FEDERAL TRADE COMMISSION

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I N D E X

P R O C E E D I N G S

DR. HYMAN: I'm David Hyman, special counsel here at the Federal Trade Commission. Let me welcome you all to the reconvening of the Hearings on Health Care and Competition Law and Policy jointly sponsored by the Federal Trade Commission and the Department of Justice.

This is the latest in a series of hearings that started in February and are going to last through September, perhaps October, unless I can make it September, and represent an ongoing investigation of the performance of differing parts of the health care market with regard to the cost of the services that are provided, the quality of those services, and the extent to which ordinary Americans can access information about those services and obtain those services at a time and in a fashion that is desirable to them.

This morning we have a very distinguished panel and extensive bios for each of the speakers, not all of whom, unfortunately, are here just yet, and are published in this beautiful book that's available outside. Our rule is, accordingly, short introductions because you can read about the people in the book.

The format we're going to follow this morning is our first speaker, Newt Gingrich, is going to make somewhat extended remarks. And then there will be a panel discussion

of those remarks, and we'll include, as time allows, members of the audience in that discussion if they have questions or comments that they'd like to make.

And then following the time that we've allotted for that portion of the program, we will then move into presentations by individual speakers. At the end of that time, we will then have a moderated panel discussion among the speakers about the issues that we'll be discussing today.

The focus of our discussion today is financing options and consumer information. It's essentially a constellation of subjects relating to how Americans get their health insurance coverage, the availability of information regarding that coverage, the extent to which current institutional arrangements insure a range of options available to them, and the impact of those financing arrangements on the delivery system for health care.

Our first speaker of the morning is former Speaker of the House Newt Gingrich, the author of seven books, including one he's going to speak about today, "Saving Lives and Saving Money." And there's a very nice handout outside that outlines some of the book, which presents Newt's vision of a 21st century system of health and health care.

Newt is currently the CEO of The Gingrich Group, a communications and consulting firm specializing in transformational change. He recently launched the Center for

Health Transformation, which advocates for market-oriented health care.

And just two other preliminary announcements. If everyone can turn off their cell phones. The Speaker likes nothing better than being interrupted by the sound of your cell phone. And second, time will be kept by Cecile Kohrs over at the table there. So if the speakers can just keep an eye out for that, it will ensure that we'll have adequate time for discussion.

Newt, you can either sit or stand at your option.

MR. GINGRICH: If it's okay, I'll just sit, if that's all right. And I'll try to go through this pretty rapidly as an outline.

But first of all, Dave, let me thank you and the Federal Trade Commission and the Department of Justice Antitrust Division for hosting us today. I think trying to think about impediments to competition in health is a very, very important topic, first because of the rising cost of health care, second because the scientific and technological breakthroughs are likely to increase the cost of health care, and third, because the aging of the baby boomers guarantees that the sheer volume of health care over the next decade of 15 years is going to continue to go up.

If you look at the current crisis in Europe and Japan, one of my mentors, Steve Hanser, just spent a month in

Europe. I called him when he got back. I said, "What did you learn?" He said, "Well, I was in four countries and there were four issues: pensions, pensions, pensions, and pensions," he said, "with the cost of health care and unemployment being a distant second and third."

And I think if we don't in the next few years bring to bear a much different approach to how we have a competitive health system, that in fact we will rapidly move towards some kind of bureaucratic redistributionist and, I think, mediocre system.

So what you're focusing on is exactly at the cusp of either finding really dramatic solutions or getting in trouble. As you mentioned, we just finished a book called "Saving Lives and Saving Money," and we just opened up a website called the Center for Health Transformation, which is at HealthTransformation.net, or you can go to just my first name, Newt.org. But in "Saving Lives and Saving Money," we outline a model for transforming the health system.

Let me start by making an argument that I think gives the Federal Trade Commission a particularly important role in the next ten or fifteen years. It should be the natural product of a scientific, technological, entrepreneurial, free market system to produce more choices of better quality at lower cost.

And I'm going to repeat this because I think in

both health and education you see a tremendous impediment of government blocking what should be a natural pattern. The natural pattern should be more choices of better quality at lower cost.

And in a sense, Wal-Mart is, for the 21st century, what Alfred Sloan and General Motors were for the 20th century, in the sense that Sloan's investigation of consumer-led mass production defined management for most of the 20th century.

Wal-Mart's model, that lower everyday price is a function of lower everyday cost, and that they see themselves as the largest and most efficient market makers in the world, is something really worthy of study.

And any institution that gets 100 million Americans to voluntarily show up every week is worth looking at and saying, what is it they're doing right? I mean, without arguing about other aspects of Wal-Mart, it seems to me that they are an institution worthy of study.

What we're suggesting is that lowest everyday price being a function of lowest everyday cost should apply to health and health care, and that producing more choices of higher quality at lower cost should apply to health and health care, and that to the degree it doesn't, it is largely a function of the mis-design of the current system.

Now, there are three areas where you see real proof

that traditional market behaviors work. They're all in health. None of them are in the third party payment system.

The first, which we have here copies of, is looking at a paper that was done by the National Center for Policy Analysis, which looked at the cost patterns for cosmetic surgery. And it turns out -- and the chart is very, very revealing -- it turns out that all goods goes up at a certain rate. Health care goes up at a much more rapid rate. Cosmetic surgery went up at less than the rate of CPI. That is, cosmetic surgery actually increased in cost from 1992 to 2001 at a lower rate than the consumer price index, while the rest of health care went up dramatically faster.

The second example is laser surgery. The average cost of surgery per eye dropped from $2,079 in 1999 to $1,631 in 2002. Now, again, this is a health procedure. It's a fairly sophisticated health procedure. This is not a question of cheap medicine or inappropriate medicine. This is, in fact, an area where the breakthroughs technologically have continued to accelerate, and the ability to perform laser surgery has gotten better with better outcomes at declining cost.

The third area is over-the-counter medications, which have actually declined by about 2 to 3 percent in cost as compared to the consumer price index and are dramatically under prescription drugs.

Now, our argument, both in "Saving Lives and Saving Money" and at the Center for Health Transformation, is that you can't succeed in reforming the current system, that the current system is inherently, by design, mal-designed so that a third party payment model is inherently conflict-ridden because you have the person receiving goods not responsible, the person paying goods confused about who they're responsible to, and the person who's paying the money irritated with both the provider and the patient.

In addition, we suggest that you want an individually-centered system, not a patient-centered system, because you want to use early diagnosis. You want to use nutrition, attitude, and activity to extend individual healthy behaviors. So we always talk about health and health care. We don't start by talking about health care.

Interestingly, Dr. Zerhouni, the head of NIH, believes that if you had a system that was refocused on maximizing health and delaying the need for health care and designing health care to be return to health rather than long-term maintenance by the system, he thinks you actually could take 40 percent out of the system.

That is, instead of having an increase of 20 percent a year or 15 percent a year or 10 percent a year, it would be 40 percent less expensive. Interestingly, Dr. Bill Stead, who's the head of informatics at Vanderbilt,

independently from his perception of building expert systems at Vanderbilt University believes you could also get about 40 percent out of the system.

So what we're describing is a transformation that could literally be worth, if you're an optimist, 5 percent of the entire economy. If you think that's too high, it could be worth 3 or 4 percent, which is still fairly big money.

We think there are four drivers of this change that the FTC ought to look at. The first is patient safety and patient outcome. And the reason I start with that is health is inherently moral. We called our book "Saving Lives and Saving Money" in that order because saving lives is the moral cause and saving money is the practical cause.

If you start with patient safety and patient outcome -- and I used to serve as the ranking Republican on the Aviation Subcommittee; this was in a distant past when we were in the minority -- and I represent the Atlanta Airport. We value life in commercial aviation by several orders of magnitude more than we value life in the health system.

So when the Institute of Medicine reports that we lose at least one New York to Washington shuttle a day to medical error in hospitals, the country says, yes, hospitals are dangerous, and we go on to the next topic. If we lose a shuttle, the National Transportation Safety Board, the Federal Aviation Administration, the airlines, the

manufacturer, all collaborate in a stunningly intense effort to change the system, and when they learn what needs to be changed, they retrain the pilot, the manufacturer, or the maintenance people within 48 hours.

By contrast, the Institute of Medicine reports it can take up to 17 years for a doctor to learn a new best practice, and over 80 percent of doctors do not practice best outcome medicine. Now, that's unacceptable in civil aviation, and I simply tell every audience we should value you as much in the health system as we value you in aviation and you'll get to a dramatically better system.

The second driver should be information technology, computing, and communications. The amount of information we could get is stunning. I just talked with Dr. Korpman at Health Trio, who runs an information system. One of their major clients is Brigham & Women's.

As soon as they went to electronic information, they reduced the number of call-backs each month by 30,000 phone calls a month to verify prescriptions. At $6 a call, that's $180,000 difference for one hospital.

But more importantly, Dr. Corpman advised the Blair government in Britain, who have now put out a request for bids on a national electronic health record. His estimate is that they will sustain that record once it's established for ten cents per month per patient. That means you could have a

medical record in the U.S. that was sustained for around $29 million a month.

Now, that is an absurdity not to have that. And you go down the list of things IT, information technology, should bring you, almost all of which are inhibited by the current structure of the health system, legal structure, cultural structure, and incentive structure.

The third thing we focus on is quality, a system and culture of quality in the sense of Deming and Juran. And again, if you look at manufacturing in the last 80 years, essentially all of it is coming out of the Western Electric/Hawthorne experiment and the rise of systems analysis at AT&T's manufacturing system in the 20s, which Deming actually was part of. And then you look at Deming teaching 75 percent of Japanese industrial capital in 1951 in a four-day course which led to the Japanese creating the Deming prize for the best-run company in Japan.

We have had stunning explosions of productivity and quality in manufacturing because we recognize it is a system and we recognize you need a culture of quality. None of that has happened in health. And it is -- despite the best efforts of a number of people, it has simply not penetrated again because the distribution of power in the health system has allowed people to simply say no and walk off.

The fourth thing we focus on is the notion that you

have to re-center the health system on the individual. The individual has to have the knowledge. They have to have access to clear information. They have to have real power in order to make real choices.

And they have to be held accountable. You need an incentive system which says, you know, if you're diabetic and you don't manage your diabetes, you have a responsibility. This is not just a magic system where you can do nothing, live badly, and then demand that the doctor fix you.

And I say this having helped author the welfare reform legislation. And the direct parallel I would argue is if we as a country are prepared to say to the poorest people in the country, you have to go out and get a job or get an education, we should have the nerve to say to every American, you have a responsibility for monitoring your own health, for having a health indicator system.

And again, one of the things that we should be looking at is what is it that inhibits us from creating marketing and having a system in which people could literally monitor their own health on a regular basis.

Our goal is to consistently look for better outcomes at lower cost, and we think if you aggregate those, it is startling how many places there are where you can get very dramatic improvements by applying better outcomes at lower cost.

Now, there are essentially four kinds of inhibitions. The first is the guilds. And here, Adam Smith is very clear in the wealth of nations, for everybody who believes in free markets, let me just suggest to you if you think of being a doctor as a guild, you understand a great deal of what I'm about to talk about. If you think about being a lawyer as a guild, you understand a lot of what I'm going to talk about.

The second thing to look at is obsolete laws which are based on a different era and which is based on an era of a different kind of economy, a different kind of information flow, and a different kind of capability.

The third is the impact of bureaucracies, both public and private. I mean, large corporations and large insurance companies are truly as bureaucratic as large governments, and bureaucracies have inherent patterns of avoiding competition and avoiding change that are valid whether they're public or private.

And the fourth is we create the wrong incentives. We create incentives which are acute care-focused. We create incentives which are doctor-centered rather than individually-centered. And we created incentives which do an immense amount once you're sick, but almost nothing to incent you not to get sick.

Let me suggest six quick areas where I think the

FTC could profitably explore. I'm not suggesting here you necessarily have rulemaking authority, but because of your underlying instruction from the law that you should be looking at how markets could operate better and what are the impediments to market, I think if you explore these six, you would have recommendations to the Congress that would be very, very helpful in directing congressional exploration of these issues.

The first is the degree to which we artificially constrain and raise the cost of insurance for the self-employed, the unemployed, small businesses, and family farms. There is no inherent reason we can't have a nationwide market based on something like eBay, where people can go online with very little intermediation cost and buy into a national risk pool. That is, no one should ever buy individual insurance. You should individually be able to buy group insurance. But you need pooling.

Every effort I have seen to block a nationwide rise of large-scale insurance for small businesses, the self-employed, family farms, and the unemployed, every effort has been essentially an effort to restrain trade on behalf of people who have large market share within the 50 states.

It has nothing to do with the capacity to do it technologically or the desirability of doing it for citizens. We've seen studies that indicate you could lower the cost of

insurance by 40 percent for the self-insured -- I mean, for individuals, small businesses, and notice that under ERISA we're quite cheerful about doing this for the biggest companies in America.

So the biggest companies in America are exempted from the 50 state mandates. They're exempted from the 50 state insurance commissioners. And if you get to be big enough, you get to play in one league, but if you're not that big, you're actually in an artificially -- and I want to emphasize artificially -- dramatically more expensive league.

The second thing I want to suggest to you is to look at medical rules that break America up into 50 states. There's no doubt in my mind that many of the restrictions on doctors are explicitly guild behavior designed to minimize competition.

But beyond the question -- and I would argue that there ought to be some kind of national registry, and if you're a board-certified doctor you ought to be able to practice in all 50 states. We live in a modern age. We live in an age where information flows worldwide. The rules that grew out of a 19th century industrial model strike me as obsolete.

But in addition, you want to be able to move medical information across state lines. The Mayo Clinic exists in three states, Arizona, Minnesota, and Florida.

They should be able to have a control digital database, have you have an MRI in one state, and if the best person in the world to read that MRI is in a different state, it is irrational and destructive of life and money to say that you can't have access to that.

So second, you ought to look at the degree to which state lines today artificially inhibit these things. And let me point out that in terms of interstate commerce, there is no constitutional reason that the health system shouldn't be seen as a national system.

And, by the way, the minute you have a SARS threat or an anthrax threat or a new model of flu, we behave like a national system. So I think this is when you look at what's the additional cost in inhibition, both for lives and money, by the current model of state-by-state guild behavior?

The third is to look at what inhibits the rise of the right kind of investigation systems. There's a firm called Health Share which has taken the Medicare data and has developed an expert system which enables you to pull up hospitals based on the Medicare data.

And it is very interesting that consistently the best hospitals tend to be the least expensive. It is the inverse of the automobile business. In the health business, you very often can get a Ferrari for the cost of a Subaru, and if you go to a Subaru quality, you very often pay the

price of a Ferrari.

And this is a system which indicates -- and, now, it's only Medicare data today; it's not all data -- but it really begins to give you an ability to access what are outcomes, how many medical errors are reported, how many hospital-induced illnesses are there, what do they charge, how many days do you spend in the hospital, et cetera.

There are all sorts of inhibitions against these kinds of systems growing up, including -- and I'm going to come to it at length -- the liability system, which inhibits the development of this kind of information, but also, the unwillingness of doctors and hospitals to share data.

And one should look at the question -- there was a huge fight a number of years back about whether or not you could put prices on cars. And as with all good guilds, the manufacturers and the auto dealers did not want to put prices on cars. And this was a big fight over the public's right to know what does a car cost.

Well, let me suggest to you that you're in the same cycle right now. Interestingly, in 1999 12 percent of the country went online to find the price of a car before they bought a car. In 2002, in three short years, that number exploded to 58 percent of the country. And on average, they save 2 percent on the cost of the car they purchase. So I just want to suggest there's no inherent reason that you

couldn't have an accurate information system about capabilities and cost.

The fourth change, though, is one which you only have an indirect interest in but a big interest in the market, and that is HIPAA will almost certainly have to be modified both for research data and for price and outcome data. And there's no reason you can't design it so that you can have a patient confidentiality-compliant system.

But the way HIPAA technically is written right now, for example, it's very difficult to do longitudinal research under HIPAA rules. And NIH will probably be making recommendations on this topic. But again we have to say, to what degree does the government become self-destructive? Because in the name of protecting your privacy we have designed a rule which actually makes it more likely you'll die.

And so I think we have to look at, in the age of electronics, how do we both protect your privacy and enable the gathering of quantitative data that we need very badly.

The fifth proposal I want to suggest to you is a radically different way to think about purchasing drugs. The current drug system -- and this is particularly timely because of Medicare, but again, it goes back to the issue of how do you get markets to work right.

The current drug system is wrong on a couple of

accounts. First of all, there is no pricing for drugs. Drugs are almost -- particularly if you're in any kind of group purchasing plan, drugs are purchased as a function of rebates or kickbacks.

It is as though the Ford Motor Company announced that they had a $600,000 truck, but for you there was a $560,000 rebate so it's only a $40,000 truck for you; whereas the Chrysler Company said, we have a $45,000 truck, and for you we're willing to take off $5,000. Somehow, psychologically, taking off 560,000 sounds better.

So the current system actually incents the pharmaceutical manufacturers to optimize the price of the drug in order to have the widest possible margin to rebate to the pharmacy benefit manufacturers.

