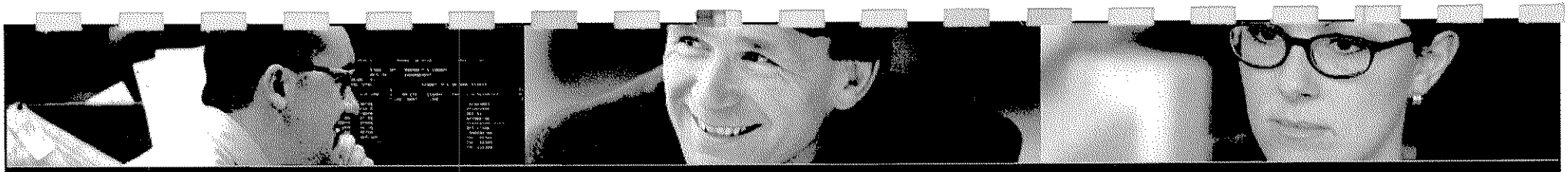


Willis

Employee Benefit Practice

THE MONSTER AMONG US

Are We Doomed to Face Ever Increasing Medical Insurance Costs and What Can Be Done About it?

Douglas J. Ley
Vice President / Director
National Actuarial Practice – Willis Benefits of North America
330 East Kilbourn Ave Suite 1400
Milwaukee, Wisconsin 53202
(414) 203-5248

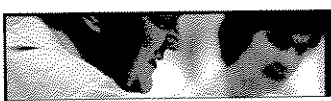
Willis

Employee Benefit Practice

THE MONSTER AMONG US

Are We Doomed to Face Ever Increasing Medical Insurance Costs and What Can Be Done About it?

Douglas J. Ley
Vice President / Director
National Actuarial Practice – Willis Benefits of North America
330 East Kilbourn Ave Suite 1400
Milwaukee, Wisconsin 53202
(414) 203-5248



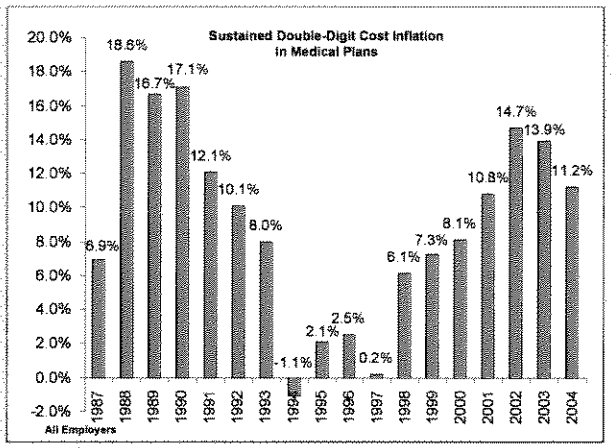
Insight into the Monster

Increasing health care costs put me over the expenditure cap - I need to cut something.....
Typical City Budget Director

Increase in health insurance premiums ate my raise.... *Typical employee*

Willis

The Monster's History



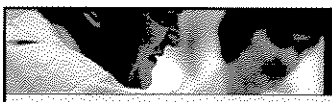
Willis

The Monster's Future

How has the City done compared to national averages?

- Average national increase for 2000 to 2004 was 12.8%
- Average increase in City expenditures 2000 to 2004 was 10.3%
- City increase in 2006 over 2005 is estimated to be 10% versus national estimates of 9 – 11%

Willis



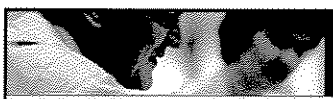
The Monster's Future

There is no reason to be optimistic about health care costs in the future… ….

- Upward pressures will continue as the population ages
- We are running out of quick fixes and takeaways
- The uninsured population is growing
- A plethora of factors drives cost; none of which appear to be abating

If annual medical trend is 10%, the City's medical plan cost will double every 7 years assuming no change in enrollment

Willis



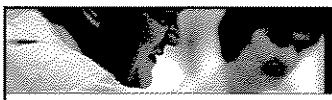
What Can Be Done?

Can the Monster be controlled?

May I have a silver bullet please!

No economy can indefinitely support a sector that grows at multiple of the whole

Willis



The Search For The Silver Bullet

- **Is volume purchasing the answer?**

  Put a lot of monsters together and you have... a lot of monsters, further administrative fees are low, less than 2% of the total Basic Health Plan costs and about 10% of HMO costs. Further, these expenses are not volume sensitive.

- **Are bigger discounts the answer?**

  We have been asking for bigger discounts for years and what has it done? What's retail? Further, as we will see in a minute, health care cost is driven by much more than cost per unit!

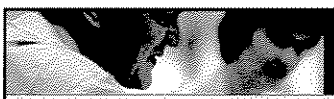
- **Is more "managed care" the answer?**

  What more can we manage? Have we been managing the wrong things?

- **Are consumer driven health plans the answer?**

  They only address one piece of the puzzle.

Willis

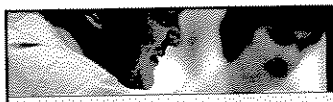


The Search For The Silver Bullet

Is the Federal or State Government the answer?

- Impact of the Balanced Budget Act
- A word from our friends in the EU
- Government can't outlaw illness
- Price controls will buy the 1970s revisited
- The willingness to take responsibility for almost 15% of GDP
- Current initiatives do not address the real factors driving costs

Willis

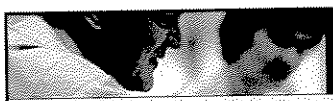


The Search For The Silver Bullet

Are employers the answer?

