money I'm paying for health care. What they don't see is that their hospital bill, which possibly was \$2000 10 years ago is now \$30,000. What they don't see is the prescription that they're taking that's a 30-day supply is three times what their premium is. We need to find a way to let the consumers know that the true cost of health care is. Now that sounds like a pretty simple idea. But you heard the panelists before me and you all know from your own experience that it's not a simple idea. There are costs that are shifted, there are a myriad of effects going on here that we can't sort through, and when you try to sort through it you just kind of feel like giving up and going home. So I don't have an answer for us on that but I want it to be part of the dialogue that we talk about how to involve the consumer more in recognizing what the true cost of care is.

Now he didn't tell everyone what our topic was. Do you have the agenda there, Tom? It's Cost Containment and finding a more, I think it was a systematic way to cost containment. So cost containment is the key. Driving toward a more systematic and widespread approach to ways

humane cost containment can be integrated into our health care system. So I thought about this topic and I said, hmm, cost containment. Well, what I know is that consumers don't want cost containment done to them. And we were talking at our table earlier about an experience that one of our participants had where a family member had a loved one who was in the hospital for quite some time and ended up not surviving the situation but had millions of dollars - \$2 million I think it was - worth of bills. And at the point at which the health carrier started talking to the hospital about is this person going to make it and should we continue to put money out at the level that we're putting money out, the family members were up in arms. The family members wanted nothing to do with that discussion because they didn't want cost containment as an issue with the health care of their loved one. So that's a huge hurdle for us if we're going to talk about cost containment in that sense. And who was it earlier, one of the other earlier panelists, I think it was the hospital district spokesperson, saying that he had 50 ways to reduce costs. And that's great and we need to look at all of those ways, all of those methods. But we still need to have personal ownership of that cost containment issue. That's what I believe. Consumers, they're going to look at who's making a profit in the system, but ultimately if they're spending somebody else's health care dollar, they're not going to be as careful with that dollar as they would if it was coming out of their own pocket. Right? So we always spend other people's money more readily than we spend our own, which is why consumer directed health plans, which is the buzz word in our industry, are all the rage. Are you all familiar with consumer directed plans and the idea behind consumer directed plans and kind of the two-pronged approach of giving people choice but giving them money and having them take responsibility for where they spend those dollars? And I think that that is a valid method of eliminating that disconnect. Because people who have high deductible plan but who have a pot of money to use towards the cost of their health care are going to the Department of Managed Health Care Web site and SOBIMO (?) and all of these other places that we talked about, where you can find out how is this hospital rated for orthopedic surgery vs. this hospital. If you don't have a financial stake in that as a consumer, do you really care? Or are you going to look at what is convenient for me, this hospital is down the street, my friends and neighbors say it's the place to go. You're going to go off of that kind of experience, rather than looking at the true efficiency as it's reported in the quantitative data. But if you have a financial stake in that, you're going to be more careful to look at, gee, where am I best going to spend my health care dollars? I think everyone agrees that by nature we are going to do that.

One of my passions, one of my pet peeves is the prescription drug problem. The whole idea behind paying a co-pay and never seeing the cost of that prescription drug. Because as we have heard from the health carriers, that is one of the most significant driving forces behind the increases that we see. And yet people have no idea. They have no idea. So just to throw out something that I think should be done, is somehow creating a liaison or some sort of a relationship with the pharmacy systems so that they give you something when you get your prescription that shows what the cost of that drug is, so that you know as a consumer - wow, this was really expensive or this was really worth it. The only people who really know are those who are uninsured and who are having to find ways to pay for their prescriptions. And for those people, they are looking at public areas to fund that. So we need to find some way to cross those barriers and bring that information to the consumer in a meaningful way that will influence their choices and their behavior. Otherwise people's behavior won't change at all and therefore costs will continue to be driven up.