The second thing wrong with the current system is that requiring copays up front perversely maximizes the price of the drug for the person who has the choice. If I'm going to put up $10 as a copay and my choice is a $40 drug or a $70 drug, I actually psychologically want the $70 drug because I get the seven-to-one return on my money. The ideal model would be to reverse that, that is, to put the subsidy up front, so that every additional dollar cost came out of my pocket.

Two other points. Historically, we couldn't handle data as it related to the sheer flow of drugs. And in 1965,

when Medicare was developed, drugs were a relatively small part of medical care. Anyone who's gone to Travelocity, Expedia, or Gallileo knows you can handle huge volumes of data 24/7 for free. You can allow people to know every airline flight in the world and go on and pick the seat they want to be in and know every price permutation and pick based on a combination of time and price.

NDC Health is a firm which handles four billion drug transactions a year, 70 percent of the market. They handle half of all of the doctors' practices of one, two, and three doctors. They believe unequivocally you can design a Travelocity model in which you'd get two kinds of prescriptions.

You went to the doctor, the doctor said, you have a unique genetic requirement. The only drug you can take is X, and they issue a unique prescription. You get that prescription, and say in the case of Medicare, it ought to be subsidized if people want to subsidize it.

But in a very large number of cases, there are multiple drugs available. Imagine the doctor then gave you a class prescription and said, you need an allergy drug. There are nine allergy drugs available, and I would explicitly include medically appropriate over-the-counter drugs.

The idea that Claritin drops off when it becomes cheap tells you everything you need to know about how

perverse the current system is. This is a system that because the doctor gets no psychological reward out of prescribing a nonprescription drug -- you went to the doctor, you want a prescription.

If the doctor said to you, you know, last year or two years ago this was the second most prescribed drug in the world -- I mean, for the FTC to just say, what's wrong with this picture and how come the market isn't working, strikes me as a very important investigation.

So here's how it would work. You'd have a Travelocity-type page. It would list all the drugs available and medically appropriate indicators. Your government, which loves you, will pay 100 percent of the least expensive and will give you the same dollar value for any other drug.

So it's an open formulary. You don't get into politics. You don't get into bureaucrats picking. You don't get into the kind of things we're going to see with all the various closed formularies. And the drug company has to tell you an honest price. It can't give you a rebated price that's totally artificial because it's out in the open.

NDC Health believes they could provide for the government every night the subsidy price for the next day because they handle over ten million transactions a day. Now, I just offer that as a model, but if you had a model like that, the patient would have more information -- it's,

by the way, a pharmacy benefit administrator system where the patient with the pharmacist or the doctor is the manager.

So you return to a genuine marketplace. You empower the patient. You have a downward-pricing mechanism, which I think all the airlines will tell you is stunningly powerful. And you would have a system in which you would come back and have to raise the question at the level of the FTC talking with the FDA and NIH, which is, building the page that lists the medically appropriate drugs becomes really important.

And you have to ask yourself why these things haven't happened more rapidly, although there is a firm called RXaminer. It's R-X-a-m-i-n-e-r dot com, I believe, which actually does a variation of this for people who are paying for their own drugs, and on average saves them between 60 and 70 percent of the cost of drugs.

The last thing I want to talk about is the impact of the legal system. It is very important in a free society to have an orderly, predictable system of law. A few lawyers is central to the health of a free society. An epidemic of lawyers is a disaster. And we clearly have a malfunctioning system in which the signals are being sent to drop out of medical school and go to law school so you can sue your friends who were too dumb to follow you.

This is very dangerous for the country. And I want

to suggest three areas for you to look at that I think are central to having a healthy system.

The first is the degree to which there is conspiracy behavior almost in a RICO sense when you have -- recently, for example, the New York Times reports a hundred law firms creating, in effect, an investment pool for suing. It strikes me that this is behavior that has no relationship to justice and no relationship to appropriate solving of problems, but every relationship to an increasingly self-directed profession of greed that designs strategies to maximize -- to judge shop, jury shop, and maximize return on investment. And that if one were actually to have access to the internal documents of these law firms, you would be startled by the degree to which this is economic behavior, not legal behavior, and economic behavior essentially of a predatory nature.

The second thing I think you need to look at is the cost to the system on inhibiting the flow of information about mistakes. In the aviation administration, one of the things we did when I was a very junior member is work with the FAA to change how pilots reported near-misses because pilots wouldn't report them because they're afraid they'd get penalized.

So they were simply suppressing the information, and it was dangerous. And the ground rule came up that you

could report it anonymously and that no disciplinary action would be taken unless there was some extraordinary circumstance -- you'd been drinking or you were doing something really stupid in the cockpit.

The result was a dramatic increase of reporting near-misses and significant systems modifications that ultimately saved people from running into each other and killing people.

There ought to be some tie between quality reporting, error reporting, being open about things like hospital-induced illnesses and protection with a reasonable framework for having participated to improve the outcome of the system to save lives.

And again, I draw a distinction. If the doctor is drunk, if the doctor is egregiously misbehaving, if there's a boundary condition that clearly is what would historically before 1963 have been a guilty behavior, then you ought to be able to sue in a different fashion. But there ought to be protections and structures.

The last thing I think you have to look at is the degree to which -- and you see this now in Pennsylvania, West Virginia, and Mississippi and Nevada -- the degree to which predatory legal behavior is actually beginning to endanger lives because the principles that are being established drive people out of practice.

I was told recently that in Las Vegas, there are no obstetricians willing to take any new patients. Now, there has to be a public health cost here. An epidemic of lawyers can be as dangerous as an epidemic of SARS, and literally dangerous in the sense that by driving doctors away from behavior they would otherwise engage in. We are killing people. And there should be some way for this to be investigated in a straightforward manner to find out to what degree it is not, in fact, legal behavior but is economically predatory behavior, and to recommend to the Congress ways of thinking about these problems.

Because our interest is to have an orderly system in which we optimize the activities that are productive and in which we optimize the desirability to become a doctor or to run a hospital or to provide good health, and in which the individual citizen is guaranteed justice if they are aggrieved, but we don't create classes of behavior as a result of which we are economically self-destructive.

Thank you for letting me outline all this.

DR. HYMAN: Okay. Well, let me just start by throwing it open to the panel generally and asking any of them whether they have questions, comments. I have a whole series of them, but let me defer to the panel first.

Warren?

DR. GREENBERG: I must say it was a very

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

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

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

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

the Wal-Mart. Instead, it's ABB, blah, blah, blah, Fidelity Mutual. We don't even know how good they are. But why don't we have that development of brand names?

And this is what I'd like to address in my talk, and I would ask you if you can believe that maybe this is the way we ought to tie in information, and ask you and perhaps other panelists, what are the imperfections that we have that we don't have health plans. And it's not only the department store approach. I'm talking about automobiles. I don't know anything about what goes into a Lexus or who the mechanics were in making that Chevrolet. But somehow, I know a Lexus works better than a Chevrolet.

Why don't we have these brand names, from good to bad, with prices, as a way to provide information to every consumer in America?

MR. GINGRICH: Well, let me say first of all, Dr. Greenberg, I agree with your core vision that -- with this caveat, which I think you also agree with, because I want to make this clear so we don't get some kind of attack on the idea of markets.

Part of the genius of the modern system has been the invention of regulated free markets in which, if I go into McDonald's, I know that the water will be drinkable and that the beef will actually be beef. And this is not a small thing.

If you go back to the rise of the Food & Drug Administration under Theodore Roosevelt, this was in fact an appropriate response to the need to have a refereed or regulated framework within which the market operates and the delivery is by the market, but it's a delivery guaranteed by the government in terms of quality.

And I say that because otherwise we're going to get somebody attacks us: How can you compare health to -- within that framework, you're exactly right. Now, interestingly, when we first went out to begin working on "Saving Lives and Saving Money" back in 1999, we started by looking for branding.

What are the startups? What are the better outcomes at lower cost, et cetera. You have some limited branding. The Mayo Clinic is a world-class name. The Cleveland Clinic is a very good name.

But what you discover early on is that the inhibitions against their growing, it almost resembles Lancashire cottage industries prior to the rise of the mills and the degree to which you can't aggregate behavior. It's very hard. So that we look at firms -- Visicu is a Johns Hopkins spinoff that deals with electronic intensive care units.

Every hospital in the country ought to have either their own intensivist or they ought to be attached to an

electronic intensive care unit, period. I mean, this just should be a minimum standard.

But when you go to the local intensive care doc, he says, wait a second. What are you saying to me? Or you go to the local group of doctors and you say, well, I don't know that I want my hospital to do this, even though statistically there is no question: If you go to a -- if you have abdominal surgery in a hospital without an intensivist, the odds are three times as high you'll die.

And so what I discovered, to go back to your point, is it is very hard to get the rise of these branded structures. Probably the Hospital Corporation of America is as close as we've come to that kind of a model. But it's also really hard to get to the aggregation of behavior. And part of it is because of doctors and the way they're trained by medical schools, which has to be redone. Part of it is by legal inhibitions.

The other point I'd make is that historically, the mistake that was made in the '80s was creating a so-called health management approach, managed care approach, which actually was about managed cost. There was no data for managed care, and so you ended up in the wrong kind of fight and you actually -- I think society was pushed back a step because the design was backwards.

DR. HYMAN: Helen?

MS. DARLING: Yes. I'd like to get back to one of the excellent points you made about your vision, and particularly combine your history as a politician and your current activities as transforming the health system, for which I'm sure everybody in the room will be very grateful, especially if you can do it.

Over-the-counter drugs and generics offer the consumer much of what you're talking about. First of all, the minute they become generic and over-the-counter, a lot of other things happen, usually. And just generally, you know, you can debate about some of the data and what it shows, especially absent the competitive system -- that is, more than one generic.

But generally, consumers and employers will save a lot of money to the extent that drugs are moved to over-the-counter generics. But the industry, as you know, has, shall we say, kindly made it as difficult as possible for that to happen even to the extent that trying to use the authority that the Congress has given, both the FDA and themselves, to limit either movement to generics or anything that could possibly work.

Could you please talk a little bit about your thoughts about how, number one, we move that along faster, and two, if there are other barriers that we should be paying attention to that keeps those kinds of changes from happening

in a timely way.

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

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

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

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

And that's my message, basically, to the pharmaceutical companies. I am for people paying the appropriate price with knowledge in a competitive setting for the drugs they get. I think a system which is dominated by detail people, a system which is dominated by rebates, a system in which doctors prescribe in ignorance, is a system that is doomed to failure. And let me talk briefly about how that will happen, I think.

First of all, I have talked to no audience in the last six months where you describe automatic teller machines, self-service gas stations with credit cards, and Travelocity, and then you mention the phrase "paper prescription."

They don't just get it. I mean, all of their common experiences every day now are that you can have electronic interfaces that are stunningly accurate, and then you get a paper prescription. And paper prescriptions require a massive volume of call-backs. Forty percent of all prescriptions require a call-back. And the doctor very often doesn't even know what else you're taking. So start with that.

At a large scale, what you want to do is simple. You want to take something like Scholar, which is a Stanford spinoff that has been certified by the AMA for continuing medical education, and you want to have a Scholar-quality page, much like Travelocity, so the doctor is an informed

prescriber. You can put it on a Palm. You can do -- but doctors ought to know, here are the nine drugs and here's what they cost.

By the way, in the studies that have been done, when doctors do know the cost, they consistently prescribe less expensive drugs. I mean, some outliers don't, but as a general rule, it does have an impact.

Second, you want electronic prescribing. My hope is that the Medicare drug bill is going to mandate electronic prescribing. You want computer order entry in hospitals of medications, and you want every drug that you get to have an electronic indicator on it so that you automatically can match up the drug and the patient.

And again, Pfizer has taken the lead in developing that, but I think you're going to see it happen -- this has been going on in grocery stores now for about 40 years. And I think it's finally migrating into health. All of these things have a big impact on accuracy, safety, and cost.

But what the country has to say, and I think the Medicare drug debate may be precisely the place to start saying it, is -- and this is historically how -- we historically get change out of two things. We either have a grievance, you know, again, Nader versus the big auto companies, which whatever you may think of Ralph in terms of being, from my standpoint, much too liberal, his crusade in

the '60s and '70s clearly changed the standard of safety in America, despite the fact that the biggest companies in the United States were opposed to it. But in the end, they couldn't stand up to the public debate.

Similarly, the most successful companies in America right now may well be the pharmaceutical companies, but when the country decides, A, this is what I'm missing -- you know, why am I paying 65 percent more than I should be paying, or why is it that a detail person's ability to get the receptionist to schedule ten minutes becomes an integral part of which drug I get.

And so I think you will see a different model emerge fairly rapidly, and I think it will almost certainly be an internet-based model. It will almost certainly be an information-rich model. And it will happen either because the government shifts in the direction I'm describing or because ten or fifteen large payors shift and decide that they'll subsidize 100 percent of the least expensive.

And again, what I'm arguing for is an open formulary. So none of the pharmacy benefit management companies are going to like this because it takes away the rebate model and the information control model which is at the heart of their being an intermediary.

But the modern information systems take out middlemen, empower you to make choices, and drive prices

downward by letting you choose what you want.

DR. HYMAN: Greg?

MR. KELLY: Yes. Going back to what you guys were both touching in, Mr. Speaker and Dr. Greenberg, a little earlier on quality and how you were mentioning it. One of the questions I wanted to ask you to maybe elaborate on a little further is how some of the best hospitals out there are the least expensive.

And I think, from my standpoint, what is going to be important going forward is for the consumer to have value, which is the equation of both price and quality. And looking at the car example, it's kind of an intuitive sense that we have. We're spending our own money, and when you spend your own money, you do it wisely and you don't add in all of the data.

When I go and take a look at a car or buy something at the store, I don't look at all the data. But intuitively I know, since it's money out of my own pocket, what is the best mixture of both price and quality. I'm not going to buy the most expensive thing out there, but at the same time I'm going to get the best deal for my money.

So you were elaborating a little bit on the direction of where that was going right now, and I was also inquisitive on why the best hospitals out there are also the most -- the least expensive. Is it because the consumers are

gravitating towards those hospitals, and just because of the volume, the prices are lower, or what is the reason that is currently taking place right now?

MR. GINGRICH: Well, it's interesting. I was a student of Edwards Deming, and I ended up being a student of Edwards Deming in part because I went down to Milliken, to their annual management retreat, because I wanted to learn more about management in the '80s.

And they spent a half-day out of their three-day retreat redoing Deming's red bead experiment. And I asked Roger Milliken how they'd gotten so deeply involved in Deming and in quality, and he said he'd read a book by Phil Cosby called, "Quality is Free."

And Cosby is the popularizer of Deming, and Cosby's point was if you do the right thing right the first time, it is cheaper -- quality in a manufacturing sense is never more expensive than sloppiness. It's an exact mis-design.

And in fact, it was Phil Cosby's argument that as a general rule for most manufacturing in America in 1980, about a third of what they were doing was waste. And as Milliken said, since he was the owner of Milliken, it suddenly hit him that was his money.

And so they dramatically changed the entire company from the ground up, made a remarkable -- made it far and away the most effective textile company in the world in terms of

output per dollar. So I studied under Deming as a result of that experience.

You start with a premise: If you're really, really good, you're probably less expensive. Toyota is less expensive than Mercedes. In fact, there's a terrific book by Womack called, "The Machine that Changed the World," which is the MIT project on automobiles. They make the point that Mercedes and Toyota produce about the same quality car, the difference being Mercedes rebuilds one-third of their cars; Toyota rebuilds 2 percent of their cars.

Then they make the point that if Mercedes can't learn the Toyota production system, that you cannot compete very long at the same price, if I have to rebuild a third of my cars for quality and you're rebuilding 2 percent of yours.

And that's why Paul O'Neill, who had brought the Toyota production system into Alcoa and had dramatically reduced days lost to occupational accidents, had dramatically reduced cost of production, he then migrated it into the Pittsburgh health system in what I think is maybe the most interesting experiment in trying to get doctors, for example, to do statistical analysis of outcomes. So let me start with that.

A place like Mayo that first of all selects out in its recruiting for people who want to be part of teams, that selects out for people who want to learn best practices, that

selects out for people who want to engage in research -- so you have to start with the idea that, I mean, best of class very often recruit to best of class.

Second, they have the professional commitment to force themselves to learn things they don't want to know, which is very, very difficult. And it's part of the key to a quality culture.

Third, if you in form, do it right, you don't have medical errors and you don't have medication errors and you don't have hospital-induced illnesses, all of which cost money. There are two million hospital-induced illnesses a year in the United States. If you stay in a hospital longer than four days, the odds are even money the hospital will give you a disease which it will then charge you to cure. This goes back to perverse incentives.

The U.S. government ought to pay a bonus to every hospital which has significantly less medical error and has significantly less medication error, has significantly less hospital-induced illness. One specific example: When Wishard Hospital went to -- Wishard Memorial went to complete order entry of drugs, they reduced the average stay by nine-tenths of a day per patient. Now, seen from the standpoint of the CFO, they just reduced their income. But they saved nine-tenths of a day per patient by going to computer order entry.