- They keep searching for for the silver bullet
- Want to transfer cost
- Can not or will not restrict choice
- Can't require personal responsibility
- Abandon health insurance - the ranks of uninsured are growing

Willis

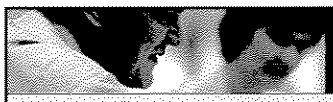


The Search For The Silver Bullet

Are physicians the answer?

- The incidence of invasive procedures vary from place to place – why is geography destiny?
- "Treat and street" versus maintaining health
- What is "wellness" and when should screening be done?
- The more that is done, the greater the reward
- What do you call the person who graduated last in his or her class at medical school?
- No pay for performance

Willis



The Search For The Silver Bullet

Are hospitals the answer?

- There is little evidence that patient safety has improved in the last five years

  Dr. Samantha Collier, Vice President
  Health Grades

- Some studies say 1 in 25 are harmed
- A computer in every hospital room?
- A hospital is really just an expensive hotel, and only a physician can make reservations.

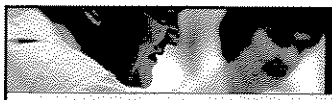
Willis

The Search For The Silver Bullet

Are consumers the answer?

- Why do we demand and physicians prescribe Nexium when Prilosec is available OTC?
- Why prescribe an antibiotic simply because mom thinks junior should have it?
- Are doctors' offices clogged with employees needing an excuse to get paid?
- Does requiring the patient to pay the bill confer on them a medical degree?
- Do we really know what is best, what it costs and do we care?

Willis

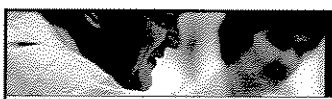


Pointing Fingers

Who is to blame for all this?

- Providers (nurses, doctors & hospitals)?
- Insurance Companies?
- Lawyers?
- Employers?
- Pharmacy Companies?
- You?
- Fate?

Willis



Who Is To Blame?

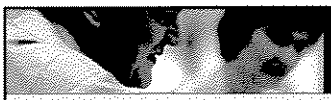
Everyone needs to take a look in the mirror

- **Federal and State Governments**
- **Employers**
- **Physicians**
- **Hospitals**
- **Patients**
- **Everyone in the room**

We all contribute to four massive problems. First, health care is both vast and extremely fragmented. Thousands of health care organizations can make decisions on behalf of their own interests independent of their impact on the whole. Second, there are not enterprise-wide management capabilities that allow the system to clamp down on costs or force efficiencies in ways that other industries take for granted. Third, we have an extremely litigious society that exacerbates all the inherent inefficiencies and errors that result. Fourth, we don't take responsibility for ourselves.

First three courtesy of Brain Klepper Center from Practical Health Care Reform

Willis



What Can Be done?

Can the Monster be controlled?

Maybe, but to succeed.....

We need to understand what drives cost, stop pointing fingers, take responsibility for what we can change, live with what we can't and participate in global processes to change those factors beyond our local control.

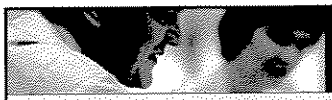
There is no silver bullet for a multifaceted problem!

Willis

What Causes Medical Cost Increases

"Grant me the serenity to accept what I cannot change, the courage to change what I can and the wisdom to know the difference."

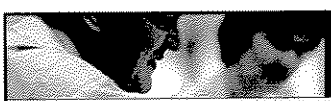
Willis



What Causes Medical Cost Increases

	City Can Control	City Can't Control
• Inflation in Fees		
• Use of Services (Utilization)		
- Aging Population		
- Employee Demand		
- Physician Practice Patterns		
• Litigation		
• Fraud		
• New Technologies		
- Machines		
- Drugs		
- Therapies		
• Cost Transfer		
- Federal Government		
- Bad Debt		
-Charity Care (uninsured)		
• Duplication of Service		
• Life Style		
• Consumer Insulation from Cost		
• Administrative Complexity		
• Outcome		
• Lack of Information		
- Provider		
- Patient		
• Lack of accountability		

Willis



Predicting The Future

What determines total health care cost?

Price per unit x $Volume_1$ x $Volume_2$ x $Volume_3$ x $Volume_4$ adjusted for Outcome = Cost

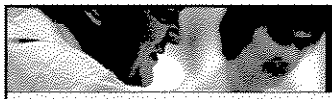
Volume 1 = Determined by physician practice and billing patterns

Volume 2 = Determined by patient preferences and expectations

Volume 3 = Determined by patient health status and lifestyle

Volume 4 = Determined by payer

Willis



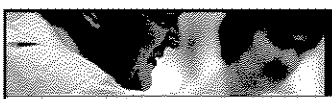
Predicting The Future

What defines cost in the health care environment?

Outcome = Benefit to the patient as determined by:

a. Efficacy:	Which treatment produces the best result for the patient?
b. Effectiveness:	Does the treatment result in superior outcome when applied in the delivery system?
c. Appropriateness:	Is the treatment used appropriately at the right time in the right place?
d. Execution:	How well does the provider perform the procedure?
e. Patient Compliance:	Does the patient understand and comply with the treatment plan?

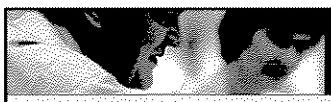
Willis



Predicting The Future

Most historical efforts to control cost focus on a single issues, either price per unit or administrative cost and ignore the principal issues that drive cost.