The other area that just is an amazing and sad thing to me is – one of the products that we sell are individual health plans. When you purchase an individual health plan you have to fill out a very lengthy health history questionnaire and the carrier will underwrite that risk based upon the answers on your application and any medical information that they obtain from your physicians. We see trends in what people are taking – drugs, what kind of treatments they’re taking. And there are so many people taking antidepressants and steroid-based inhalers that even from our tiny perspective of it’s almost like “A Bug’s Life” – we are just such a tiny perspective of this whole issue and yet we can see that this is moving towards a crisis situation. And we see people who are taking these medications for years and years and years, with no treatment of the underlying condition. It’s simply, take this pill, you’ll feel better. So again, one of the themes here is getting consumers to take responsibility and I think that part of that responsibility has to be that they seek medical treatment when it’s necessary and that they seek treatment in total rather than simply a pharmaceutical solution to their problems. And that kind of dialogue has to encompass physicians and carriers and hospitals and everyone that’s a stakeholder.

So the other thing that I will say is that we deal mainly with individuals and small groups and we have a few groups in the thousand range. But most of our clients are individuals and small businesses. And we look to the larger groups as barometers of where the cost is going to go. As a small business owner, we don’t have the actuarial data that may be available to a large health plan like a city or a county or any kind of alliance or health plan alliance that other large groups may be part of. We are flying blind when it comes to where the health care dollar is. Because what happens with a small employer is that we have basically book rates. Our rates are based upon the age of our group, the overall health risk of our group, and the plan that we choose. But we have no influence over what those rates are. Once they’re published by the carrier, that’s it. And you can go to 10 different brokers and you’re going to get a 10% range in cost depending on what rates that broker is showing you. So as a small group advocate, we need to find ways for those small employers to come together and share data that’s meaningful to our community like you talked about earlier and one of the other panelists talked about earlier.

So just some perspective that comes from the consumer’s point of view and from the small group point of view, and I’d be happy to take questions later when we do that. Thank you.

SKIP: You all met Tom earlier this morning, some of you know him from the past. He’s going to expand on his remarks.

TOM: Thanks, Skip. Although I disagree with a lot of what Pat said, I do want to echo and support one of her themes which is that we need to know more about the costs of care. So I’m going to give you an example of fact-finding in the costs of care that may interest you. This is a result of research done by SEIU Local 250 in Oakland on the impact of the Sutter hospital system, Sutter Health, on the cost of care in northern California. CalPERS reported last year and repeated again this year that based upon their charges, charges paid by Blue Shield and Blue Cross as agents of CalPERS, the Sutter hospitals’ prices are as much as 80% higher than the statewide average – 80% higher. They are as much as 60% higher than the average for comparable services and patient severity matched patients in northern California. As an example, the government data reveals that in 2002, Sutter’s average charge for a simple cesarian, uncomplicated cesarian, the third most common type of medical procedure in the state that’s an issue in itself, that cesarians are third most common medical procedure in the state – indicates

once again that the lure of high-priced cesarians is distorting the delivery pattern in an otherwise healthy female population, but that that is 60% higher than the average for non-Sutter hospitals in the Sacramento region. That's the kind of information I think consumers ought to have. Being told that a hospital admission costs \$1400 vs. \$2500 is not going to change whether we get admitted or whether we get the service. The issue is not going to be made at the point at which the medical need is evident. The decision needs to be made by collective purchasers, not by individual purchasers. We're not a bit interested in going back to the '40s when everybody had to go out on the street, workers included, and buy individual health insurance and get individually rated. The medical form that Pat referred to is a basis for denying coverage. And the research in the consumer driven plans across the country indicates that it's a cherry-picking market for the insurance carriers and it is not providing affordable health care. The fact that you know you're going to be impoverished by health care does not mean that you'll stay away from it.