Visicu, according to Centera Hospital, has -- Visicu is the electronic intensive care system -- Centera, which has it in five hospitals connected to one office for electronic screening, says that they now save 20 percent of the time per intensive care patient, on average, in moving them through the intensive care unit because there are fewer errors, fewer hospital-induced illnesses, better treatment.

So you actually -- true quality should actually improve hospitals, not cost them more. And true quality should actually improve doctors' incomes, not make them poorer. But the incentive system does, in a perverse way, almost incent you to have the errors and have the illnesses because you get to charge for them.

DR. HYMAN: You get to double hit. You're having them in first and then again.

Mike?

MR. YOUNG: I guess before I ask a question, I will say -- you mentioned HIPAA. And HIPAA was a consulting gold mine for us in the first -- for consultants for the first quarter of this year.

But I absolutely agree with you that it has clearly gone way too far, and we have a number of situations where the access to data is very hard to get and seemingly, you know, each holder of data makes their own determination of how they use HIPAA, either as an excuse or a realistic way to

protect peoples' rights. So I absolutely agree that it's gone too far and I think we need to come back.

But what I'd like to touch on is this whole issue of a lot of the consulting that I do is in rural communities. And I've been doing it for many years. And two of the things we see are situations -- and I'll use Hot Springs, Arkansas as an example. They have 30,000 people there. They have three hospitals. They have eight MRIs. And so there's just an incredible glut of providers, if you will, more than they need.

And then we see other communities where there are a lack of physicians, especially. And I've found with rural communities especially, there are two types of physicians. One are the people that tended to either grow up in those communities and want to give back and go back and work in those communities. And, quite frankly, another group that goes there to hide from the system.

And so there's kind of this double-edged sword. In some of these communities, there seems to be such a glut that everybody in Hot Springs who has any possible illness gets an MRI, and in other areas there's just -- the only doctor in town may not be a good doctor, but he's the only doctor in town.

And how do we kind of allocate, I guess, resources among those types of communities?

MR. GINGRICH: Well, you raised a couple of things. Let me go through quickly.

First of all, rather than complaining about HIPAA, people ought to start drafting the modifications. Congress writes laws so Congress can meet to hold hearings so Congress can write laws. I mean, instead of saying, gee, this is now locked in concrete, we ought to say, okay. This was a good try in the right direction. It's largely better than having no law. Now, what do we have to fix?

And just -- I think people should say certainly by early next year that Congress should be holding hearings on the better patient safety, better information model of HIPAA based on what we're now learning. And this will be an ongoing iterative process as we get used to living in an information age.

Second, you reminded me, there really should be a nationwide database, for example, of doctors who've been disbarred or of doctors who have been heavily sanctioned. And it ought to be an accessible database. That is, I should be able to find out whether or not I'm dealing with a doctor who has lost 14 malpractice suits in 14 different states.

Today there are state databases, but they're not accessible. They're not together. And there's no reason you couldn't have a nationwide database. This is pretty easy.

And at a minimum, it will flush out the worst

doctors, which ought to be flushed out. I mean, there's no reason the worst doctors should be allowed to practice. We would not allow the worst airline pilots and the worst airline mechanics to practice. We say there is a standard above which you have to be or you kill people.

Third, when you have eight MRIs in a town that size, as long as you know what the price is and as long as that price is public, the least efficient ones are presently going to go out of business unless they're self-directed, which gets me to a fourth point.

But I think this is part of why pricing has to be out in the open. Three hospitals won't survive unless they can survive. I mean, I don't care how many retail stores -- back to your point about department stores. I don't ask you how many stores there are in a town. You know, if they can make a living and they're willing to do it, that's fine. You could have 30 MRIs if they can do it. But what I object to is that they pass the cost on and it becomes part of an embedded base of what we mean by health care costs. I think that's inappropriate.

The other thing that's wrong, where I think the FTC could usefully look at, is when you have a doctor-owned facility which is also self-referred. And I want to draw a real distinction because I think we made a mistake in designing this.

I have no problem with doctors investing in hospitals unless they refer to the hospital they invest in. But if you end up in a situation, as was described to me the other day in another part of the country, where the doctors -- the cardiologists are really pretty clever.

If it's going to be an easy cardiology problem, it goes to their clinic. If it's going to be a really expensive, hard cardiology problem, it ends up in the local general hospital. Now, that kind of behavior strikes me as absolutely wrong and unprofessional and inappropriate, and we need to figure out how we monitor that.

The other example is places where hospitals tend not to run emergency rooms so that they don't get the heart attack patient until the second day when they've stabilized, which again means that they have a very high likelihood of success rate without having run the big risk.

The last point I want to make about rural America: Rural America will profit more from the rise of internet diagnostics and internet-based capabilities than will urban America. And properly designed, you could have a Visicu for an entire rural state that would literally allow you to have an intensivist for all the hospitals in the state simultaneously.

Visicu, for example, is now going to be monitoring the intensive care unit in Guam for the Air Force from

Hawaii. And there's technically no reason not to do that. So you could imagine two years from now every rural state in the country could have a connectivity to an intensivist even for very small rural hospitals, and the coaching improvement would be dramatic.

I'd also say for small rural areas -- and again, this is the cultural crisis -- you know, you're now talking to the local doctor who's been totally in charge for all their life. No one has ever questioned them. They're the only doctor within 25 miles. And somebody is now going to look over their shoulder?

I mean, this is a -- you know, and what I'm arguing is, yes. For patient safety reasons, for public outcome reasons, you're right. And the other example I would cite is Active Health, which is a very good firm, which works for large corporations. And they basically get world class doctors to coach your doctor if you have an expensive illness.

And it turns out that by getting the world class doctor to work with your doctor, your doctor's quality of care goes up dramatically. And again, for rural America, these things are potentially doable, but they're only doable from the state level down. They're not doable by small hospital by small hospital because they never aggregate the resources to do it.

DR. HYMAN: Let me ask a question about information. I mean, information is an important part of a functioning market. You've emphasized it in your remarks. And the absence of good information is a quite traditional and well-recognized justification for regulation.

But -- and you knew that was coming -- in health care, the presence of information can result in adverse selection problems on the coverage side, and moral hazard problems on the delivery side; that is, knowing more about what you've got will influence what kind of health care you sign up for and what kind of benefits you end up receiving.

So I guess I'm wondering how you sort of see a patient- or consumer- or individual-centered health care system dealing with the problems that we've had that have resulted in some of the institutions that you've criticized here.

MR. GINGRICH: Well, I think -- first of all, the absolute bias has to be in favor of information. I mean, there is no evidence in the last 300 years of rising prosperity and rising positive outcomes and longer lifespan that keeping people from knowing things is a good idea.

So then you have to deal with the consequences of the information. In some cases, we'll do that, I suspect, by law. That is, we'll say, you can't use a certain kind of information in employment decisions, or you can't use certain

kind of information in insurance decisions.

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

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

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

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

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

Saving Money." We propose that Congress should pass a law creating a personal health account, which would in essence mean that when you first went to work, you'd get, say, a $1500 deductible and we'd put the $1500 in your account so you're now spending your dollars.

It would be -- it could carry and have tax-free interest buildup. So when you're young, you probably wouldn't spend it, and within a very few years, you'd be at the 20-, $30,000 deductible level with it being your own money.

When you got above the value at which you got any kind of break on the -- now you would be on a true insurance system because now you would have set aside your maintenance health money, which you'd be spending, and the insurance company would actually be offering genuine insurance.

The other piece of that is probably we need, whether it's designing a government-sponsored enterprise that would be competitive or some other model, we probably need only to go to a reinsurance system, that is, to create a national pool where, whether it's a $200,000 -- there's some dollar value where the price becomes so large that you can never really create smaller risk pools that make any sense.

Because what you want to do is take the cherry-picking out of the system by saying, there'll be some kind of universal reinsurance cost for -- whether it's 200,000 or a

million or something -- probably done by a government-sponsored enterprise.

But I think the inability today to have that kind of insurance pool means you get grotesquely expensive small business insurance plans because they are buying a risk premium against one bad event in a way which really optimizes cherry-picking.

So I'll just close by saying part of what you want to do is think through a design which minimizes the incentive for cherry-picking.

DR. HYMAN: Dr. Comstock, did you want to have a question? Or Mr. Lansky, do you have a question or an observation you want to make?

MR. LANSKY: I'll ask a question, yes.

The managed care/managed competition model foundered for a variety of reasons. Its original premise was system integration, integration of care delivery and accountability for performance. And then in that model there may have been a market to choose integrated systems.

The consumer-directed models, as commonly discussed, radically fragment the system into individual commodity services that are bought and sold. And you could have an information flow and you could have pricing of those individual elements. A mammography is one price. A doctor visit is another. An insurance coverage policy is another.

The information burden and the lack of integration and coordination in the highly fragmented model are two big problems. So one question is, how do you see the relative balance between essentially bundling, creating continuity, integration of services which manage, for example, chronic conditions or end-of-life care, complex care, rather than a highly fragmented marketplace?

And secondly, what do you see as the balance between the regulatory function on the information requirements in such a market and the self-issued information opportunities?

And I'm probably interested in -- to the extent that I've become more and more of a believer that there has to be government standardization of information requirements and disclosure requirements and so on and of infrastructure, as you've supported for a long time, electronic infrastructure to support that information capability.

But that becomes massively complex in a highly fragmented system in which you've got very diverse products competing, and the kind of lack of information that Dr. Greenberg talked about.

MR. GINGRICH: Well, I mean, the fact is we've had a very long track record, starting with railroad track size and the development of the Morse code and the rise of standard time, which are late 19th century developments, all

of which are proof that you can have systematized national standards.

There's a -- and I can't remember the name of it right now; some of you will know -- there is a national association founded, I believe, in 1916 for electric standards during a period when the government wanted to ensure things happened but didn't want to do it itself. And so all electrical appliances in the United States go through the same standard-setting, which is actually a private association, legally empowered to do that.

You could -- you know, and whether you have HHS set an information standard or you have the government establish a freestanding commission for medical information, which may be the right parallel -- but your point's exactly right.

I mean, jumping out five years, or no more than eight but within five years, automatic electronic health record -- I want to distinguish a health record from a medical record. A health record is all the information that you should carry with you for the next doctor. The medical record is everything the doctor and the hospital need to keep for the lawsuit. A very big difference in detail, in level of detail.

Everybody ought to have an electronic health record. It ought to be compatible across all the systems. All the major providers of these kind of systems should be

part of an open systems architecture as opposed to I'm going to design some cute device so once I have you, you're a captive and you can't use anybody else's equipment.

And again, all of us who use the internet and who use laptops are -- you know, everybody who uses a cell phone has experienced this. And I want to draw a distinction between two different points you made, and then talk briefly about managed care.

The model that Dr. Greenberg described is a model of stunning consumer choice. You know, I decide today I want to go buy X. I have lots of places to go buy X. It's the job of the aggregator to provide me a reputation and a price and a convenience I want to go to.

And then you're exactly right in your analogy. You know, there are all sorts of places I can go for what I want, and I get signals from the system about reputation, et cetera.

So you could have a consumer-driven system in which you had a very high level of common information, more, I would say, than you get today. That is, if I had an electronic health record so that the next doctor knew what the last doctor had prescribed, you'd already be at a quantum jump above current behavior.

The second part, though, I think, is a misnomer about what happened with managed care. It goes back again to

the moral cause. Health is different than buying clothing or buying jewelry. There is a moral component because it's about my life or my daughter's life or my granddaughter's life or my mother's life.

And so the minute I think that a decision about their life will be profit-driven as distinct from profit being derived from the right decision, if it is a profit-driven decision, I am very suspicious that I am now going to have my granddaughter get bad care so somebody has a better quarterly report.

I mean, the analogy -- and by the way, I'm told this all the time. Insurance companies will tell you with great openness, we don't do preventive care because people don't stay with us long enough to justify it economically. Well, that's like an airline saying, you know, we're going to be as safe as our quarterly report permits. Now, we wouldn't tolerate that for one minute.

So what the insurance company is tell you is they are putting your health needs below their profit margin. And it is a perfectly rational behavior in the current market. And that's why people have this deep suspicion of the financing of health care, that a decision will be made, I won't get what I want.

Now, I'll give you a couple of examples. And here, AARP and others are actually showing some real leadership.

Comorbidities are the largest single problem in Medicare. Five percent of the people on Medicare use up 50 percent of the money. That 5 percent has, on average, somewhere between five and seven comorbidities. It's very clear they ought to get managed as a complete person and not have five to seven separate verticals.

That can be done in a system where you basically say, we're going to incent the doctor to have full information through an electronic health record. And we're going to incent the doctor to deal with all the comorbidities at one time.

And you can design a system that does that while still allowing the patient to pick which doctor they want to go to. So it's not an either/or. It's not either that we've got to trap people into a system where it's controlled for them, or they've got to be out here in a chaotic jungle without any kind of information.

If you use the incentives right and you use the structure of information right, you can migrate to a system in which I still have choice, but it's choice among a series of very high value products with much more complete knowledge than we have today.

I would argue if you've got the right electronic health records and the right kind of requirements for electronic prescriptions, et cetera, you will have

dramatically better health almost overnight in terms of the way in which we minimize medication errors and other kind of mistakes.

DR. COMSTOCK: I do have a comment, actually. I think everybody in this room, and certainly around the table, agrees with a lot of what Newt has said. And whether you believe that there's 30 percent waste in the system or 40 percent waste in the system and all of these dollars were there that could be easily used to do things like create access for everybody in this country or create the infrastructure, improve the transparency of information, we have been involved in a community project across the country.

And when you talk to health care leaders there, fundamentally they say, well, it's all well and good to say that money exists, but you can't wait to take all of that efficiency and put more efficiency into the system. There needs to be an investment now.

And what we're doing is we're talking about -- we're not really talking about what we really want to achieve. We're talking about where the dollar is coming from.

And I guess I'm wondering whether you have any ideas of how you manage that transition from an economic perspective. I mean, do we suddenly decide we're going to spend X billions more money in order to squeeze the

efficiencies into the system and take that waste out so that we can create access and infrastructure, or do we wait until we've gotten some dollars up? It's all about money.

MR. GINGRICH: Well, okay. Let me give you three parallel answers because I think there are actually three different components.

First of all, we recommend strongly in "Saving Lives and Saving Money" that the federal government pick up the equivalent of Eisenhower's interstate highway system because if you look -- we have a long chapter at the back of the book on biological warfare. I personally am convinced that biological threats -- if you're listing all the weapons of mass murder, that biological threats are 80 percent of the danger, nuclear is about 19-1/2, and chemical is about 1/2 percent.

And I talked to one Nobel prize-winning biologist and said, if we had an engineered virus, what would a reasonable casualty rate by? And by engineered, I mean something which was not susceptible to a current vaccine. He said, 50 percent. And I said, that would be 145 million. He said, that's a reasonable number. And he said, I won't say that publicly because I haven't got any solution.

But if you go back as a historian and you look at really good epidemics, it is breathtaking. Florence as late as the 1440s was losing 20 percent of its population in one

year. This was some 80 years after the bubonic plague first began sweeping through Europe.

So let's just start with the idea none of us -- and we get scared by SARS, which has killed a couple hundred people. I mean, none of us has seen what a real epidemic would be like, and it would be horrifying.

So I would argue that under homeland security requirements, we need about a $40 billion investment in the equivalent of the interstate highway system. And in our book, we quote Eisenhower, who specifically had the interstate highway system as a national defense act, although it's obvious from the middle class that it has been enormously successful in other ways.

That system should also include a virtual public health service which connects all 55,000 private pharmacies, all retired nurses and doctors as well as currently active nurses and doctors, and includes veterinarians. Because if you lose a central city, one of the largest sources of health resources in the surrounding countryside will turn out to be veterinary hospitals.

Second, I want to suggest to you that here's a place where there are opportunities for huge improvements. We work with the people at IBM who do logistics supply system modernization, where they take huge amounts of cost out of logistics systems.

And I was talking the other night with doctors at the major medical groups, who said that the paper-handling transaction cost of getting paid is three or four times greater in health care than it would be if you were dealing again with the big department stores you were describing.

Imagine a -- and it's particularly stupid for the self-insured. I mean, for a self-insured company to engage in a long-time value of money for doctors means the doctor will countervail by charging more to make up for the lost value of money and will then have to add clerical staff, et cetera.

So imagine a system where doctors filed electronically with your health record and your bill simultaneously, by one click, and were paid every night by electronic funds transfer on a post-payment reconciliation system.

Now, you'd have dramatically fewer clerks. There was a study done, I was told, for Blue Cross -- I have not seen this, but a study, I was told, was done for Blue Cross of Massachusetts that they figured out if you could have realtime verification of eligibility, you would eliminate one-half of their clerical staff.

Now, this is not heavy lifting. I mean, if you think about what happens worldwide when you use your Visa, MasterCard, American Express, you name it, I mean, we somehow

are able to stand at a restaurant or at a store buying a tourist trinket and in virtually real time, 20 seconds, two minutes if it's a bad location, you know, they know who you are no matter what country you're in and they validate the payment.