Willis

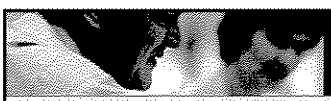


How Do I Do Something?

Knowledge is power….

- Understanding the facts (coming to grips with what we just discussed)
- Understanding the past (what is driving our costs)
- Predicting the future (where are we headed)
- Doing something about it (beyond repeating the failures of the past)

Willis



Understanding The Past

Where is the money going – what are the principal cost drivers?

- Top 25 drugs – generally statins, PPIs, non-sedating antihistamines and antidepressants
- Top 25 diagnoses – generally heart related, digestive, cancer, joint and renal
- Top 25 procedures – generally office visits, pap tests, psychotherapy, chiropractic and therapeutic procedures

Willis

Understanding The Past

What are the principal cost drivers?

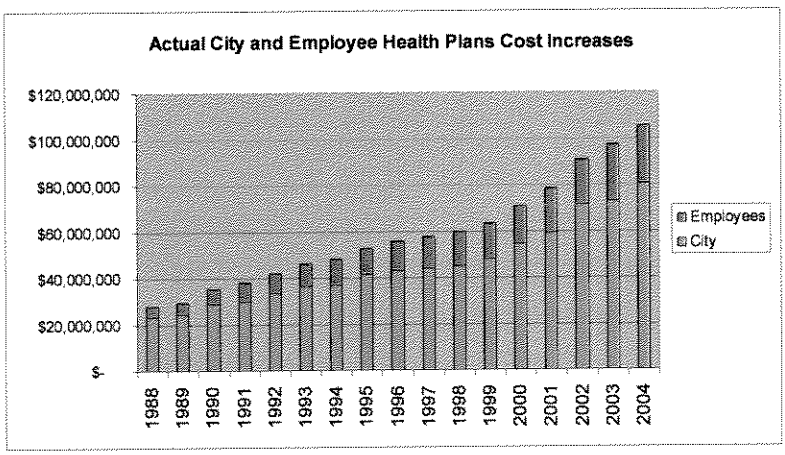
A small number of "things" drives a significant portion of the cost

- 25 drugs equal 30%-40% of total drug cost
- 25 diagnoses drive 35%-45% of total hospital cost
- 25 procedures drive 30%-35% of total professional cost

Willis

What Is The Benefit Of Doing Something?

Even small changes can produce large savings



Willis

What Is The Benefit Of Doing Something?

The benefits of small changes can produce large savings

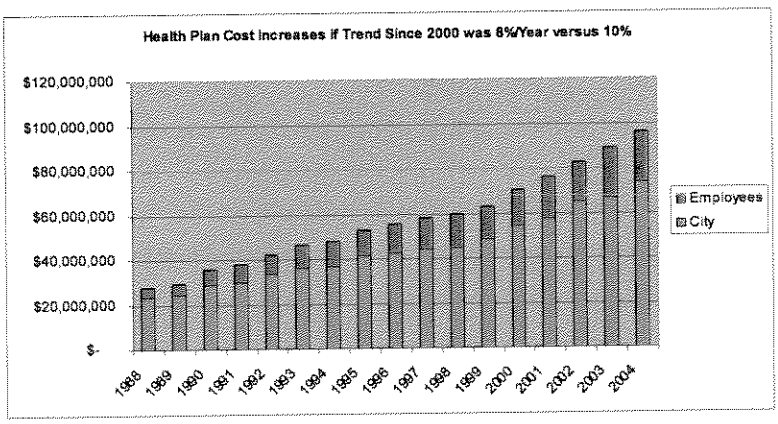
From 2000 through 2004, the cost of the medical coverage increased a little over 10% per year.

What would have happened had the City been able to hold the rate of increase to 8% a year from 2000 through 2004?

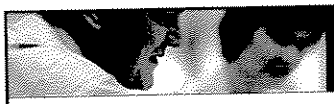
Willis

What Is The Benefit Of Doing Something?

Even small changes can produce large savings



Willis

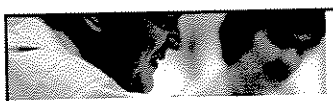


What Is The Benefit Of Doing Something? Bringing it Closer to Home

Had the rate of increase been 8% versus 10% over the last 4 years, the savings would have been significant to both the City and Employees.

Year	City	Employees	Total
2000-2001	$1,647,402	$532,774	$2,180,176
2001-2002	$6,480,804	$1,742,465	$8,223,269
2002-2003	$6,229,407	$2,098,979	$8,328,386
2003-2004	$6,867,534	$2,074,337	$8,941,871
Total	$21,225,147	$6,448,555	$27,673,702

Willis



Bringing it Closer to Home…

Can you really reduce trend?

Yes – provided you are willing to understand what factors drive cost and take active collaborative steps with all stakeholders to address them.