Here's something on the profitability. The statewide average for non-Sutter hospitals, their margin – this is the operating margin – was 2.9%. Sutter Tracy's was 33%. Sutter Roseville 23.9%. California Pacific Medical Center – that's the hospital in San Francisco whose medical director once said "We're going to become the Ritz Carlton of hospitals." They're on their way. They were 19.8%. Sutter Solano 17.8%. Sutter Delta 15.7%. Sutter Amador 17.7%. Memorial Hospital Modesto 12.9%. Sutter Maternity and Surgery Center 13.6. Now these are the operating margins but this is after a business structure – I wish I had a picture of it – a business structure that shows that just beneath the nonprofit Sutter Health Corporation is a series of for-profit subcontractors. These are organizations that carry out the business of Sutter, much of it, and they are for profit. They are also what are called related party organizations, which means that their owners include staff or board members or some people who have significant roles in the Sutter organization. Now we've had two major scandals in California's medical history with similar structures, one of them going back to the mid '70s when the prepaid health plans on the Medi-Cal program were nonprofit by law. What we found when we audited them was that the capitation payments were immediately diverted into for-profit entities that were owned by the founders of the nonprofit, or spouses, or children, or nieces and nephews, or lawyers, friends, legislators in many cases – members of the legislature. This was a perfect system for diverting a revenue stream into for-profit entities which were not producing any significant level of service. I believe we're seeing that again in the hospital industry and the reason that it can happen is that there is no real accountability. Health plans to some degree – Pacific Care, Health Net – are regulated by the state agency, by laws that were written finally in reaction to their abuses. Hospitals, business and accountability, is essentially unregulated. Clinical care, quality of care to some degree, through the licensing process, although I would dispute Bob Shirrell's earlier comment at length about this being the finest medical care in the world. We do not on any objective measure, on any single objective measure by the World Health Organization, rank first. We don't even rank in the first 10 in most cases. I have long yearned for us to ask Castro to solve the shortage of health professionals in the foothills in the rural areas. Castro is now sending about 5,000 relatively well trained docs through Central and South America and around the world, out of that little country, to provide medical care that will not be provided by any of the United Nations or our allies in the country.

But now back to Sonoma County. Here are some things we could do and I think we should seriously consider. The Kaiser system, for better or for worse and mostly for better, is a self-

contained rolling operation. I wish that Ms. \_\_\_\_ were still here because I would have one comment. She said something about the problems of the care for the frail elderly. For several years when I was associated with the On Lok Senior Health Program in San Francisco, we tried to get Kaiser to pay attention to the possibilities of using that model to deal with their increasingly elderly and frail population and the irony is that it is the Kaiser model extended, but they kept saying we're not at risk for long-term care, so they're not going to fool with it. Well, they are at risk in a way and their hospitalization rates among their elderly are too high and they could be significantly mitigated by using that system. But you don't have to wait for Kaiser to do it. One thing that should be considered here, urgently considered in this community, is the development of an On Lok-like model. If you don't know what that is, look up On Lok Senior Health Services on their Web site, or look up PACE, Program of All Inclusive Care to the Elderly, which is a federally sponsored, federally licensed program that was created after On Lok. That is a very successful, very affordable and self-sustained program. Once started, it does not require continuous infusion of community funds. That's one possibility. The other is really a newly emerging subject that's come up, and that is the possibilities that lie in local coalition direct contracting. And the reason that I mention the local coalition is based on the experience we've had at CalPERS. CalPERS is usually held up as the great gorilla on the block. Well, this gorilla has turned into a pet monkey because even with 1,200,000 beneficiaries, it doesn't have the muscle at the local level to radically influence the direction of the industry. The numbers aren't there, particularly if you take out the numbers that are in Kaiser. What you need in order to make an impact on the health industry structure and its prices and its quality is the action of purchasers, not the health plans. The health plans are largely impotent. First of all, they're afraid of the providers, they're afraid of the Sutters, they're even afraid of the large medical groups. If they don't have good relations with them, they'll walk out of the system, the health plan won't be able to operate to provide the choices that are essential to their marketing, and they have become intimidated by the organization within the industry. What can get the industry's attention are the purchasers themselves, the people who ultimately write the checks, whose funds pay the bills, whose dues and payroll deductions go into those funds. A coalition of purchasers could make, I think, great advantage of the possibilities of direct contracting. Now you will not read about this in the paper as much and it's certainly not in the literature, but there are a number of outstanding success stories in California where small single purchasers or small coalitions of purchasers dealing directly with providers, as Burrows suggested earlier, have managed to get not only very favorable rates, but agreements about some of the services we were talking about earlier in prevention, education and outreach. The health plans are not going to do it. They will strangle themselves and die before they change their business model. The reason that that will happen is that their business model depends upon short-term returns to an investment community that will not tolerate will not tolerate, long-range investments and return because they don't see it out there and there's no evidence that they'll ever see it. The community can realize a return from an investment in education and improved preventive services, but the health plans will not necessarily.