And American Express doesn't have 600 people doing physical labor reading your paperwork. I mean, that's not how it works any more. So imagine you could take 2 to 4 percent out of the total cost just by going to the electronic fund transfer with reconciliation.

But I want to make one last point, which is, hospitals and doctors who explain to you that they can't afford a Palm pilot -- I want to stick with electronic prescriptions, which can be done on a Palm. This technology has been around for at least six or seven years.

There have been three or four firms that have designed systems on Palm -- I think Hippocrates is one of them -- where -- and over a quarter million doctors have downloaded Hippocrates because it's free, and it gives you the formulary and all this stuff.

The notion that it's a price problem is just plain baloney. And part of the reason you don't get change in health care is people who are doctors and people who are hospital administrators assert the right in a totemic manner to explain to you that you don't know anything, and therefore

you just don't understand because it's so complicated.

And the correct answer with some of this is, that's silly. I mean, to tell me that a doctor can't afford to go online and pull up Dell or Gateway or Compaq and get a computer, when they have one? To tell me they can't use a Palm?

It would be like somebody saying to you, I'd like to use a cell phone but, you know, cell phones are so expensive and we just can't invest in cell phones. I mean, you'd break up laughing because you know all of their teenagers have one.

So I would just assert that some of this stuff isn't done because they don't want to do it. The excuse they use is malarkey. And I say that in the context of saying, I think we ought to have a nationwide IT investment of about $40 billion in health care, and I think that we actually ought to have the federal government much more concerned about realtime connectivity. But I don't accept the idea that you couldn't go to electronic prescriptions tomorrow morning because doctors couldn't figure out how to use Palm Pilots.

DR. HYMAN: Well, the panel has been such a vigorous participant in the discussion, I'm afraid we've run out of the time that we had allotted for having Newt speak. So although he's going to be with us for a little bit longer,

I'd like, since he's going to have to leave in the middle of the presentations, a round of applause for the presentation.

(Applause.)

DR. HYMAN: I'm just going to introduce everyone on the panel at once, and we can sort of go across. People can either speak from where they're sitting or up at the podium.

The first speaker, since he's over on the far left, is going to be Warren Greenberg, who's a professor of health economics and health care sciences at George Washington. Next will be -- he's going to speak for about ten minutes.

Next, David Lansky, who is sitting to Newt's left, who is the president of the Foundation for Accountability, has been the president since the organization was founded in 1995.

Following him will be Michael Young, who is senior vice president at Aon Consulting, focusing on health and welfare issues.

To my immediate left is Helen Darling, who wins the frequent flyer award for the panel because she has spoken more than anyone else on the panel, and I think probably more than anyone else we've had, she's such a wonderful speaker. She's the president of the Washington Business Group on Health.

Seated to Helen's left is Dr. Marcia Comstock, who's the chief operating officer and a member of the board

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

And then finally, batting cleanup, Greg Kelly, the executive director of the Coalition Against Guaranteed Issue, and I believe also the Coalition for Affordable Health Insurance -- Council for that.

And so without further ado, why don't we start with Warren.

DR. GREENBERG: Thank you very much, David. It's a pleasure to be here and it's a pleasure to be with this distinguished panel and the audience here as well.

I understand I only have ten minutes, but I'm glad that the Speaker's talk was so comprehensive because I'll be able to just fill in the blanks, I think, from what he had to say.

I was at one time staff economist with the Federal Trade Commission. I believed that every imperfection at that time in the marketplace was due to an antitrust violation. I soon found out that in addition to antitrust violations, which are remedied by the FTC and DOJ here, that there are many imperfections due to ill-conceived government interference in the economy or simply market failures.

In this testimony, I suggest three examples of

these latter imperfections. My goal, as I believe is the goal Chairman of the Federal Trade Commission as well as the entire FTC, is to achieve both price and quality competition in the health care sector, and I mean the entire health care sector, not just the Medicare program.

The three imperfections I'd like to focus on are: the failure to tax employer-paid health insurance premiums; adverse risk selection for health plans; and U.S. and state "any willing provider" laws. This is filling in the blanks, perhaps, for the Speaker's talk you heard previously. Now, I shall go over each one of these in turn.

The failure to tax employer-paid health insurance premiums has led to the retention of employer-paid health insurance. Absent this tax, there would be no advantage to the employer paying health insurance premiums instead of providing increased wages in order to retain employees. Employer-paid health insurance, which would be subject to state and federal income taxes as well as Social Security and Medicare taxes, would become less attractive for the employer to offer and the employees to receive. It would soon disappear if it were taxed.

An individual-based health insurance system without the involvement of the employer would be much more conducive to the introduction of quality and price into the marketplace. What am I talking about here?

There is a substantial amount of turnover in the U.S. labor force. Although this differs by geographic areas, location, type of job, age and gender of workers, it has been estimated that job turnover is between 12 and 16 percent throughout the economy. In higher turnover industries, such as agriculture or construction, the turnover rate is even much higher.

And we talk about incentives here. When job turnover is high, there is little incentive by the employer to invest in health plans, to invest in expensive but perhaps better quality treatment and procedures, as well as superior physicians and hospitals, which can improve quality of care and perhaps lower cost in subsequent periods. Why? Because within one or two years, those employees are going off to other jobs with other health care plans.

In contrast, if there were an individual-based health insurance system rather than an employer-based system, individuals would retain their health plan whether employed with the firm, self-employed, retired, or disabled. Individuals would choose a health plan from a variety of health plans during yearly open enrollment periods.

Individuals will buy health insurance in the same way they purchase automobile insurance without regard to employment status. Income-adjusted premiums may be needed to help those with lesser incomes if universal coverage is

desired.

Individual-based health insurance is found in many European countries and Israel. In an individual-based system, individuals might belong to a health care plan for many years or decades, providing incentives for these health care plans to do disease management and to try to insure quality early on.

There would be greater incentives for the health plan to invest in a person's health and to improve quality of care rather than the current system that we have in force with our individual -- with our employer-based health care system.

However, under an individual-based system, and this was touched on by the Speaker, precautions will be needed, however, to insure that health plans are not avoiding high risk enrollees. And therefore I would suggest we also need, in addition to employer-based health insurance, the idea of a case mix risk adjustment system.

Why? Because if health plans competed on a quality of care basis, and we touched on this before, the plans which provided the highest quality of care, in the language that we talked about before the Nordstrom's, the Lord & Taylor, perhaps, would attract the highest risk employees in the following opening enrollment period, increasing its cost considerably.

This leaves little incentives for health plans to compete on a quality of care basis or to disseminate information on quality. This is why I say we don't have Nordstrom's and Bloomingdale's. One health care plan that comes out and says, we are the Lexus of all health care plans, next year will see its costs go through the roof.

Changing these incentives will be therefore a factor in achieving quality in health care. And how might we focus on that?

A risk adjustment payment should be applied to each competing health care plan. There's a market failure here. We have to somehow solve it somehow. Risk adjustment may improve quality of care, creating a marketplace based on quality and price for the first time among competing health care plans. An accurate risk adjustment payment will create incentives for health plans to deliver a higher quality of care to attract higher risk individuals since they will be paid for enrolling these higher risk individuals.

However, achieving an accurate risk adjustment payment has been difficult. But even Medicare has been trying it under their risk adjustment PIP DCG approach, and other countries have tried it with some success. The Netherlands examines age, gender, employment status, and region of the country. Germany uses age, gender, and disability. Israel uses only age.

Health plans would be reimbursed by a neutral party according to the number and severity of the individual enrolled. Those health plans with a great number of high risk individuals would be reimbursed at a higher amount. This would create incentives for health plans to compete on quality in order to attract the higher risk individuals.

Those health plans which do not necessarily compete on quality, and perhaps stress lower premiums, would receive little or no risk-based reimbursement. Price and quality competition here. Each of the health plans would be required to help finance the payments to the health plans which have enrolled the high risk individuals.

Again, I won't repeat what I said before. But under these circumstances, I do believe we will see the department store approach where health plans are competing both on price and quality, the same way we might see a Saks Fifth Avenue and Bloomingdale's approach.

Under this kind of competition, the difficulty in determining quality of care would also be less daunting for the patient. It is also possible that individuals with the same price/quality tradeoffs may differ on their view of particular department stores, yet with its faults, many individuals are satisfied to make this one of our most important buying tools.

Finally, in the third step, each health plan should

be encouraged to utilize every avenue to improve both quality of care and lower price. This would include selective contracting with a limited number of physicians and hospitals in the geographic area to attempt to achieve the lower cost or higher quality.

Lower cost may be achieved by playing providers off one against another to achieve increased volume and lower cost. Improved quality can be maintained by contracting only, perhaps, with the Cleveland Clinic or Mayo or a limited number of hospitals. And physicians who increase volume may translate into higher quality.

Unfortunately, recently the Supreme Court ruled that "any willing provider" laws may be enacted by state governments in which a health plan must contract with all providers which would like to sign a contract with the health plan. "Any willing provider" laws, if enacted by state governments, would eliminate the potential for contracting with only a limited number of providers.

In order for health plans to compete based on price and quality, states should no longer to attempt to enact these "any willing provider" laws, and those laws which have been enacted should be repealed. Thus far, in 17 states, "any willing provider" laws have been enacted to prevent selective contracting with physicians. Thirteen states have enacted laws which prevent selective contracting in regards

to hospitals.

Health care expenditures, including studies here by economists at the FTC, have been shown to be much higher in those states where they have "any willing provider" laws.

I would sum up by saying these three steps -- an individual-based health insurance, which could be achieved by taxing employer-based health insurance; a risk adjustment payment; and selective contracting -- are necessary to achieve both price and competition in health.

Each of these steps is interrelated and is essential to competition. Without the possibility of both price and quality competition, the health care marketplace will remain inefficient. There will be over-investment of price competition at the expense of improved quality, resulting in economic loss for those who desire improved quality. Even those who put a greater emphasis on price competition will be confronted with a downward spiral of quality if there are no incentives to provide quality of care.

With $1.4 trillion spent on health care in the United States, it is imperative to create incentives for improved quality as well as reduced costs and to eliminate these three market imperfections to compliment the antitrust efforts of the FTC and the Department of Justice.

DR. HYMAN: Dr. Lansky, your PowerPoint is up on

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

DR. LANSKY: Thank you, David and the Commission, for letting me join you. I appreciate it.

My particular area of interest is in the information requirements of consumers to be successful in this health care system and market. And you had a marvelous set of witnesses in the last few months covering much of what I would normally have wanted to say.

So given that, I thought I would take a particular slant on a theme, I think, that has not been adequately addressed, which is the genuine experience of patients seeking and getting health care, and what information is needed in the course of our real lives, leaving a little bit aside the legal and technical requirements that I think are vital but I do think have been fairly well addressed.

So I'll introduce the term person-centered. And the Speaker has certainly emphasized that throughout his work. And I'll give you -- I wanted to start with a couple of examples, but I'll have to figure out how to -- okay.

Just briefly, our organization, the Foundation for Accountability, was founded in '95. It was primarily founded by large purchasers, including HCFA, General Motors, American Express, large consumer groups like AFL-CIO and AARP. And our charge at that time was to make managed care work by developing a set of quality measures that could be used to

support competitive purchasing.

We developed about fifteen different sets of measures addressing a number of chronic illnesses, end-of-life care. We've done a great deal of work the last five years on child and adolescent health, particularly to support the CHIP and Medicaid purchasing requirements.

In the course of doing that, we quickly learned that measures and data per se were not sufficient to support a successful market, and we had to think about a framework for presenting and communicating information. We developed such a framework that's summarized very briefly here, and NCQA, the National Quality Report, the IOM, Newsweek Magazine, a number of organizations, have used that approach we recommended.

More recently, the last three or four years, our shift has been very much toward understanding what do consumers do with information, how do they make decisions, and how do they access information. We've done a lot of work on how do you present comparative information to consumers for their use, a set of interactive web tools to allow people to make their own decisions using available comparison information.

We've been doing quite a bit of work on the personal health record the Speaker just spoke about, the idea that you own your health information, that it's

interoperable, it's transportable, and it is lifelong. And we are just now working on a project with the maternal and child health bureau here to develop what we call a data resource center, which allows the consumer or a policy-maker to access all the knowledge there is that may help them understand and advocate for health improvements.

We've done about a hundred focus groups in the last few years. We've done very large surveys. We do a lot of interviewing. And we spend a lot of time working with patients, veterans, labor organizations, to understand what their constituency may be concerned about.

So that is context. I think the main theme I want to mention today in terms of the quality, information, and field that we work in is that the history of the last ten years or so in this field -- and the Speaker spoke about the idea of guilds influencing the behavior of the delivery of care.

It's equally true in the information field, that the information constructs that are often used to communicate to the public are actually driven from above, not from the experience of the person who needs to make a decision.

So the categories we use to fund health care and the categories of specialty training tend to be the categories we use to collect and disseminate information. I don't think those always serve the needs of a real family

making a difficult health care decision.

And therefore, I think as we think about the future marketplace in health care and the use of information in health care, we need to think harder and work harder at embracing the patient and family experience, and having them tell us what information they need to make decisions.

So let me tell you a couple quick stories. The first one, of course, is a personal story. On the left of this picture is my mother-in-law. Grandma Lou, we call her. She at the time of this story was 72 years old. She was a coal miner's daughter from up in the Canadian border area of Washington state. She started smoking when she was 13, stopped when she was 55.

When she was 72, she went in for a routine primary care visit. They did an x-ray. They spotted an apparent tumor on the x-ray, referred her for a CT scan. The primary care doctor was concerned, referred her to a community surgeon.

I asked around in my network to see if this surgeon was any good, a common question we all ask. I was very much reassured that not only was he good, he was a very aggressive surgeon, which for cancer is taken to be a good thing.

We went to see this surgeon. He said he could not biopsy the tumor in this location that was revealed on the film, and therefore he immediately recommended a lobectomy,

removal of the section of the lung to remove this tumor.

Obviously, my mother-in-law and my wife were paralyzed with fear and anxiety, and immediately wanted to pursue the doctor's recommendations. But my wife, on the far right of this picture, being at least interested in the web, got online. And this is her weekend's work, between the time of the recommended scheduled surgery and the end of the weekend.

She found a lot of resources to try to assess what was going on in this case. You'll see the one on the left there says "Probability of malignancy in solitary pulmonary nodules," which is actually an online calculator that allows you to enter the information that you may have from the film and get a prediction of whether or not this is in fact a malignancy or benign.

And my mother-in-law's data said it was 24 percent chance of being malignant. So whether it was appropriate with a 24 percent probability of malignancy to do this radical surgery was certainly something needing a little more discussion than we'd had the first time around. You also see information from the cancer support groups, and a quick education on imaging.

It turns out that one of the articles my wife found has an NCBI study that she found in 1999 when this occurred of a three-year-old study which talks about the evaluation of

solitary pulmonary nodules by PET scanning, which was a relatively new but not brand-new technology. And at the bottom of this and circled, it says, "This technology is highly accurate in differentiating malignant from benign solitary tumors."

Now, the surgeon, in his guild and in his own personal experience and community, had brought none of this information to our attention. It turns out four miles down the road from the surgeon's office was a PET scanner at the University of Washington.

To make a long story short, my wife got involved in this process, redirected the care to the PET scan. The PET scan showed a benign tumor. That was four years ago and no surgery took place. The taxpayers and Medicare were saved 40- to $60,000 of cost. My mother-in-law was saved a lung. And the story has a happy ending.

One footnote to that story, just on the question of choosing quality. Among the decisions to be made was where do you go for this operation, if it had in fact been needed? This data is available for some states. I happened to pick this New York because I gave this presentation, or parts of it, in New York.

You'll see that the Speaker again referred to the differential mortality rates in different locations. In this case, for this lobe resection surgery, there's about a

fourfold difference in mortality if you go to a place that does a lot of them versus a place that does only a few of them.

And if you look at this New York City data, one of our concentrations of medical excellence in America, only one hospital in the entire central area of New York City performs above the threshold number of lobe resection surgeries in a year. A huge number of hospitals perform one, two, seven operations a year in this very complex and very invasive procedure.

My mother-in-law again had no information whatsoever provided to her to guide her decision. And as I suggested earlier, even in this one story, there are maybe ten, fifteen important consumer decisions to be made: the primary care doctor, the first imaging center, the second opinion, the second imaging center, the facility to have the operation done in, the surgeon to have conducted the operation, in a moment of enormous anxiety, pressure, and fear. It's a very complex set of consumer decisions to unravel in the real world.

A second example I want to give is our development of a set of quality measures for HIV and AIDS care. And this would -- we had a wonderful commission or advisors, the chairman of the President's Commission on AIDS, and a great group of experts.

And they listed, as you see here, about eighteen things which they think are important to measure to describe the quality of HIV and AIDS care. And if you're a patient or if you're in an oversight position and you want to evaluate the quality of care in this arena, here are the things you might want to look at.