Willis

Bringing it Closer to Home…

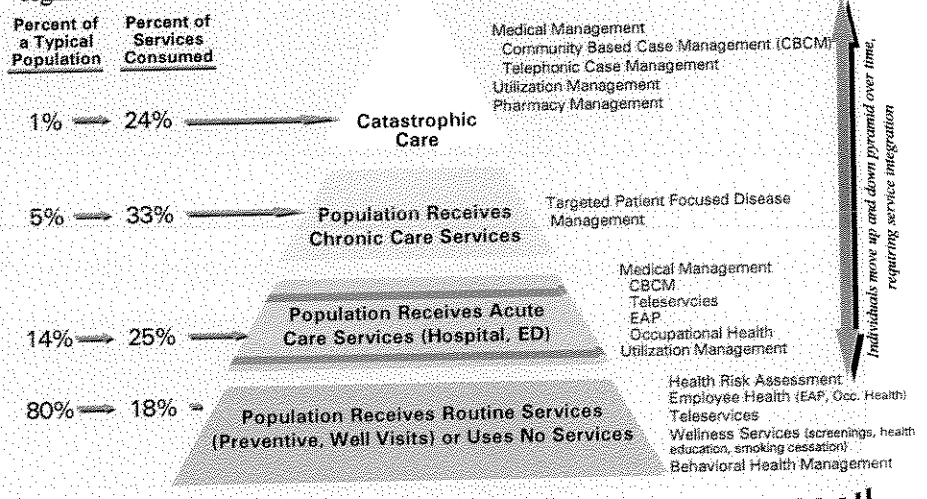
It doesn't need to be cost transfer – we need to get smart - can we afford <u>not</u> to do the right things?

The result of inaction will be defacto rationing…..

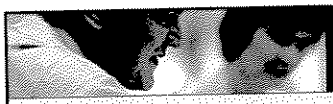
Willis

Understanding The Future

What strategies do I need? A successful strategy must focus on managing all population segments



Willis



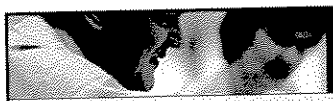
Succeeding In The Future

Keys to Success

The City has done better than the national averages. However, to succeed in the future, the focus needs to be on integrated global approaches which recognize the contributions that all parties make to the problem, not just the solution du jour. The focus must be on:

- Knowing what is driving costs and get smart about the solutions
- Educating all stakeholders
- Expecting both City and Employees must spend wisely
- Keeping people well,
- Effectively treating episodic and chronic illnesses,
- Selecting appropriate providers,
- Managing peoples movement up and down the pyramid,

Willis



Succeeding In The Future

Keys to Success

- Removing barriers to communication
- Partner with providers
- Partner with vendors
- Restrict choice – you can't have accountability with a free for all
- Foster knowledge and accountability
- Monitor progress and results
- Labor and Management must partner – not fight

Can we afford the cost of inaction and the status quo? - the nation's health care bill is almost 15% of GDP and increasing, can we afford this? There is no sliver bullet just many small opportunities that add up to big dollars

Willis

The Concise Guide To Economics

by Jim Cox

7. Price Controls

Price controls are the political solution enacted to stop price inflation. [See Chapter 21 for an explanation of the cause of inflation.] The controls do not work. Prices are determined by supply (willingness and ability to sell) and demand (willingness and ability to buy). The price resulting from supply and demand which clears the market is not changed by a price control (a legal limit on price). The legal price is merely a misstatement of the actual conditions and is comparable to plugging a thermometer so that it never can read greater than 72 degrees even though the actual temperature may be higher. The law of supply and demand cannot be repealed.

People will call for price controls as a way to make goods available cheaper than they otherwise would be. The price controls do not make the goods cheaper and in fact cause a shortage of those goods as the demand quantity will be greater than the supply quantity. Not only do price controls cause shortages but they in fact make goods MORE expensive!

How can this be? The shortage resulting from the price controls causes consumers to pay for the good in question in ways other than a price payment to the seller. To take an example from the experience in the U.S.: the price of gasoline was legally limited between August 1971 and February 1981. At a time when gasoline could not be legally sold for more than 40 cents a gallon, the estimated free market -- supply and demand -- clearing price was 80 cents a gallon. Using a ten-gallon fill-up it would appear that the consumer is saving $4.00 per tank full (10 gallons x 80 cents versus 40 cents). While consumers are not paying as much to the seller for the gasoline directly, they are in fact paying dearly for the gasoline in other ways.

Probably the greatest expense is in the form of the consumer's time. The shortage results in extensive time spent waiting in line for the purchase. Time is money; a consumer's time has value. Using a minimum figure of the consumer's time being worth $2.00 per hour, a two-hour wait in line per fill-up wipes out any alleged saving from the price controls. But the consumer is not through paying. The idled gasoline used waiting in line is another form of consumer payment, say 10 cents per fill-up. Now we have the price controls actually costing the consumer an extra 10 cents per tank full. And there are yet more costs to the consumer. There is a difficulty in buying gasoline when there is a shortage in that it takes extra mental energy and planning which is an aggravation (that is, a cost) for the consumer he would much rather avoid. (Doubt this last point? Check your own behavior: Do you call around to the gas stations in your area before stopping for a fill-up, or do you avoid that aggravation although you know that not checking will often result in paying a higher price than

necessary?)

These extra expenses continue in the form of the violence and the fear of such violence that can result from tensions mounting while waiting in long lines for gasoline (shootings did occur in this situation during the 1970's price controls). Other expenses might include the purchase of a siphon hose for legitimate or even illegitimate gasoline transfers from one vehicle to another. Also, siphoning gasoline carries its own severe health and safety costs when poorly executed!

The fact that there is more demand than supply of gasoline generates a further consumer cost in reversing the normal buyer-seller relationship. The normal buyer-seller relationship is one of the seller courting the consumer, attempting to please the consumer as a means to the seller's financial success. But with the price control-induced shortage it is the buyer who must please the seller to be among the favored whom the seller blesses with his limited stock of goods! In the 1970's this reversal was played out as sellers dropped services from their routine -- no more tire pressure checks, oil checks, windshield cleaning, etc.