The other thing that we ought to be considering doing here is building agreements between all these agencies that have information to create a single pool from which we can derive utilization and charges information, from which we can make common judgments about the performance of the industry. The trouble with the structure now is that the rate that is paid by one purchaser is not the same as, nor will they even tell you what it is, as other purchasers. So that the fragmentation in purchasing goes to the fragmentation in cost information and the fragmentation

in utilization information. If we say to a buyer, a purchaser or a health plan we have reason to suspect that there is an excessive rate of cardiology services being provided at a facility and they go to their own data, they represent such a small part of the total population in the community that the numbers are not statistically significant enough to be decisive for strategy. We've got to learn to share data. We have been in a dialogue with CalPERS, and a dialogue with CalPERS can be a very long talking session indeed, but we have been in a dialogue with CalPERS that's been very promising. They have a new and very well designed decision support system, a huge data warehouse and information system. We have suggested to them that they invite the data from other purchasers, put it in the data bed so that if you look at the Sonoma population or Sacramento population you see not only the experience of the CalPERS beneficiaries but you can pick up the SEIU locals that are not in CalPERS, the carpenters, the teachers, the school employees, all of the other residents of this area who are buying health care and using it and they're spending their money in the system, but who are not getting concrete information about provider structure, performance or behavior. That is without that common sharing of information at a level that makes it statistically significant, you can't really figure out where your problems are.

In my earlier presentation I talked a little about tools that are out there, that are valid but are not used in California. I'll give you one concrete example, and that's a methodology for measuring the burden of illness in populations that was developed at Johns Hopkins. It is still under development at Johns Hopkins. The project was originally begun with federal funds. Then it was taken over by foundations and now I think it's largely self-sustaining. It's called the Johns Hopkins Adjusted Clinical Groupings. What it does, the methodology is simple. The outcome is very sophisticated and very sensitive. What happens is, they take all the medical records of populations and they weight them, so that if I go into the doctor with a sore shoulder and that turns out to be a sprained muscle, that is one weight. If I go in with a sore shoulder – same symptoms – and it turns out to be a torn rotator cuff, it's a heavier weight. So that over time, by accumulating this information, you build profiles which in our experience and work that I did several years ago with an information system company, it turns out to be a very accurate method of saying, this population really is sicker than that population and here are their characteristics. And then you can begin to identify where you need to target the weight reduction programs, where you can also target certain occupational hazards. Years ago I was doing some work in Monterey County and we discovered from the OSHPA (?), from the state data, unusually high orthopedic procedures that seemed to be – it was a DRG for extremities or something like that. It clearly was a main body frame, it had to do with hands or feet of something. So we get into it, it didn't make any sense. We looked at the ZIP codes, most of these admissions were coming from four or five ZIP codes in Salinas. It turns out – so I got in touch with the Salinas social worker in Monterey County in the Health Department and she said, I know those people. That's a population whose main employment is in the vegetable packing sheds. So we took a sample of those medical records, it turned out these were nearly all carpal hand and wrist injuries from the work. But they were not showing up in Workers Comp. The way the employers were steering their employees, they were steering them to either get paid for by the County because they had no health insurance, or they were being paid for by the basic medical coverage so they'd keep them off the Workers Comp books.

Now when you get into local system behavior and economic structures like that, you begin to uncover the issues that are affecting your costs, your quality of life, and the quality of Medicare

in your community. A favorite metaphor that's flying around is that health care is in a perfect storm. Well, baloney. Storms are largely the result of sun spots, for God's sake, or some other massive atmospheric event over which none of us have any control. This system we made, either by neglect or by active participation or by foolishness or by losing battles that we should have won. This is our creation. The health system we got is one that we brought on ourselves and either we fix it or it ain't gonna be fixed. This is not something you can expect anybody in Washington to do. I say this now as one whose first contact with national health policy was driving with my father down to a meeting of the Young Democrats in Salem, Oregon to listen to a speech by somebody campaigning for Harry Truman for the Wagner-Murray-Dingle Act. And we thought – my God, driving back to Portland with my dad he said, "We'll see it come. It will come. We will see a national health program if not in this administration, in the next one." We are farther from sound national health policy now because of the stupidity of this administration and the polarization within our Congress than we have been in 50 years, and we're drifting farther every day.

Mike urged taking action locally earlier. I tell you, if you don't you have nobody to blame but yourselves. The tools are there, you've got the money, you spend the money, you earn the money, the benefits are yours, the money is in your hands, the taxes are in your hands. For God's sake, take hold of it or quit complaining because nobody else is going to fix it – not in Washington, and not in Sacramento.