We asked the experts to rank order which of these eighteen things are the most important to use to assess the quality of care for HIV and AIDS. And you see the rank ordering they have here. The first was that the patients receive anti-retroviral therapy, the second that they be regularly assessed for viral load, the third that we have treatment to prevent opportunistic infections, and so on.

We then asked a series of focus groups of patients how they regarded the priorities in making a decision on where to seek care. And here's the ranking the patients provided. We tapped quite a variety of different kinds of patients -- gay white men, IV drug users, people who were not primarily English-speaking -- to find out what their perceived needs were in quality. And these are people who on average had been diagnosed eight years earlier, so they were very experienced patients.

Their number one concern was the prevention of opportunistic infections. Their second most important criterion was that they be involved in making decisions about

their care. The third most important was that they can function, down at the bottom of that slide, that they can live.

The doctors had actually recommended we not include that as a quality measure at all because they thought it was beyond their ability to control and not a fair measure of their performance. It was a pure outcome measure, and therefore not within their responsibility of scope.

Now, the patients -- I'll just give you one quote from one of the focus groups. "I'm not taking any drugs or anything like that," basically because, he says, "I'm a young black male and in my age group there's very little research being done, and as a black male most of it doesn't affect me. It's for white people 35 to 45. So until there's more research, I'm not taking those drugs."

And a number of these patients said, if I don't trust my doctor and if my doctor does not respect and understand my life, I'm not following their advice. So the concept of constructing information for consumer decision-making has to capture the real behavior and real criteria of patients themselves.

The third example I'll just mention just for one observation from it, we've been doing a series of projects in Vermont with family practice and pediatrics to understand what do people want to know to evaluate their care. And this

was actually given to the doctors, not to the patients.

But the thing I found most interesting in talking to many patients -- these are parents of sick children -- was that what they said was, I don't want to choose a new doctor. I don't want to be told my doctor is poor. I want to make my doctor better. I've been using this doctor for four years, ten years, whatever. It's a place I'm comfortable getting care. I want to know what they're doing poorly so that I can basically beat them over the head with it and I can work with them to improve the quality of care they receive.

So I think the ah-hah for us who had done an awful lot of worn on exit, on choice, was that a lot of patients really want voice and they want tools to improve their interaction with their providers. So it's a much more complex use of information than we had previously discussed.

Just to tie this all together and again reveal the complexity of it, this is a map we did with the General Electric workforce to identify all the information patients want to know in real life -- these are people who've been diagnosed with breast cancer. We asked them, what do you want to know to get the best possible health care?

And as you look at a spectrum from the far left, where people are at risk of breast cancer but not diagnosed, to the far right, where they have had successful intervention and are now living with the disease as a survivor, there's a

lot of information.

And it's very contextual, not surprisingly. The information a young woman who may feel at risk for cancer because of her relatives' experience wants to know is dramatically different than someone who's about to have an operation to remove a vital part of their body or deciding on a form of therapy postoperatively.

So the sensitivity, the specificity, the personalization of information is in some ways self-evident, but most of our discussions about making the market work have not been very finely attuned to where patients are in their experience of seeking care.

And one other footnote on this particular example. This is a study done in comparing care in Massachusetts and Minnesota for breast cancer. And I think there are two astonishing numerical figures on this slide.

One is that twice as many people in Massachusetts as Minnesota are even seeing an oncologist as part of their decision-making, let along deciding which oncologist to see or evaluating those oncologists. And ultimately, then, twice as many women, almost, are not told that they have an option of breast-conserving surgery, having been given a diagnosis of early-stage breast cancer. And these are in two, nominally speaking, excellent states for medical care and for the dispersion of medical knowledge.

So my conclusion, much like the Speaker's, is that we need a modern information strategy which is sensitive to these complexities of real life, and one which understands that in a democratic consumer culture, people can and must be capable of using information.

Let me just tick off some of the dimensions I think we have to address in building such a modern information system. First, medical care is very complex. My wife, knowing nothing about medicine, is suddenly an expert on PET scanning and solitary pulmonary nodules. And she had to be. There was nobody else in the entire enterprise of medical care in the Seattle area who stepped up and made the investigations and decisions to support her decision-making.

Secondly, we have many, many sub-specialities and many, many layered organizations. We have doctors, nursing homes, home health agencies, and so on, all of which play a part in achieving successful care.

Thirdly, care is multi-dimensional. There is technical care, guidelines-based care, humanistic care, patient education care, care in dealing successfully with daily living, and simply the service aspects of care, all of which have to be addressed by consumer information strategy.

Fourth, I am increasingly aware, as I mentioned in my Vermont pediatric story, that what people are seeking in health care are relationships, not transactions. So to treat

medical care as a bundle of transactions underestimates the complexity of the human exchange of information and decision-making, let alone therapy, that goes on.

Fifth, the population is not uniform. Not only do we vary where we are in the course of an illness, but each of us in this room has a different way of processing information and using it. And in a vital area like health care decision-making, this is a very subtle and complex problem.

We did a segmentation model that identifies four types of American health care consumers. And we differentiate them partly by their level of independent action and partly by how much they listen to their doctors. And depending on which type of these four groups you see at the top of the slide a person may be, that will affect the kind of information they want and how they will use it.

Next is the issue of transparency or, actually, lack of transparency. But there simply isn't the information available, period. Not only does the patient not know the information they would use to make good marketplace decisions, neither do the providers. Neither does the government. The information does not exist. It's not known.

Next, the issue of third party payment all of us have talked about for quite a while creates a barrier between the purchaser, the financial transaction source, and the person who actually needs to receive the superior care.

We have mediating decision-makers. In my mother-in-law's case, there was a primary care doctor referring to a surgeon, and a surgeon referring to a hospital. The actual locus of control had been taken away from the patient. We differ in where we are on the trajectory of illness, as my breast cancer slide suggested, and we have to target information to where a person really is in their decision-making.

Therefore, just as we in getting medical care expect personalization -- we want someone to hear our history, understand our allergies, understand our values, and help us make a good decision -- so in the information arena we have to personalize the support of marketplace information to the specific needs of each person.

Now, fortunately, as the speaker suggested, the web and related technologies enable us to do that. But we haven't really put our effort behind that so far. We've tended to have very blanket strategies for public information.

Finally, as I mentioned in my family's case, there is nobody else out there who will do this for you. We may not be confident that every American can step up, master all this information, and make successful decisions. But there really isn't an alternative.

There are some mediating organizations who will

certainly help. There are information advisors. There are ombudsmen. There are a variety of other sources. But for the vast majority of us, there's no one else you can rely on to take your illness as seriously as you do.

So what can be done about it, and what can the FTC and other agencies do? A couple of focal points I want to suggest. First is we need to do more work on outcomes, not process. As I suggested in my question earlier, the more that we try to have a process measure for every fragment of the American health care system, the more crazy we will become. We have an enormously rich and technically complex system, and we can't possibly cover the landscape with everything.

And unfortunately, most of our research and others' shows that there are not good correlations between being good at A and being good at B. A clinic may be great at heart disease care, and the same group of doctors, nurses, technicians, could be terrible as asthma care. And they're sitting in the same offices. You can't say because they're good at heart disease, I'll go there for my asthma. There's no correlation in any evidence we've seen so far.

So what do you do? Do you expect to have a set of quality measures for every conceivable health problem? That's not very practical. So the benefit of focusing on outcome measures is it drives innovation because people

compete to achieve better results. It drives integration because you cannot achieve a good result by only doing the operation and then not doing the rehabilitation. And it drives person-centeredness because ultimately the person wants to get back to school, back to work, and achieve the best functioning they can.

Second general point that I think many of us agree on is we want more disclosure of information. The public should be able to access information about the care and the cost of the care that's provided. I put disclosure in quotes, however, because again I'll say I don't think anyone knows the information we'd like to disclose.

It's not sitting stuffed in a file cabinet in the basement of the HMO or the medical group practice or the nursing home. They don't know, either, how they're doing. So we have an enormous problem of building infrastructure which would provide that information.

I would encourage FTC and others to involve more patients in their deliberations. Patients experience the care. They are the taxpayers. They are the underwriters of the benefit plan through their wages. And they have ultimately to be convinced that they are receiving good care if we're going to make a more successful system.

As I mentioned earlier, we should deal with the voice as well as exit, that is, use information about quality

not only to help individuals make personal choices, but to help all of us see where quality is good and bad and influence public policy and professional practices.

And last thing, the national health information infrastructure at the bottom of this slide. I think we need to use disclosure as a driver to force, as in the case of e-prescribing that the Speaker mentioned -- we need to force institutionalization of health information so that if we require disclosure, that may in turn require PBMs or providers to make more information available, and therefore build the infrastructure to do so.

Lastly, we have learned, to our sadness, that distribution of information is absolutely as important as simply getting data. So you can mandate measures. You can mandate data collection, what CMS is doing now. You can publish report cards on nursing homes and dialysis centers and hospitals.

Frankly, it doesn't matter. It doesn't influence much behavior. It influences a little behavior at the margin, but if you don't distribute that information in ways that it is actionable in the context of real experience, you're not really contributing to solving the problem.

Therefore, several -- four ways one might think about distribution that are a little different than the norm. Think about infusing that information into the relationship

between a patient and doctor. We've been working on something we call the ASK, the Agreement to Share Knowledge, which is actually an agreement between a patient and their doctor about the way they will each play their parts in the care relationship and the way they will share information with each other.

Using information intermediaries, whether it's AARP or senior centers, to distribute information and make it usable to people.

Providing interactive coaching of information on the web. And I don't mean just simply portraying a table of numbers on the web, but providing interactive decision support tools.

And then finally, personalized choice aids using the patient's own values and preferences as a way to help them make decisions with this information.

I just wanted to illustrate a couple of ways on the web that we've been approaching that, but let me just conclude. Where I think there's a regulatory role per se: In particular, I think it's the information infrastructure. That does include what to measure and what must be disclosed, but I think it goes further than that, and it goes back to the Speaker's example of the interstate highway system.

There has to be a massive commitment and a public awareness that we will not be able to improve this health

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

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

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

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

based care.

And finally, as public agencies, I hope that these groups will realize that there is no one else out there representing the patient and family. Everyone else has a legitimate but primarily self-directed interest in the health care system.

The public sector, part of why we use public funds and why we have election is that someone has to say, we represent the interests and the will, and we have means of listening to the voice of, the American public in its breadth and diversity. That's a very daunting challenge, and I'm very concerned that some major initiatives going on at present in the government don't fully make the effort to listen to the public will.

Thank you.

DR. HYMAN: Okay. I think we'll take about a five-minute break and then we'll continue with the rest of the speakers.

(A brief recess was taken.)

DR. HYMAN: I'd like to get started again. Our next speaker will be Michael Young. Your PowerPoint should be up right now.

MR. YOUNG: Thank you for having me. When I first saw these hearings, I talked to Ed and then to David. This was exciting for me to come down from Philadelphia because

for 25 years I've been working with employer groups of all sizes, from 50 employees all the way up to 50,000. And invariably, each year it gets tougher and tougher to get through this process that we go through this time of year, which is helping companies strategize about how to deliver health care benefits to their employees for the next year.

So I was really excited to be able to come down and share some of the thoughts. And what I did was I actually took the questions from the hearing and threw them at some of my clients of all sizes to get their perspective. Because what I'd like to do today is be one of the panelists that kind of shares with you, you know, what the specific employer problems are and what their issues are when it comes to some of the things we've been discussing today.

And the Speaker was right. Being from Pennsylvania, I will say that not a week goes by that my wife or another family member or a neighbor or somebody tells me about somebody whose doctor has left the state. It is a very serious problem in all of Pennsylvania, more so in Pittsburgh and Philadelphia but just in the state in general. So clearly, a significant issue.

What I did is actually -- because I work with actuaries, although I'm not one. I'm somewhat anal about this, so I actually put the questions into the overhead so I knew what they were.

But I thought, you know, I'd spend more time -- since we don't have a lot of time and I'd like to leave space for the other panelists and some questions -- but basically wanted to talk about, you know, how do employers go through that process of determining what kinds of health care benefits they're going to offer the employees. And again, I'll talk a little bit more in a minute about the various size of employers and how that affects things.

But the bottom line is -- and I don't think this is a surprise to anyone in this room -- employees want good coverage at a reasonable price. That's fairly simple. And what employees usually get when they deal with -- you know, with their company is they tend to get choices.

They tend to get choices of health care plans. Depending on the area, the geographic area they're in, the size of the employer, the number of choices may vary. But they get some choices. We find that invariably employees like choice. They like to have a feeling that they can take health care plans that they can pick because they meet their particular families' needs.

A second thing they get is catastrophic coverage. And what that means is that, you know, most company plans provide a benefit for large catastrophic situations. Most company plans have one million or sometimes two million or sometimes even unlimited lifetime maximum benefits. So from

the standpoint of being covered for a traumatic, large-cost situation, employees tend to get that coverage.

They also get typically some sort of preventive benefit covered -- we'll talk a little bit in a minute about the move from HMOs to PPOs -- but the Speaker was right. It's kind of a mixed bag. What we find is what one company, what one client of ours or what their insurance company might define as good preventive care benefits versus another could vary drastically.

We have some with very -- schedules of benefits based on peoples' ages and the types of tests they have, and then we have other clients who basically say, well, we'll give you $300 each year towards preventive benefits. You decide how you want to spend them. So although preventive benefits seem to make sense to a lot of employers, they don't know how to deliver the right kind of preventive benefits.

What employees would like beyond those is lower cost. And I would say clearly the vast majority of our clients each year, and certainly this year, are going to be passing along larger cost increases for health care coverage than they're going to be passing along salary increases.

So at the end of the day, a lot of our clients will have employees whose payroll deduction for health care will be greater than their increase in their salary. And what happens is their take-home pay becomes less.

They also would like coverage for alternative treatments. As you all know, there are more and more types of treatments out there -- you know, acupuncture, biofeedback, and all kinds of things that are on the horizon. And employees are becoming more savvy. They are reading the -- you know, they are going to the internet. They are finding some of these kinds of treatments. They are making suggestions that they would like to get those treatments done.

Typically, though, the clients we have, the companies we have, tend to rely on the insurance company, the Blue Crosses, to set the standard as to what's covered and what's not covered, what's considered valuable and reasonable treatment and what's not. And that tends to lag from where the marketplace is. So we have kind of a lag period, and as employees find these kinds of information, they tend to get pushed back from the plan still not covering them.

Administrative ease: Yes, we are getting close to a world of having all this data pass electronically, but we are not there yet. And it still does vary by each of the claim intermediaries that exist. Some are better than others. Some have spent more on technology and IT than others. So it's still -- there are certainly still a lot of employees out there who find, you know, working through the health care system to still be an administrative nightmare.

And then finally, coverage after retirement. I think the latest study showed that there's only 23 percent of large employer who provide a retiree medical benefit for retirees after the age of 65, which is a continuing and fast-dwindling percentage of employers.

Employees recognize, I think, at this point that that trend is not going to change or reverse. What we see now from employers, though, is at least the understanding that they've got to educate their employees that even though they're not going to provide a benefit, that you're going to need to save significant amounts of money during your active life to have that money to supplement Medicare, even with the possibility of prescription drug coverage, when you do retire.

There's a great article in Fortune, I think it's this week or last week, suggesting huge amounts of money that need to be put away prior to age 65 that you would need to have to cover those expenses as you go forward.

I also had some other statistics. This is from the Robert Wood Johnson Foundation. Again, 43 -- I thought this was interesting -- 43 percent of people that were polled said they feared that their employer or their spouse's employer might eliminate some health benefits within one year, some of their benefits.

Twenty-one percent said they feared that out-of-

pocket expenses will increase to an unaffordable level, and 8 percent said that they fear that the company plan may just go away in one year. So there's continued fear, there's continued uncertainty, as to the role of whether the employer is even going to provide a benefit in the near future.

I don't want to -- we can talk a little bit about distortions. Again, I was very intrigued by what the Speaker said. I think that there is a role for employers in this process, although it does -- today, the way it's set up, small employers clearly do not have the same size, the same leverage in the marketplace as large employers to get the kind of coverage they need.

And benefit levels, types of plans, those things, are going to vary by the ability of a company to pay -- what's their bottom line, whether they are a public or private company, those kinds of things -- and whether they need to be competitive.

And again, though, saying all that and despite all that, I do believe that the employer does have a role here. And I say that, and I think employers in general believe that, although as the costs continue to skyrocket, there are employers saying, you know what? Maybe we were the right people to do that, but we're just not doing it well. The infrastructure is not in place, and therefore maybe in the next five years somebody else ought to come in and do that.

We're hearing more and more of that from employers every day.

And again, I just wanted to put up this statistic because I think it shows that the key problems that smaller employers had -- and the Speaker made mention of this -- because of the risk pools and the abilities for these small employers, employers that have 24 employees or less, you know, what kind of health coverage can they get?

And you can see that if you take employers with less than 25 lives, 40 percent of those employers do not provide health coverage today. And what that means is that the spouse's plan has to pay or these people may be going uninsured, you know. But in any way, it exacerbates the problem in the system.