All of these further consumer costs only make the expense of gasoline that much greater than the free market price. Consumers have the choice of paying the free market price for gasoline in dollars directly to the seller or paying an even higher controlled price in a combination of dollars and other costs. But there is a difference in these two forms of payment for gasoline. The difference is that the direct dollar payment to the seller is an inducement to supply gasoline. The payment by the consumer in other costs encourages no such supply.

- Block, Walter, editor
  Rent Control, Myths & Realities,
  (Vancouver, British Columbia: The Fraser Institute, 1981)

- Katz, Howard
  The Paper Aristocracy,
  (New York: Books in Focus, Inc., 1976)
  pp. 113 - 115, 117

- Reisman, George
  The Government Against the Economy,
  (Ottawa, Illinois: Caroline House Publishers, Inc., 1979)
  pp. 63 - 148

- Rothbard, Murray N.
  Man, Economy, and State,
  (Los Angeles: Nash Publishing, 1970)
  pp. 528 - 550

- Schuettinger, Robert and Eamonn F. Butler
  Forty Centuries of Wage and Price Control: How Not to Fight

Inflation,
(Washington, D.C.: The Heritage Foundation, 1979)

- Skousen, Mark
Playing the Price Controls Game,
(New Rochelle, New York: Arlington House Publishers, 1977)
pp. 67 0 86, 109 - 126

Center for Practical Health Reform
P.O. Box 87080
Baton Rouge, LA 70879

Interview with Brian Klepper

A Framework for Reform: An Interview with Brian Klepper, PhD, Founder and President of the Center for Practical Health Reform, Jacksonville, Florida

Interviewed by Richard Reece, MD

Interviewer: Dr. Klepper, five years ago you founded The Center for Practical Health Reform. Why did you do it?

Klepper: For 12 years I had a health care consulting practice that worked around the country and internationally with physician groups, hospitals, health plans and other health care organizations. Our focuses were the strategies and operations associated with business repair and development. I continually monitored health care market dynamics as a way of defining strategic imperatives: how my clients should anticipate the marketplace, given the opportunities and threats that were coming down the pike.

About October 1999, I realized that the American health system was edging toward a financial cliff. Health costs were crossing thresholds of affordability for mainstream Americans. Unrestrained cost growth throughout the highly fragmented health care industry would ultimately price increasing numbers of individual, corporate and governmental purchasers out of the health coverage market. That, in turn, would reduce revenues available to the health care industry. Because health care is the largest economic sector – one of 7 dollars and one of 11 jobs – a downturn would have ramifications for the economy as a whole. As I thought it through, I became very alarmed.

Interviewer: And that was the genesis of your reform effort? What action did you take?

Klepper: I visited my mentor, Dr. Brooks Brown, a retired surgeon and a great human being, who had founded not one, but two, regional health systems. He challenged me to figure out what to do next. We held a meeting of prominent health care practitioners throughout Florida, and we asked two questions: Could the system actually fail, and what would you do to fix the system?

The answer to the first question was a unanimous "Yes." That gave everyone pause. And then, after a lot of bickering, the group developed and unanimously agreed on seven principles for change. We thought it was profound that, when pressed, these adversaries could transcend their special interests to come to consensus on the things that mattered most. That evening we debriefed in my living room and Nick Gieschen, one of the original group behind the effort, suggested that we should replicate this elsewhere and forge a national reform effort.

I wrote a conceptual framework and sent it out to the most prominent people I could get to, inviting them to a follow-up meeting. It has occurred to me since that because I was unknown, the people who responded –

Harris Berman, CEO of Tufts Health Plan; George Lundberg, Editor-In-Chief of Medscape; Jerry Reeves, CEO of WorldDoc and Human's former national Medical Director, Joe Spiak, Bank of America's SVP of Healthcare Public Finance, Norbert Goldfield, VP of 3Ms Health Care Informatics Division – were very open-minded.

That group, about 20 or so individuals, came to a meeting that fall in Jacksonville They revised and clarified the principles, making ten where there had been seven before. They argued about everything; the wording of the principles and what we should be about, but it was the right start. We pushed out from there.

Interviewer: You have reduced those initial seven and the subsequent ten principles to three overarching principles. Why was that?

Klepper: Someone pointed out that ten is too complicated, and that we should make it three. And I thought, "How am I going to do that?" But we realized the principles morphed naturally into three sensible categories. The first two, *Management Capability Standards* and *Basic Coverage*, are connected at the core. The third, *Rebalancing Health Care Liability*, is important and has a lot of political profile, but at a practical level pales in significance to the others.

Interviewer: Talk about the two core principles.

Klepper: The first principle focuses on our ability to get cost and quality under control, which are the issues at the heart of the crisis. The problem is that, despite its many successes, American health care has never developed standardized management infrastructure at the enterprise level.

So we urge changes in five areas: 1) standardized performance measures at every level of the system, 2) compatible (or interoperable) information technology platforms for easy exchange of information and for data aggregation so that we can identify problems and opportunities, 3) evidence-based medicine and management, 4) pre-market technology assessment and post-market technology surveillance, and 5) paying for outcomes rather than services.

The second principle is equally important and is focused both on social justice and our health system's financial stability. America must establish a floor of coverage for basic care for everyone in the country. Rapid increases in the nation's uninsureds and underinsureds are overwhelming many safety net hospitals and clinics. If we don't find a way to associate basic care funds for every patient that presents, our safety net infrastructure will collapse and we'll literally lose tens of billions of dollars that we've invested over decades. A national program that provides coverage for basic care would protect our safety net hospitals and clinics as well as our market-based coverage system. It would also make it easier for people with fewer resources to get access to health care coverage. It would be a win for everyone.