What changes have there been? Clearly, there's been a move away from the more tightly managed HMOs -- and again, the Speaker was absolutely right, it wasn't managed care, it was managed cost -- to more loosely managed PPOs, which the employees embraced, getting away from the referral mechanism and all the paperwork with that, was just something that they were very much in favor of.

But what that led to is, it's led to more cost as it's become a more unmanaged system. So what employers have done, what our clients have done, is basically used -- you know, the good message is, we're getting rid of your HMO and we're putting in a PPO, which is less managed. The bad news

is, your costs are going to go up just as ours are at a faster rate.

Clearly, most cost-sharing with employees, whether it's in payroll deductions or higher deductibles, copays, again, as companies feel that's the only way they can affect their bottom lines.

I say more choices of plans. It's actually more of a consolidation of vendors. There are far fewer vendors in the marketplace today. There really is only a small handful of national vendors -- Blue Cross, the association Blue Cross, Cigna, Aetna, United Health care, and some would argue they're not even national any more. So the number of vendors has really dropped.

And consideration of consumer-driven plans, we could probably have a whole segment on that. It's certainly something that's out there. The whole concept of the consumer-driven plan has been touched on, as we've discussed this morning. The idea of financial incentives and providing consumer education so that patients will more effectively buy health care services is at the root of consumer-driven plans.

Unfortunately, we don't have enough data yet to support whether that will happen or how well it will affect utilization. But I will say to you is that many employers will embrace consumer-driven plans, as they did the HMOs in the '80s. Most of them will embrace it not because they

philosophically believe it's the right thing, but quite frankly because they have no other option and they're desperate. Okay?

They probably wouldn't know the underpinnings of why consumer-driven plans actually work, but their CFO has said, we have to cut cost. It is a new thing to try and they don't have many other strategies. So I think you'll see a great proliferation of consumer-driven plans.

Is it going? No, it's not. Okay. Here we go. Actually, this is from the Washington Business Group on Health and I just wanted to touch on some of the access to health care information. Again, because we're running low on time, I'm going to skip that. Helen can certainly talk about that. I think they do a wonderful job.

The Speaker did talk a little bit about group underwriting, about the fact that when you're in an employment-based situation you're able to take all risk -- good risk, bad risk, whatever. Certainly, in the individual market we've seen all kinds of issues with employees trying to get coverage, questionnaires, you know, being selected against, paying higher rates if they have certain medical conditions, and then seeing the rates go up maybe on a quarterly basis versus an annual basis. So clearly, the individual market, unlike life insurance, is not anywhere near as competitive as the group market.

And I think what I would do to summarize this, because I don't want to -- I'd like to save time for some questions and things -- is just to leave you with the fact that employers out there are questioning their roles today. They're not ready to give up the ship yet, but they recognize that they can't continue to maintain the structure the way it is.

And I think the structure today has a lot of inherent problems with it. And if we don't do something soon, I think you're going to see employers start to take more drastic actions. Thank you.

DR. HYMAN: Next is Helen Darling from the Washington Business Group on Health.

MS. DARLING: Thank you. Thank you for the opportunity for the FTC and the Department of Justice taking on these complex issues that have burdened the system since the turn of the century. But we're very grateful that they're paying so much attention to these matters.

I'll skip some things that I would have said both because they've been said by others and because they are probably less central to what we need to -- I know that actually Marcia will talk about some of these.

I'd like to talk about the trends in an employer-based system and try to hit some of the things that haven't been said, although I would say that what has been said in

fact is very true, and especially what Michael was talking about. Not just our data but his experience as well sounds very familiar.

Also, you have researchers. Our very own David Hyman and others like Judith Lave have done research. And for those of us who are real benefits managers at heart or have been at some other time, I think we are pleasantly surprised to see repeated data of how much employees value their benefits.

Because if you actually manage them, all you hear about are the problems. Nobody says, yes, we really think this is great. But interestingly, in the last five years, thanks to the work of some really great health economists and some survey researchers, we have seen evidence that employees really do greatly value their health benefit. And we see evidence, which again we didn't see till this past five years, that employees actually are making decisions about where they work, you know, relative to the benefits.

So if the economy turns around, health benefits again could become a competitive advantage, which is one of the things that had kind of gotten lost in the shuffle in the last two years. I mean, things are just generally so bad out there that, in fact, it's hard to sort out what's happening.

But if what we saw up until about two years ago is true and the economy begins to pick up, then the companies

that offer these better -- as the Speaker said, better quality and more choice at a lower cost, those initiatives will become far more important.

What I would like to say is that employers are doing the best that they can right now to try to balance the competing pressures that they have of trying to control cost. And several people commented on the relationship between wages and health benefits.

For the first time in my career, which is as long or longer than anybody in the room, I'm sure, we also saw direct tradeoffs. As the economists say, all benefits are foregone wages or other benefits paid for by the worker. And unfortunately, the worker doesn't get that message very often, although we keep trying.

But for the first time, we actually began seeing with this recession -- which, as you know, it's lasted longer for particular sectors like the tech sector and others over the last couple of years -- we saw companies like Charles Schwab and Goodyear and others absolutely suspend their contributions to 401(k) for their workers. They made some changes in the health benefits, but they didn't suspend those. But they did the 401(k). And, of course, you've seen some of the strikes that have happened, and you see labor unions going in and sitting down and saying, okay, this is another nickel on the wage package.

Now, the amazing thing to some of us is that they will take the health benefits. And actually they'll take the thing that's the worst thing for them, which is overly-comprehensive packages with very low copayments and, you know, further sheltering themselves, we would say foolishly, from even getting the information on cost.

And when again, all of us try to explain, do you realize not only are you giving up cash wages and other benefits which you need, especially given how slowly wages have grown, but you're also fueling the inflation in the health system by doing it this way -- and, you know, my experience and the people I talk to is they look at you like you're crazy and they still go on strike.

You may recall that Hershey was on strike for 42 days over going from a 3 percent contribution to a 5 percent contribution, which was -- you know, it's wild stuff.

So most employers right now are trying very hard to ease into a new model, and ease is the right word. Because while those of us sitting here talking about this know what's happening because we can see across the country, and in some ways because we talk in percentages, you know, it sounds like a lot.

But in some instances we're going from a $5 copay to a $7 copay in terms of, you know, what makes people move and how that relates to the total cost of care is not so

obvious. And so people will say, well, I'd rather have the $5 copay.

So we've got a lot of confusion out there. But employers are trying to move us to more cost-sharing, and not just in symbolic terms but real cost-sharing.

We did a survey of our own members recently about what they had been doing in the last few years, and this won't surprise anybody here. They are doing more cost-sharing and generally feel that enough cost-sharing for the consumer to have a financial stake is really essential, and that coinsurance, not copayments -- many people that I talk to and work with and our own members feel that going to copayments to encourage people to join managed care organizations, where the delivery system did the management, was one thing. But copayments have really become the kiss of death for much of what we're trying to do in this system now.

Once you have a wide-open system, which we essentially have now -- I mean, even the PPOs are -- everything is wide open and the data show that -- then copayments become truly absurd. So we're moving to coinsurance across the board.

The second thing is that all of our members, our large employers, believe and are working hard that consumer involvement is essential. And if you've heard some -- and I thought David's presentation was just superb on that point.

And he's described, if you will, the world we all want to have, especially with the actual data to do it.

I actually went through for a friend a similar experience recently. Fortunately, he was being hospitalized in New York City, and New York is one of the few states where you can get information. He was going to have a radical nephrectomy. Now, you'd think that that is a rare enough event that it would be pretty easy to find out who's good and not good.

Well, this is a very sophisticated consumer, very -- had lots of time and money, really, because he was under so much medical care simultaneously. And the way we found out where he should go was by going online to the New York data set and to just put in "radical nephrectomy" by hospital throughout the state of New York.

And it was shocking, absolutely shocking, even to us cynics, that there were only about two hospitals in the entire state that did more than about 90 a year, and there were -- almost every hospital in the state did a few.

Well, you know, this is a very complicated procedure in just the postoperative care. And, I mean, you can just think -- so, you know, we know that we want consumer involvement and it's essential. But we have -- and many around the table, of course, are working to make this happen -- we've got to not only get the information out there

that's there, but we also have to make sure that people can access it and know it's there, and you don't have to know the system.

Again, David's point and others about transparency, we believe that's essential. And we have a report out on the table -- I hope you all have picked it up -- about transparency and accountability. It's essential.

We also believe that in the short term, that it would be very easy to require that all currently publicly reported information, which is already -- all the battles have been fought about whether these are the right measures and all those, and they're imperfect, to be sure.

But they're already in the public domain because they have to be reported to somebody, whether it's Medicare or the state health department or, like in Texas, the commission. If that information just has to be required to be available on the website of every hospital, and in libraries and things like that, so that people can get to it.

One of the things that we've found is it's very difficult to measure or to get information on cost and benefits because the data are limited. We also found that disease and health management programs are growing and there's a lot of reliance on those, but that's also another area where we don't have a lot of information about what works and what doesn't and what's effective. And are these

areas where some people would just be pouring a lot more money into the system and may not in fact make much difference.

And several people talked about patient safety and adverse drug events. I sit on a hospital board where just a year ago there started to be a requirement from the Joint Commission that you report near-misses, not just adverse events. And we've never had that.

The board now receives a report to the board that, in fact, gives you exactly the number of, you know, adverse events and near-misses. We never did that before. And each of those is being used to investigate the root cause of that. And just that small requirement has transformed the behavior at the board level.

I just want to take a second to mention some of the other things that are going on that are really important. We need to move the system towards more health accounts.

And I won't go into the detail because of time, but we are doing a lot of work trying to make certain that the Congress authorizes and the federal government continues its movement towards allowing employers to have health accounts, employees to have health accounts, and for us ideally to have this dream of the employee human personal health account, financial account, in which individuals are allowed to pool all of the money they may want to pool and employers can put

the money in, and that can go into retirement, if you want. Essentially, it becomes the 401(k) of health accounts, with portability and lot more flexibility.

These are times of great challenge. We are struggling with health care cost increases five years in a row, 50 percent, this year 14 percent. They say next year it's probably another 14 percent on top of that.

Some people have raised a question about whether or not employers will stay in this business. And we would say that the likelihood is that they will stay in the business, but the account and the allowance and the amount of money they pay will grow more slowly than the cost of health care will, and therefore the employees and their retirees will be spending a lot more money.

There was a story in today's New York Times, if you haven't seen it, an excellent story. It starts on the front page, Milt Freudenheim, about how the coinsurance is, in fact, beginning to have an effect. So maybe we'll see some changes soon. Thank you.

DR. HYMAN: Dr. Comstock?

DR. COMSTOCK: Yes. Good morning. When you come at this point in the panel, you have to throw out everything you were already going to say because it's already been said. But I'm not ever at a loss for words, so I'm going to pick up a little bit on some of the things that David said. But

before I do that, I'm going to make a couple comments from what I originally had prepared.

I'm a strong proponent of this whole, you know, patient-directed health care movement. But there's a number of caveats there and I think there's a number of cautions. So let me just cite a couple of them.

One of them you've already alluded to, Helen, and that is the whole regulatory framework for these kinds of accounts. And as you all know, this movement was given a significant boost last June when the IRS clarified the tax status, that these health reimbursement arrangements could be rolled over. They were tax-free.

But that is employer dollars, not employee dollars. And we need to -- one of the things that needs to happen is, as you've already alluded to, to make it even richer is to allow those monies to be blended.

Another area that's been touched on is that whole issue of selection of costs. And there are definitely concerns about these things because while about three-quarters of people spend less than $500 a year on health care and they're going to be able to accumulate funds, well, those who are going to -- who are hit with high medical bills are likely to pay more. And that's a reality. And depending on your perspective, you can say, when costs go up we can tax everybody or we can tax the high users. And that depends,

obviously, on your philosophy.

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

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

Wye River has been involved in the past year in a project where we have gone around the country to ten different carefully selected communities and conducted listening sessions with leaders, health care leaders, consumer advocates, hospital CEOs, employers, health plan execs, the entire spectrum, 25 in a room, with the White House and with Democratic support, Progressive Policy

Institute, Senator Lieberman's office, and so on. So it's a, you know, bipartisan, multi-stakeholder initiative to talk about the values and principles that should drive health policy. David Lansky participated in our Portland meeting.

The first thing I want to -- the first comment I want to make about that is that there's much more agreement than difference when you get out of Washington and you get into communities. These leaders really want to roll their sleeves up and work together to move this health care system in the right direction.

There is broad support from liberals and conservatives toward a patient-directed health care system. But there are some caveats. From the perspective of the liberal, they'll say, that's all well and good to talk about personal responsibility. But remember that 25 percent who need extra help. And also, it only is going to work if it comes with system accountability, telling the patient you've got to take care of yourself and you've got to be responsible for your health behaviors. So that's very, very important.

The other thing that's very, very heartening to me is that the most conservative elements in the meetings are saying that the world's richest country cannot afford to have 40 million people in this country who do not have access to health care. And, of course, we all know insurance doesn't equal access, and getting care in the emergency room doesn't

equal coverage. So this has to be balanced.

We also have heard in our meetings at every single community across the country that if there's one thing that we need to do, we need to start a dialogue that we've never had in this country. And that is, what is it we want from our health and health care system? We haven't even defined health and health care. And how do we talk about whether we're spending too much or too little or what kind of system we should have when we don't know what we want out of the system? So that's something that they feel very strongly.

And as we move forward into phase two of this project, we have been told by both the White House, Lieberman's office, the Food & Drug Administration, HRSA, are all interested in getting engaged more in these dialogues.

We have listened to consumers about how do we create a system that's focused on patients, that serves patients? And as David put it so beautifully, it's about relationships and not transactions. So I think that that's a very, very critical issue.

Some of the barriers. Well, you've all alluded to the financial incentives. Every one of these leaders, even when you're talking about values and principles, will say, we have the most pathetically malaligned incentives across the board and we've got to start from square one and figure out how do we create the incentives for people to be healthy and

take responsibility, for providers to educate patients, and to provide preventive care services? Because all of the dollars being spent on end-of-life care or unnecessary technology could do an awful lot. And that's why I challenged Newt this morning about, okay, we can't wait for all that money to be freed up. We need to make an investment now. And I think he gave a good answer.

The biggest barrier, though, I think, is culture, whether it's the culture of individuals or the culture of organizations. The physician culture has been slammed several times today, and I'm probably more guilty as a physician of slamming the physician culture than many non-physicians.

But the reality is, this is not a cottage industry any more. It has to move away from being a cottage industry. And in order to do that, physicians have got to take responsibility for thinking totally differently about what their role is. They have got to work as part of a team. And doctors don't do that very well. So that's another barrier.

And I've already alluded to the issue on information. We have to have multiple ways of providing information. And in part, it's not just technology. There's going to be millions in this country who'll never had access to technology. So we need to find other ways of creating outreach into these communities, these diverse communities in

these rural areas, whether it's through community health workers or lay educators. And this is kind of like, it's very low tech but it's high touch, and people love it. And we need to build that into what we're thinking about.

So I'm not sure -- you know, when I was invited to come and talk to the Department of Justice, I went, oh, God. I spent six years as a corporate medical director. I like to steer clear of lawyers. But the reality is, I'm sure there is a role, and certainly around creating the framework for a system where communities can then build their own local solutions. Because that is another theme that we hear loudly from communities, is we need to be able to work together to find the answers. But we need the support of the federal government, whether it's with regard to that structure or with regard to resources. But they want to find their own solutions.

And I'm just going to stop there and let that go. But I thought that would be something that would be a little different twist on what's being talked about, but clearly the things that you are saying about patient-directed health care and the movement is definitely borne out in the communities.

DR. HYMAN: Thank you.

Finally, batting cleanup, Greg Kelly.

MR. KELLY: Thank you, David. First of all, I want to commend David Hyman and the FTC for holding such an

ambitious set of hearings this year talking about a wide range of topics, 30 hearings on the competition in the health care marketplace. I think it's very, very important.

Today I'm going to touch on -- a little bit on what the Speaker, Dr. Greenberg, and David Hyman brought up regarding adverse selection and some of the problems in pooling of insurance and how we can move forward there. And given the questions posed today, I'll focus on how a specific regulation, that of guaranteed issue, affects costs and availability of health care coverage in the marketplace.

Obviously, in our complex health care system, there are many factors that drive up the cost of health care coverage. But even so, there's ample empirical evidence that isolates and displays the dramatic effects of one particular regulation, guaranteed issue.

Perhaps the easiest way to take a look at that is to look at the three different market segments. We have a private insurance market system that is segmented into three very distinct categories, the large group market, the small group market, and the individual market.

I'm not going to spend a lot of time talking about the large group market because it's the least regulated of the three. There are no federal guaranteed issue requirements on insurers to issue plans to large groups. Insurance is widely available. There tends to be a choice of

coverage. And so the focus of where I'm going to be looking at is the federal and state regulations in the small group and individual market.

The individual market, which accounts for about 10 percent of private coverage, is primarily regulated by the states, while the small group market, which accounts for about 25 percent of private coverage, is regulated by both the state and the federal government.