Interviewer: You continuously stress that high costs cause rapid erosion of private coverage with subsequent revenue shrinkage for the health industry. This may then lead to economic chaos in the economy as a whole. As you try to recruit troops to your reform effort, does that message resonate with audiences and decision-makers? Do they believe you?

Klepper: It depends. Most decision makers believe me while I'm talking with them, but then they go back to their organizations, which are making money and doing fine at the moment. They aren't in pain, and this is abstract, so the message becomes less compelling.

Other groups get it immediately and take it to heart. Health care finance people – actuaries, finance officers, those types – are the most responsive, because every day they watch the numbers and the underlying trends..

I find that building the argument on solid data moves the focus away from me, objectifies the problem, and clarifies the gravity of the situation. So for example I point out the magnitude and unsustainability of health care cost growth. The Kaiser Family Foundation and the Health Research and Educational Trust track the growth in premium costs and then compares that to general inflation. In 2002-2004 premiums increased 8, 6, and 5 times as fast as everything else in the economy.

And then I try to show documentation of the slippage that's already occurred. Last May, the US Bureau of Labor Statistics published an analysis that tracked private sector jobs with health benefits over the last 13 years. During that time, jobs with benefits eroded by 32 percent. Startling enough. But when you look more closely, the decline accelerated as cost priced purchasers out of the market. Between 1991 and 2000, the percentage of private sector jobs with coverage eroded at an average annual rate of 2.4 percent, but in the last three years it nearly doubled to 4.5 percent. And though premium growth has slowed somewhat recently – it's about 4 times general inflation now – there's every reason to believe that the erosion rate is accelerating. Many small businesses are dumping coverage, and mid-sized to large businesses are cutting back. Many more people are becoming uninsured and underinsured.

There are other dynamics here. The under-insurance problem bears discussion. With the new trend toward "consumer-directed," high deductible plans, people who still have coverage have higher contributions, higher out-of-pocket expenses and narrower benefit structures. If you look at this from a cost-per-unit-benefit basis, then premium growth has risen much faster than the 5-8 times inflation rates we've been considering, because we're comparing last year's more robust coverage with this year's pared-down coverage.

There is also a lot of talk in the industry and the media about personal responsibility and skin in the game, but there are two harsh truths here. The first is that, given the current scale of health care costs, high deductible plans are perhaps the only financial vehicles that can allow employers to continue offering coverage. The second is that cost now has exceeded the ability of many mainstream Americans to cope with a significant portion of it without assistance.

Perhaps the most worrisome issue, though, is that, so far, the less agile public sector has simply absorbed these explosive costs. Public dollars have propped up the system, and they have conveyed the message that the system is stable. But the health system is anything but. As legislators begin to talk now about cutting Medicaid and Medicare allocations, the ramifications could prove dire for many provider organizations and other health care firms that feed off them.

Consider, for example, that hospitals nationally now are running a 1-1/2 percent margin and that half the hospitals in the country are in the red. The combination of flight from private coverage and reductions in public health care programming allocations will hit the health care industry very hard. Because health care is such a big part of the economy, it's difficult to not believe that the disruptions could cascade to every economic sector.

Interviewer: And who is going to lead us out of the morass and save us?

Klepper: Most people look to Congress for leadership. But health care is too complicated and the cost explosion is seemingly intractable. Congress has continuously avoided trying to deal meaningfully with it. And moreover, let's be frank. Who's in charge? It would be hard for any reasonable observer to take issue

with the fact that vested interests drive Congress. Look at Medicare drug reform. An additional $700 billion over 10 years was driven into the system, but the primary beneficiaries were health care corporations and large employers. Seniors were way down that list.

Interviewer: What is the nub of what we're facing?

Klepper: The nub is the health care cost crisis that will impact everyone, and that we need leadership from the power players to bring us to health care's next phase. Corporate leaders will have to be convinced that the problem threatens them, and that meaningful solutions will accrue to their benefit. If they provide leadership, then Congress will follow their cue and take the necessary steps toward workable solutions.

Interviewer: That, of course, leads to the next question. What are workable solutions?

Klepper: Answering that requires framing the real roots of the problem. There is, of course, a very long list of problems in health care. But there are two very deep roots that underlie most of those.

The first is high fragmentation in the health care industry. Millions of professionals and tens of thousands of organizations make self-interested decisions every day, independent of their impacts on the system as a whole. In that environment, every proposal – no matter how reasonable – threatens someone in the system with the influence to kill it. So we're gridlocked. Getting meaningful health care reform done will require overcoming that gridlock.

Self-interest and gridlock are exacerbated by a second different, inter-related problem: the lack of an enterprise-wide management infrastructure. Because we still lack standards and a way of monitoring performance information, we can't see the outcomes of most processes throughout health care. We can't identify problems and opportunities, or cultivate optimal performance. Results remain invisible, so we can't manage very well.

Worse, this opacity keeps the market from working. Because we don't have information, companies can take advantage of their positions and we can't hold them accountable.

Together, these two problems create a health care marketplace that lacks the tools to work properly. This is an important point. Some health care corporations would argue we should leave everything alone and let the health care market work. But as the economist Adam Smith pointed out, markets require what he called "perfect information." In health care, we have virtually no information.

Rather than point fingers and say "It's the fault of – pick one: the health plans, the drug companies, the device companies, the docs – the better solution, at the level of policy, is to shine the bright light of transparency and standards into the health care marketplace and allow the market to work. This would impact all the stakeholders in the same way. Only then will we get the kind of efficiencies and economies that are possible. That would be the best, and the most American, of all possible solutions.

Interviewer: You've painted the picture of the health system as an uncoordinated giant without a central or peripheral nervous system.

KIepper: That's really true. Pat Salber, CPHR's Medical Director, and I were visiting the AMA Health Care Reform Task Force the other day, and one panelist commented that there's no leadership in health care and that there's no one group

at the helm. That echoed the remarks in last month's *Health Affairs* by Dr. Don Berwick of the Healthcare Improvement Institute and Dr. Bob Galvin, GE's health leader, that health care's leaders have demonstrated "a deficiency in will and ambition" in getting things to work.

Pat and I said, "Yes, but these leaders haven't yet been convinced that it's in their interest to change." We think we have to first establish the reason why everyone should want health care reform. People buy into self-interest, not ideals. We think the threat of economic collapse is the common threat, and it creates a common goal. To our knowledge, this is a key point that has not been clearly articulated by any other group.

Interviewer: You said earlier that corporate America generally shapes the health care system. This brings up the subject of the so-called supply chain – those corporations that supply the goods, services, technologies for hospitals and doctors. These are large corporate interests that are feeding at the health care trough.

Klepper: They also supply the miracles that we all expect.

Interviewer: These companies are a pivotal part of the cost crisis, yet their roles have been largely invisible to reformers.

Klepper: They keep a low profile. When I look at the pharmaceutical and device manufacturers, I think, "What wonderful stuff they make. What they've developed has become the basis for the greater part of medicine. These drugs and devices – they've changed everything."

The rub comes when the firms push out beyond the level of appropriateness: selling more than we need or selling to people who shouldn't be using their products in the first place.

Interviewer; This brings up to me the image of Pfizer, who has been hit recently by the COx-2 inhibitor/heart risk safety fiasco. Pfizer last year had revenues of $52 billion and profits of $18 billion. Wall Street is portraying their relative business slowdown as a crisis. Is it?

Klepper: Well, we see the world from where we live. A lever in the reform process is that the market typically interprets a 3 percent revenue decline as slippage, even when it occurs to due to broad environmental conditions and to an immensely wealthy company. For Pfizer and other firms, the stockholder ramifications of a market disrupted by declining resources and increasing demand are enormous. The threat of absolute and relative loss is also an opportunity to galvanize support for change.

Similarly, it's ineffective to be moral outraged when companies behave inappropriately. A better strategy is to call for transparency in industry so that it becomes more difficult to behave inappropriately. We recently had occasion to see the power of this.

We held a meeting of senior executives in the health care supply chain. During the discussion, one participant acknowledged that the supply chain's lack of transparency had resulted in perceptions of conflict of interest inside and outside the sector. The group agreed to develop more comprehensive operating standards and performance measures.

The GPOs, who are under Congressional scrutiny now, are putting their best foot.

But these principles – standards and transparency – would apply would throughout the sector. This doesn't seem like a big deal until you consider that supply chain products account for 35 percent to 40 percent of acute care costs, and it's growing at around 14 percent a year. It's a huge part of overall health care cost growth.

Interviewer: An example of what you're describing is the Styrker Corporation is Kalamazoo, Michigan. It supplies hip, knee, and spinal implants for aging pages and the tools to install them. Its earnings per share are growing at 20 percent per year, and its shares are worth $18.6 billion – roughly the same as corporate heavyweights like International Paper, Volkswagen, and General Mills.

Klepper: Self-interested inappropriateness is one of health care's most pernicious devils. Dr. David Soffa, the Chief Medical Officer at American Imaging Management points out that, currently, 10 to 12 percent of all commercial health plan expenditures result from ambulatory imaging. Manufacturers of PET scanners and other imaging devices appear to have no protocols that govern who they sell to. Doctors that buy them have financial stakes in the devices, and there are no protocols governing their application. Health plans have been asleep at the switch, but now they've identified this problem. So the case is made for distribution and application protocols.

Interviewer: There's another aspect to the imaging explosion, and that is that the public has come to expect routine imaging as representing the standard of care. I was speaking to a friend of mine, and he said, "You know, I have had four MRIs in the last six months, and I feel a lot better." He thinks of MRIs as not only a diagnostic but a therapeutic device.

Klepper: Not surprising, but ironic. In an environment that lacks professional guidelines, doctors appear to be more susceptible to defaulting to patient expectations, even when they're inappropriate. We have excess on one side, and a failure address other, larger problems.

For example, twelve percent of the national health care expenditure– something like $220 billion – goes to diabetes. We know that there are twice as many diabetics as we can identify. Of the ones we do know about, only half of those are getting the minimum protocol, a HbA1c every six months. So three quarter of the diabetics in the country have exacerbated conditions and care.

If we managed that population, just paying attention to who they are and what they need, we should be able to save $50 to $75 billion. That should make a dent toward replacing our entire national health care information technology infrastructure, which we desperately need, because it's the predicate to really turning things around. We've done an exquisitely poor job of managing resources. And the crazy part is, its not like we're not already spending adequate dollars.

Interviewer: That's a manifestation of the highly fragmented doctor population and the highly fragmented industry. Given the current structure, you can't get everybody on the same page simultaneously and you have little transparency and accountability.

Let's switch the subject. Over the last five years, you have traveled all over this vast continental nation, talking to groups of hospitals, doctors, health plans, actuaries, associations, health resources experts, chambers of commerce, and supply chain executives. What have you learned from this tortuous and tortured journey through the hinterlands and backrooms of the American health care industry?