Given these different regulatory environments, we have guaranteed issue imposed by the states in certain individual markets while guaranteed issue is opposed across the board by the federal government on the entire small group market?

First of all, what is guaranteed issue? Guaranteed issue is a law that requires insurers to accept everyone who applies for health insurance, regardless of their health condition. Under guaranteed issue, an individual who has no health insurance and becomes ill may apply for private insurance coverage and must be accepted. This is comparable to allowing a person to purchase auto insurance for their accident after being involved in a car wreck.

When people know they can get insurance when they're sick, they'll forego it when they're healthy. Younger and healthier people cancel their policies. The health insurance pool gets smaller and sicker. Escalating

premiums occur, and eventually the pool is left with just the sickest and most -- and people with the most expensive health care needs.

We eventually reach a point where many insurers are no longer able to offer a product under such chaotic conditions. The end results are: inordinately high prices for insurance; considerably reduced choices for coverage; a greater number of uninsured; and ultimately, a health insurance market where few, if any, insurers are offering coverage.

I want to look at both the states' individual market and what's happening on the state level as well as what's happening across the board in the small group market. Let's look at the state examples first.

States such as New Jersey, Maine, and New York have passed guaranteed issue laws in the 1990s, with disastrous consequences on competition and affordability. Rates have increased and insurers have left these states.

For example, a family living in Portland, Maine pays a minimum of $1,176 a month for a $500 deductible PPO policy. A similar family living in Trenton, New Jersey would pay $3,576 a month for a similar plan. In New York, you cannot even purchase a PPO or indemnity plan, and if you live in Ithaca, you have a choice of one plan and it costs $1,113 a month.

Conversely, in states without a guaranteed issue law, health insurance is much more affordable. Average families in Arlington, Virginia, Pittsburgh, Pennsylvania, and Madison, Wisconsin can purchase a $500 deductible PPO policy for $410, $461, and $335 a month respectively. And there tend to be a wider range of coverage choices and options.

The bottom line is that no state has implemented blanket guaranteed issue without a loss of consumer choices and a dramatic increase in price. So it's pretty easy to compare the wide range of affordable products available in non-guaranteed issue states with the limited choice and expensive coverage options, or non-options, should I say, in guaranteed issue states.

Now I'd like to look at the small group market. Remember that the small group market is a hybrid where we have a mixture of both federal and state regulations. In 1996, HIPAA imposed guaranteed issue across the board in the small group market, and almost all states have followed with restrictions on the price that insurers can charge small groups.

This means that insurers must make all plans available to any small employer that applies for coverage. And insurers are often limited in the variance on what they can charge employers with different characteristics.

Like in the individual market, guaranteed issue destroys the basic risk classifications of insurance. Very small employers, especially baby groups of ten and under, will wait to obtain coverage until one of their employees need it, or under guaranteed issue other employers will switch to a plan with more generous benefits when one of their employees need it. These adverse selection problems cause healthier groups to leave the market, prices to skyrocket, and insurers to stop offering coverage.

Small group guaranteed issue has impacted the cost and availability of coverage nationwide. Mark Littow, an actuary with Milliman USA, who has priced small group products and premiums for over 27 years, recently provided congressional testimony on the abysmal shape of the small group market.

Mr. Littow has estimated that the small group is poor to questionable in 35 out of the 50 states. He determines this ranking based upon an environment where losses exist for almost all group insurance companies, even with prudent management.

He attributes much of the deteriorating market to the federal guaranteed issue laws and the state rating restriction laws. He submits that the small group market is only viable today in about ten states.

With these losses, evidence clearly shows that the

carriers are exiting the market in droves. The General Accounting Office recently completed a study that showed a disturbing market concentration in the small group market, with the top five carriers controlling more than 75 percent of the market share in the majority of the states that the GAO studied.

Healthier groups are dropping coverage because of escalating prices. For example, in Colorado, the state division of insurance has reported a loss of 14,663 small groups, covering more than 125,000 individuals, in just the last two years. The state attributes much of this problem due to the guaranteed issue requirements in the small group market. Healthier groups are just leaving.

While the increases in health insurance costs and the loss observe coverage options do not occur in a vacuum, guaranteed issue is the one regulation where you can see the distinct impact on the cost and availability of coverage.

Given that guaranteed issue is nationwide in the small group market and limited only to certain states in the individual market, guaranteed issue is one of the contributing reasons why the small group market is more expensive than the individual market.

Contrary to popular conception, the small group market is, on average, much more expensive than the individual market. For example, even though coverage is not

quite as comprehensive always in the individual market as it is in the employer-based market, policies sold through e-health insurance are on average 25 percent higher for small business members than they are for individual members, and this is done in a state-by-state comparison.

So we get into a tricky situation. Results show that if you make insurance available to everyone, it's simply not going to be affordable. And if you make it widely affordable, it's not going to be available to absolutely everyone.

So if we want affordable and accessible policies, instead of regulating 100 percent of the market, regulations or programs should be designed to address the 1 to 2 percent that cannot obtain coverage. For example, high risk pools are such programs that allow the market to work for the 98 percent of the population who can obtain coverage while providing a strong and viable safety net to cover the sick.

States with the least regulatory burden successfully rely on high risk pools to cover their uninsurables, and have affordable health insurance for the rest of the population.

Since the effects of guaranteed issue, regulations on the cost and availability of coverage can be pronounced and identified. These regulations can often be repealed. For example, on the state level, Kentucky, Washington, and

New Hampshire repealed their guaranteed issue laws recently after these laws caused a complete dearth of health insurance options in their states.

With the deteriorating state of the small group market, Congressman Mike Pence is planning on introducing legislation to repeal guaranteed issue in the small group market.

The clearcut effects of guaranteed issue on competition, price, and availability of coverage should be helpful to policy-makers as they revise these laws, and I hope that this examination is helpful to the participants in this room as we look at the effects of regulation and competition in our health care marketplace. Thank you.

DR. HYMAN: Thank you. Well, everybody has done a great job of staying on time. You're all very public spirited. And so we've got about 20 to 25 minutes left to have a panel discussion about these various presentations.

Let me just start, and people can feel free to ask questions themselves of other panelists if they want. But I'll exercise the speaker's privilege of filling the uncomfortable silence that might otherwise result if I just threw it out at the start and just ask the following question.

There's been a lot of discussion today and in past hearings about the extraordinary saliency when it's time to

actually receive health care of the need for information, of picking the right provider, of deciding whether the recommendations that you're getting are sensible ones, and the difficulties of obtaining information about that.

But the options that you have and who you get to see are tremendously influenced by the nature of your coverage. And the saliency of the coverage tradeoffs, it seems to me, is a different matter entirely.

So I guess the question I would ask is how do you make the coverage tradeoffs more salient to people? Is consumer-directed health care a way of finessing that by putting the burden on the patient to make those decisions at the time they receive care? And is it really realistic to expect people to pay close attention to their health insurance when they only get to choose once a year and it's aggregated for them, for many people, by employers? So that's, I think, a range of questions we can start with.

Helen?

MS. DARLING: Well, I'd like to take that one on. Actually, I'd like to take on your assumption.

DR. HYMAN: Go right ahead. Then it's a really good question.

MS. DARLING: Yes. Because actually, most people have choice. I mean, if you look at the numbers of -- you know, you look at visits by coverage, between the fact that

more than half of the employees are in PPOs. And usually there's not a lot of constraint. There's some, but not a lot. And you have -- a lot of the health care is under Medicare and Medicaid, where with a few state exceptions, it's still pretty wide open.

So actually, I almost wish it were the coverage because that's easier to manipulate and do something about than it is to deal with the lack of information when you're ready to make a decision.

There may be some challenges on particularly kind of obscure problems where research and experimental treatment is the only thing that's available. But the vast majority of care in this country is not that, and it is covered and you do have lots of choices, but you don't have the information that -- some of the things that David talked about.

So the pressure ought to be on that point, it seems to me.

DR. HYMAN: Marcia?

DR. COMSTOCK: Some people only define consumer-directed or patient-directed health care when there is actually a decision made at the point of service as opposed to just once a year. Because the reality is, under a cafeteria plan that exists today, you can say, well, that's consumer-directed health care.

But you're not incentivizing, thinking through

decisions actually at the very time. Same thing in the pharmaceutical business. I mean, if at the point of purchasing something you have coinsurance and you make that decision, as opposed to later on getting a bill for whatever it is, you're not really going to drive good decision-making.

A couple thoughts. One, when people are really sick, that is the great equalizer of everything. They want -- they're not in a position, really, to make major decisions. But assuming that you have some kind of a consumer-directed plan where you have a high deductible policy that's pretty broad and that you can basically go to whomever you really want, the decision-making, as you say, it's really around -- you're trying to drive the decision-making toward that discretionary kind of care, not toward those critical kinds of things.

And the other thing that I find quite interesting is that almost by definition, quality is incompatible with complete choice in the sense that every doctor is not equivalent. I mean, you know from the Dartmouth Atlas and from all the other work that's done.

So until you really have got the kind of information for people to make decisions around serious illness or whatever in terms of where they want to go, it's kind of almost funny that people want complete choice, but then that's opening you up to virtually any level of quality

of care.

MR. YOUNG: No, I agree. I mean, I think we have to be careful, though, and make sure we understand that there are kind of exceptions to every situation.

And just as we have exceptions to the fact that not everybody is going to be able to use the same level of health care information, the other exception is that under the current system, there is a need for, in the employer marketplace, a claim intermediary, whether it's a Blue Cross or an insurance company, but some sort of claim intermediary, whether it's an insured plan or a self-insured plan.

And most employees -- most employers are relying on that claim intermediary to not just process claims, but to contract with providers and to provide information to the employees and do all those things. And what happens is then the employee is kind of held to whatever that claim intermediary can provide.

And we have -- and I know you talked about this in prior sessions -- but we have areas of this country, fairly large areas of this country, where one claim intermediary has a stranglehold on that geographic market because the network discounts they have with their providers are so great compared to everyone else that it precludes any type of -- any other claim intermediary or any managed care organization, whatever you want to call them, coming into the

marketplace.

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

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

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

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

DR. HYMAN: David?

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

I think an interesting thing is going on where those who are -- whether it's the intermediary or the payor is creating transparency around the criteria of network participation. So Leapfrog, I think, was an example where they were trying to say you -- in theory, Leapfrog said, we, the purchaser, will continue to do business with you, the plan, if you in turn prefer -- do preferential business with high safety institutions that adopt certain practices.

And they supported that, with an employee education program to help the employee recognize, here's where care is superior. And I'm part of a chain of relationships with my employer, with the plan, and in a sense with Leapfrog as a policy organization, that is trying to help me seek out and get the safer quality care.

I think there's a series of initiatives in which the payor or the intermediary can either give visibility to or money to entities which adopt elements of superior care. And so whether it's transparency or pay for performance, either way it's a way to try to make the system work better without directly managing care with a heavy hand.

DR. COMSTOCK: Actually, that just reminded me of something I wanted to say earlier that the Speaker talked about, and that is, whose job is it and on whom should we rely to make certain that data are standardized and things like that?

And I would be very concerned if that became a governmental role, except as a purchaser. And to the extent that CMS and other powerful buyers in the system as a purchaser, as a condition of participation, insist on information being collected and analyzed and everything done in a standardized way, that's terrific.

But the organization or organizations that decide what those measures are going to be, I believe, has to be outside of government, and for a couple of reasons. First, there's no evidence that the government -- the government has actually essentially owned the health system about 40 to 50 percent since 1965. They have enormous power. They have never used it for those purposes. So counting on them at this point to be our guide in that regard is not a good idea. It's certainly not going to get us anything before I'm dead in my grave, I'm sure.

The second thing is that a lot of these things, as David knows because his foundation has done a lot of work and I've been involved with NCQA's committee on performance measurement, that you need a lot of people sitting around a table working as fast as possible with a nimble approach to it to get these things right and to keep making them better and better.

And when you have new information, you do a pilot. You can -- you know, FACCT and other organizations can

decide, okay, it's not going to be this. We just found this doesn't work out in Colorado, and so we're not going to do it.

So having the organizations, whatever -- you know, the private sector arm and how they're put together is less important than there are people who have that as their responsibility, organizations. They know what they're doing. They're able and willing to test. They're able and willing to bring from the best and the brightest whatever the issue might be, come up with the best measures, pilot them, test them, fine-tune them, and then they can be picked up by the larger purchasers, including the government and be driven that way. But if we try to put it in the government, it just won't happen with the kind of speed. The other thing is that once it gets in the government, it is so vulnerable to pressures from narrow special interests who have no interest in seeing progress in these areas.

DR. HYMAN: David?

DR. GREENBERG: All right. Let's take the government out of that for a little bit and put it in the third party payor. And I remember when we used to have HMOs, and I remember when women on normal deliveries used to be in the hospital for four and five days, and people having surgery used to come one or two nights before, and stayed for much longer than they are now.

That wasn't my doing as a consumer or patient, or the person next door's doing as a consumer or patient. I don't really know how long a person has to be in the hospital after a normal delivery, after a certain kind of surgery. How many days, really, does that person have to be there before the actual surgery?

That was done by a third party payor who has thousands and thousands of patients, perhaps experts on the team, who could make such decisions, provide information to that patient. Gee, a normal delivery, two days may be enough.

Okay. We can always debate that the managed care firms overstep their bounds, that they have other incentives to contain cost and only those incentives. But I would maintain that I just can't do it. I can't do it as a patient right there before the surgery in the hospital, even a couple days before the surgery.

And we have these experts as managed care firms. I still come back to perhaps my earlier point: Without the government interference, Helen, let's have those third parties -- when we pick them on a yearly basis, we decide ourselves, based on a variety of information, brand name, signaling, however you want to deal with it, the same way we pick automobiles and other difficult -- we have so many difficult products that we buy today, cell phones, whatever.

Somehow, the market works, a little bit imperfectly, but the market works.

In the comfort of our living room, picking a health care plan based on price, quality, brand name, signaling -- and I think that's the best we could do. I mean, you could find things on the Web that says, this cures cancer, and go another website and it says, this does not cure cancer.

DR. HYMAN: And we do enforcement on some of the first category for fraud.

DR. GREENBERG: But anyway, I go back to the comfort of the living room, deciding on the third party plan, and creating incentives for those third parties to provide health care cost containment as well as quality of care.

DR. HYMAN: Let me follow up on a point that got made earlier and see if we can push this in a slightly different direction because we could use all of our time just to talk on this one.

On the issue of quality, David asked the Speaker a question that I thought was quite insightful, which was, you know, there's -- basically, do you fragment or do you aggregate? And there are virtues and costs with both of those strategies.

Aggregation allows you to sort of leverage your purchasing power for both price and quality, if you choose. And I guess the challenge is how do we think about these new

arrangements for benefit design in the context of trying to deal with the problems of integration and quality? And given the information that we have, how confident can we be that this is going to head off in the right direction?

MS. DARLING: I'm not sure I understand the question.

DR. HYMAN: All right. I didn't ask it very well, then. Do we -- when we disaggregate purchasing pools by essentially open-ended choice and by allowing people to make their own decisions as to who they go to and how much to pay, it makes it much harder for employers to do things like Leapfrog because they can't selectively contract, okay, unless you're going to do it with everyone, and to impose minimum quality standards.

So I guess I'm really just trying to put a sharper point on David's question.

MS. DARLING: Well, but they could -- you can do it two ways. You can give people lots of choice at the point of care but still have a plan who administers.

The other thing is that you could provide information that's especially penetrating and useful about the providers. And you are allowing the employee or their dependents or their retirees to choose, but with information, just as they do now -- again, David's example. They suddenly have information about different hospitals.

Your pressure comes from -- and by the way, I've actually seen this happen. The pressure comes from the fact that the hospital goes on whatever it is, the website or whatever's published, and says, oh, my heavens. We are like number seven in this market. This is really bad news.

And we know -- in fact, the research on even the use of quality metrics and plans was less used by consumers, but it sure was used by providers. And I, again having been on a hospital board, actually, all my adult life, it seems, I can tell you that we pay a lot of attention to reports, even those in these kind of fluffy magazines, using what many of us would consider kind of questionable data, although it's not terribly wrong. But it's just -- you know, you're not totally comfortable with it.

But you will have hospital boards saying, what is this? You know, we're number six in this market? I mean, heads roll inside organizations when there's public information about how something stands out.

So the data will drive at least the hospitals and providers to change their behavior independent of whether or not even the employees change their behavior because of it.

MR. YOUNG: I think one of the things -- one of the criteria that employees sometimes use to determine quality is if they are in a PPO or any kind of managed care plan is their assumption is that the providers in the network are

better providers, which in most cases probably has very little to do with quality and has a lot more to do with the contracting, you know, possibility of contracting between that provider and that claim intermediary.

So you have to be very careful. I mean, there are many times -- and this is where I think we have to have pressure on -- and I keep coming back to these claim intermediaries -- to if they're going to contract, if we're going to have a structure where somebody is buying services at a unit price discount, that some of -- that the criteria for making the decisions of who those networks are has to much more involve quality.