Klepper: I've learned that when you live in a dugout, the world looks like a baseball diamond. Even though healthcare decision makers are in it and of it, I have come to believe the health care market dynamics are more dire and grave than most people in senior positions appreciate. I see the threat as more grave than they do. That could mean I'm wrong, or they're wrong. I am not convinced that I have convinced others of what I see. I worry that I'm a Cassandra.

Second, there many efforts for reform going on out there, and I worry that pride of ownership and a desire for control keeps people from objectively evaluating the design capability of certain organizational vehicles to accomplish the goals.

Some efforts hare highly focused, and are highly authoritative on various specific parts of the larger problem. For example, the information technology initiatives orchestrated through the Healthcare Information Management Systems Society (HIMSS), the E-Health Initiative, and HealthTech. Or Common Good, a neutral effort on medical liability reform. These efforts are charged with informing neutral, structural solutions in certain areas, so more power to them.

But then there are others, partisan efforts by hospitals, health plans, employers or whomever that seek to drive reform from a particular perspective, accruing, of course, an advantage to the drivers. These efforts cannot ultimately be effective, because other influential groups will do everything possible to neutralize their efforts.

And others still that are focused on surrogates of the solutions – for example, addressing the uninsured, personal responsibility. These issues may have an important role in a larger reform context but don't get at the deeper issues that are plaguing us.

The problem is that this second set of groups distract precious attention and resources from the critically important mission of coming together to get things done. They may be used to winning in a lobbying environment, but the solutions needed by health care reform must be derived through consensus, not by winning. They're not properly constituted to effect major societal change, or they're not focused on the real problem.

Interviewer: So the doctor lobby, or the hospital lobby, or the health plan lobby, or the supplier lobby, or the drug company lobby – powerful interest groups by themselves – cannot solve the problem.

Klepper: Health care is now experiencing a diminishing resource pool and an increasing demand for services. We can see this most clearly in the private sector right now, but it will soon happen in the public sector as well. When the reckoning with cost growth occurs, neither the state nor federal government will be able to stand the increase. The reductions in allocations – the correction, if you will – will be felt hard at the doctor and hospital levels, and downstream.

When it hits, every special interest will develop an agenda. And that agenda will say, all we need is for the government to give me more money. If that is allowed to happen, we will have a political free-for-all where the strongest group – like the health plans or the drug companies – will win. But in that scenario, everybody else loses, and we don't fix the problem. We will just pay a lot more to try to stave off disaster.

What we need is neutral coalition platform, undergirded by a narrow set of change principles that everyone can ultimately accept as an alternative to continued market erosion and financial disaster. That platform should be built by early adopters, but it

should be available as a refuge to the traditionally intransigent who, once they realize that the market is turning hostile to their interests too, will have a place to go rather than simply waging war on the rest of us. Properly constructed, the platform would not only guide appropriate change (once it had enough heft), but would serve as a governor on rogue behaviors by the intransigents.

Interviewer: Are we nearing Gladwell's Tipping Point, in which events – e.g., uncontrollable costs, masses of uninsured, and fraying of the safety net – converge to create a social epidemic and widespread calls for massive reform? Could the current health care cost crisis at the Autos trigger the Tipping Point?

Klepper: I don't think the Autos will trigger our crisis. But, yes, they're in a serious box. They made commitments years ago that are difficult to live with. They have a population that uses health care excessively. The unions enforce and prop up that paradigm. There's terrible dynamic tension between the companies and the unions, and while they each say the right things, neither appears to be genuinely moved by the severity or immediacy of their dilemma.

But I do think we're at a Tipping Point. Next year's premiums are going to come out in September and October. If we get another significant jump, you'll see another bite taken out of the insured, and you'll see those remaining with less affordable insurance.

Interviewer: So a universal single payer system superimposed on the existing infrastructure will not get at the root causes of the problem?

Klepper: That would only be a financing fix. The health systems in all developed countries have the same problem. Most of the cost explosion – and that's where we started – occurs because of the ways that health care is supplied and delivered. Personal responsibility matters, particularly when you realize that 65 percent of costs come from the 15 percent of people with life-style related illness. But the more immediate and pressing issue is how we care for people. And we don't have mechanisms to see and manage how health care is delivered.

Until we get that management capability in place, the financing system is just how we get the money to pay for all of that. Single payer systems – remember that Medicare is one – are highly susceptible to political influence. That 's part of the reason Medicare is in the mess it's in. Medicare is administratively efficient because it just pays everything independent of whether it's appropriate or not. It's an ideal mine for money. No, I don't think single payer solves our biggest problems.

Interviewer: We're nearing the end of this interview. Any concluding remarks?

Klepper: A long time ago, someone told me I would become very disappointed as a result of this effort. That hasn't happened. It's a grand problem and, in working on it, I've learned a great deal, not just about how the world works but about the human condition. And I would say the people I've met, almost to the one, have been fabulous. The role that I've had, as an emissary and sometimes, an adversary, to the various minions, has been possible because I've had the trust of a lot of people. So it's been a great privilege and honor to do this.

I'm optimistic precisely because I think we're close to the Tipping Point, and I believe that we'll leverage the crisis to get where we need to go. My job has been to smooth the transition, to try to make the spinoff chaos easier on the innocent bystanders. The timing is very hard to nail down, but there's no question that we're about to deal with health care in a new way, and that after some very significant turmoil, we'll have a better health care on the other side. It's not if, it's when.