DR. COMSTOCK: I mean, that's all true. Just a couple issues. One is we all know that the vast majority of health care has not definitive best practice. I mean, so much of what is done in health care does not have an absolute, this is the right thing and the wrong thing.

Yes, if you have colon cancer, you need surgery, whether to cure it or to keep you from being obstructed. But for many other things, there is no definitive answer. The real issue is: is the physician engaging with the patient in a shared decision-making process around their values and what's important for them?

But I wanted to make the comment -- you know, you said the hospitals will respond to information. I know one

of our supporting organizations is Jack Wennburg's group up at Dartmouth. And they've done some wonderful work that showed that, you know, physicians don't like to be measured a whole lot. But they have a way of doing it that's collaborative and collegial.

And what they do, for example, in the northern New England cardiovascular disease project is physicians looked at each others' processes of care and they began talking about what did they do and what results did they get. And they immediately responded. Nobody had to hit them over the head with it.

So I think that getting back to the importance of culture when it comes to any of these things related, you know, to delivery changes. You've got to recognize the culture. The hammer over the head doesn't work well with physicians but other kinds of methodologies do work well with physicians. So it's just a little bit of a flip side.

And then I just think we just have to remember that quality metrics are great, but there's only so many things that you can measure definitively.

I thought your question to Newt was different. I thought -- was it different? Was your question --

MR. LANSKY: It was a very subtle question. Go ahead. I'd like to her your interpretation.

DR. COMSTOCK: I thought you were asking a very,

very different question about is it more appropriate when you're looking at quality: to look at quality of the entire process of care, like around the chronic disease and the outcome of that, versus a particular transactional kind of metric. So I guess I misunderstood your question.

MR. LANSKY: No. I don't think you misunderstood it.

DR. HYMAN: I did.

MR. LANSKY: No. I was actively asking two questions at once.

DR. COMSTOCK: Well, you're very clever. I got one of them, at least.

MR. LANSKY: Because I think they are -- I personally think they are related problems to solve, that the good managed care model which the original theorists advocated for included both integration of care, particularly in support of both preventative health maintenance, and chronic care.

And that still seems to me to be a hallmark of those kind of care models and tying incentives to the successful performance across that spectrum. And that, in turn, built the kind of teams you both just spoke about in terms of internal recognition of quality rewards and opportunities.

And I'm concerned that the current trends we're all

talking about today may go in a different direction and also create a technical problem that measurement becomes very difficult if we fragment. And then access to information becomes very difficult if we have a high fragmented system. So I was concerned about both impulses.

I wanted to answer your question as well, David, or start a piece of it. I think most of us in this field have been fairly naive about thinking about the solutions, and we need a new way of thinking that is more subtle.

We've got a system we're talking about here in a room among ourselves that accounts for a sixth of the national economy, millions and millions of peoples' livelihoods, enormously complex. It's not a -- we use words like system and managed care and chronic diseases if we're talking about a thing that we can implement to address. And we just can't.

So we have to -- we need some other way of recognizing that it's a very layered problem. I think it is more achievable for federal agencies, the regulatory process, the legislative process, to deal with what we would call infrastructure, making sure that the highways are there and the railroad tracks are the right gauge and that the underlying structure is in place that would permit us to do all the things we've talked about today, without yet saying what those things are.

And we've gotten all of us a little bit ahead of ourselves in some of the work we've done the last ten years, fifteen years, in thinking we knew what some of the solutions were rather than building pipes and paving roads that would let us at least drive around a little bit without saying where we drive or what kind of cars we drive in.

So I would encourage you -- and I think the SEC/FASB model that was talked about a lot ten years ago and underlay the President's advisory commission report but was never implemented remains a very important model to think about carefully.

In Helen's point, you know, what does the FASB part of that need to look like, in which you have an open dialogue with private sector interests, very involved? And what does the heavy hand of government need to look like, which asserts specific requirements upon the entire regulated industry, having had that input and standard-setting done by the private sector?

I am more concerned than Helen about allowing the private self-regulating model to continue because I think we've had some experience where, in both the case of the Joint Commission and NCQA, a relatively voluntary participation leads to under-participation and whole sectors of the system not being involved at all if they don't choose to. And that is a disservice to many patients interest the

system.

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

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

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

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

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

you have a minimum amount? Or do we want to instead designate centers of excellence? And how do we guard against the kinds of risks that Greg has talked about in the context of guaranteed issue?

MS. DARLING: Well, I'll be happy to jump in on that. A couple of things. The first study I did at the Institute of Medicine was of the health planning certificate of need program some years ago, and I can tell you that when we were done, that even the most liberal people on the committee that love that stuff and believe in it in their souls concluded that it will never work in this country for a whole bunch of reasons, which I could do a whole session on.

DR. HYMAN: We'll have you back.

MS. DARLING: Yes. Okay. But that was actually when it was a lot easier. I mean, we were smaller by quite a bit. We had a lot fewer hospitals. We had relatively few surgery centers. And even at that, it just was -- and actually, there was more of a belief in those days that the government had a role.

We had PRSO programs developed. You know, there was a lot going on. A lot of people even thought we had national health insurance around the corner. So it was a very different era. But even then, with everything much more compatible with the concept, it was generally an utter failure, and actually left a lot of people really turned off

at the idea for the next 20 years.

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

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

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

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

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

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

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

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

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

And going back to guaranteed issue, if you actually

ensure that 100 percent of the people were participating in the pool, theoretically it could work. But we have a voluntary system in this country. And if you take auto insurance, for example, we have mandates in the auto insurance market and we suspend peoples' licenses.

We impound cars. We have financial penalties, and we still have a 14 percent auto insurance uninsurance rate in this country as well, with massive databases to also enforce the law in 47 out of the 50 states.

So when you try to go against the very principle of insurance, you have a lot of problems. So my standpoint on the heavy hand of regulation, as you brought up, is that we should be focusing regulations on areas that could work, and looking at situations where government does have a role, like insuring that what we are actually ordering is beef, but not going into areas where we're looking at a situation where, in a voluntary system, people will -- even with a mandate, will not comply with that.

MS. DARLING: Let me just make one quick additional point on this.

DR. HYMAN: Very quickly.

MS. DARLING: You know, it seems to me there's a difference between the government saying we have to have standards in this area and then asking a group to do that. We know, in fact, with a lot of the requirements and

standards, they are far too low, and frequently the voluntary are higher -- you need both. I'm not saying you shouldn't have government doing a certain thing. You need the government to make sure it happens no matter what.

But frankly, some of these standards, when you start reading about the latest -- you know, the monkeypox and things like that, I mean, who even thought about letting these creatures into the United States? You need somebody who has got really high standards. The government is always -- as a sort of general body is always going to be more the least common denominator.

So if you could combine the authority and possible legislation of government with the actual details being worked out by multi-stakeholder groups, presumably, good ones who -- and if they don't do what they're supposed to do, you could always get it done yourselves.

But at least you're more likely to get much better standards, in my judgment, not the chicken guarding the -- I mean, the fox guarding the henhouse, but if you've got a combination of the authority and you have a group of stakeholders that include consumers and others who will drive to a higher standard, that would be the best combination.

DR. HYMAN: Well, I think we unfortunately need to stop here. I'd like to thank all of the speakers for their excellent presentations and enthusiastic participation that's

taken us past our authorized time.

We're going to reconvene at 2:00, when we'll be discussing information and advertising.

(Whereupon, at 12:30 p.m., the hearing was concluded.)

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A F T E R N O O N S E S S I O N

MS. KOHRS: Good afternoon. My name is Cecile Kohrs. I'm with the General Counsel's Office in the Federal Trade Commission. And on behalf of the Federal Trade Commission and the Department of Justice, I'd like to welcome you all here today.

We're continuing our hearings on the health care and competition law, and policy. I'd like to particularly thank our distinguished panelists who have taken the time and made the effort to be present today to give us their testimony.

To put today's testimony in context, I'd like to let you know this is one of about 30 days of hearings that we've been holding on myriad health care issues. Both the Department of Justice and the Federal Trade Commission share responsibility for enforcing the nation's antitrust laws. But the FTC has the additional mandate of enforcing consumer protection laws.

This panel today will allow both agencies to look at an area of key interest to both agencies. The information and advertising issues have played an important role in both aspects of the FTC's enforcement areas.

We like to see how players -- that is, providers, hospitals, insurance companies -- should be able to coordinate in order to provide advertising and information to

consumers. And we'd like to see how that information is used by consumers and how it's interpreted.

We've already had some hearings on how consumers receive and evaluate the information, and I would commend that testimony to you. It's available on the FTC's website, which is www.ftc.gov.

So after that incredibly long setup, I'd like to introduce the panel very briefly and encourage you to pick up the more complete booklet that has the bios of all of the panelists. I'm going to keep this very, very short in the interest of moving things along so that we'll have sufficient time to have a really ample discussion of these issues.

I'd like to also ask you all if you would please turn off your cell phones because I'm sure someone is going to be saying something incredibly brilliant and I don't want them to be distracted by anybody's cell phone ringing.

I'll introduce the speakers in the order of their presentations. After the presentations go on, we'll take a short break and then at the conclusion of the testimony will have a panel discussion. Everyone will come to the front and we'll be able to have a little bit of a dialogue.

First of all, we're going to have Bernie Dana, who has come all the way in from Ohio. I think he's one of the farthest fliers in today. He's an assistant professor of business at Evangel University in Springfield -- I'm sorry,

Springfield, Missouri. Sorry about that.

Second of all, we'll have Laura Carabello, who is with CPRi Communications.

Following that will be Dr. Thomas Henry Lee of Partners Health care.

Following that will be Dr. Douglas Koch, who's come up from Baylor College of Medicine.

After that, the shortest trip was made by Richard Kelly, who's representing the Federal Trade Commission. He's an attorney in the Division of Advertising Practices. What is that, sixth floor?

MR. KELLY: Third floor.

MS. KOHRS: Third floor. Sorry. Even shorter.

Following that, we'll have Peter Sfikas, who's representing -- he's with the American Dental Association, will be discussing some of the California Dental Association issues.

And then John Gebhart of DoctorQuality.com. He's chairman and CEO. He'll be speaking next.

And last will be Helen Darling, who's president of the Washington Business Group on Health. And she'll be here talking about some of the issues that some of the employers in the region are looking at with regard to information and advertising.

So I will stop. Mr. Dana?

MR. DANA: Well, as was mentioned, my name is Bernie Dana. I chair the American Health Care Association's quality improvement subcommittee. And I'm representing AHCA today.

I'm also, as was stated, an assistant professor of business at Evangel University in Springfield, Missouri. And prior to joining the faculty there two years ago, I spent 28 years as a corporate leader and consultant in all segments of the long-term care industry, both nonprofit and for-profit organizations.

Equally important to me, and I hope to others, is the fact that I am also a consumer of long-term care services. And I'll be explaining that a little bit later.

When we talk about long-term care, we're talking about a dynamic, diverse, and evolving sector of our nation's health care system that refers to many settings, not just institutional settings like nursing homes and assisted living facilities. Yesterday you heard from our sister organization, the National Center for Assisted Living. Today I will focus our nation's system on skilled nursing services.

The American Health Care Association represents approximately 11,000 long-term care facilities of both nonprofit and for-profit ownership. Many of these facilities are providing multiple types of services, from post-acute services to special care units for those suffering from

Alzheimer's disease and related dementia.

Also, our membership includes a very specialized area of long-term care that provides services to persons with mental retardation and developmental disabilities, called immediate care facilities and group residences.

Let's talk a little bit about our customers. Nursing home care is something that most of us are likely to deal with at some point in our lives, but is not a service that very many of us are actively seeking either for ourselves or for any of our loved ones. As a result, many consumers end up not being very educated about the complex issues of long-term care until they actually or suddenly need that service.

Now, this was the case for my siblings and me when we were advised that our mother, at age 89, was going to be needing to transfer to a nursing home after a short stay in the hospital. I was miles away in Nebraska at that time, and my sister and my father in Ohio went through two days of unbelievable pressure trying to navigate all of the admission process and choose an appropriate nursing facility.

Our consumers do expect long-term care services to continue to evolve and diversify. And we can look forward to even more segmentation of the long-term care marketplace than has already happened simply because our primary customers, the residents and their families, want and demand more

options. Clearly, adaptation to the consumers' needs and wants is a positive trend and challenge for us.

Let's talk about the marketplace and how consumers make choices. Any discussion on this subject, particularly consumer choice, competition, advertising -- and remember to flip the thing, excuse me -- and quality in nursing homes must include an understanding of the relationship of government policy to these issues.

Health planning policies in the '80s and '90s was based on the concept that limiting the supply and usage of health care services would help control the costs of those services. The federal government provided incentives to states to develop certificate of need laws and regulations designed to limit or reduce the supply of nursing home beds.

As a result, consumer choices were limited and nursing home providers were somewhat assured of high occupancy rates. Under these policies, nursing home providers had little incentive to compete for customers based on quality or price.

As the cost of nursing homes increased, consumers and public policy-makers began to seek lower-cost alternatives to the highly regulated nursing homes. In response, many states began to shift Medicaid funds to cover payment of assisted living and home health care services for consumers whose care needs were on the lower end of the

spectrum.

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

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

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

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

nursing home for the services being provided. The Medicaid rate is usually significantly less than the rates charged to people who pay from their own resources, and in some cases even less than the cost of providing the care.

At any one time, approximately 65 percent of the nursing home residents in the United States qualify for Medicaid assistance, and approximately 10 percent of nursing home residents are receiving Medicare assistance. The remaining residents pay from their own financial resources, and a small percentage of residents -- and it's growing -- are covered by long-term care insurance.

Now, even though the Medicaid and Medicare programs provide payment assistance to many residents, and they also set extensive standards for providers' participation, it is the customers -- again, the families and the resident, both prospective and current, who choose where to receive those services.

How are consumers informed about these services? In addition to having a choice of where to go, consumers need appropriate information to make the best choice related to their wants and needs. Nursing home consumers rely on a variety of sources of information.

Most nursing facilities do not spend large amounts of resources to mass promote their services. Many rely on a simple brochure, a Yellow Page advertisement, limited media

advertising, a website, and a direct mail newsletter to supplement their efforts to reach potential customers through staff visits with referral agents such as physicians, hospital discharge planners, and social workers for congregate living facilities. They also rely on positive interaction with staff, residents, and families to promote word-of-mouth advertising.

Most potential customers will visit a facility or personally observe and learn about the environment of services from a facility staff. Many states severely limit the amount of advertising costs that can be included in a Medicaid cost report from which Medicaid rates are determined. Because of that, many will only allow informational advertisements.

Print or media ads usually include the facility's licensure level and may list some of the services or special features of the facility. Few if any facilities make quality claims other than to announce the winning of a quality award or perhaps provide a testimonial from a resident or family member.

The American Health Care Association provides free pamphlets for consumers through a toll-free call-in line and the web. And many nursing facilities provide these or similar tools to help educate and clear up common misconceptions.

Generally, the only quantitative information available to consumers about nursing home quality relates to the results of the federal inspections that are conducted annually and whenever there is a complaint. In theory, these unannounced surveys conducted by a team of state regulators are okay, but in practice they are often plagued by surveyor inconsistencies among regions and even within states. It is a subjective process that encourages caregivers to focus on paperwork and compliance with government regulations.

By regulatory requirement, consumers can easily access these reports at every nursing home, or they can obtain the reports from the state health department. However, it is important to remember that these reports are not designed for consumer information and they can easily be confusing or misinterpreted.

In the 1990s, the Health Care Financing Administration, HCFA, now known as Centers for Medicare and Medicaid Services, CMS, launched the Nursing Home Compare website so that consumers could more easily access comparative information about the federal inspections of nursing homes. The information is arranged to enable the consumer to obtain this information about a single or multiple nursing homes in a market area.

CMS continues to support this Nursing Home Compare website as an answer to consumer education and informed

decision-making. As a component of the Nursing Home Quality initiative, which was launched this last year, the site now includes the quarterly reporting of eight standardized quality measures that are intended to provide meaningful insight into nursing care outcomes.

Unfortunately, many of the quality measures are flawed in their construction or they simply report demographic characteristics of a nursing home's residents. The measures do little to reflect the respect, responsiveness, living environment, and quality of life that really make a difference in the satisfaction level of nursing home residents and their families. As a result, the information has dubious value in enabling consumers to actually compare and choose a nursing home.

I know this to be true from personal experience. There are three nursing homes in the community where my mother needed care six years ago before she passed away. We picked the nursing home that had the fewest deficiencies at their last inspection. In fact, they had zero deficiencies.

After Mom was in the nursing home for a week, my sister called me in Nebraska and asked me to come to Ohio because she was upset with the way Mom was being treated. I flew to Ohio immediately, and after all, I, being the executive vice president of a company that owned and operated 32 nursing homes in a five-state region, was the expert in

nursing home care for our family.

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

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

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

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

The American Health Care Association affiliate in

West Virginia publishes a similar consumer guide annually, with the same kind of issues addressed. But they have also added to the report, to the consumer guide, the percentage of staff members who are satisfied with the facility as a good place to work.

The various trade associations in Ohio have collaborated with the state health department there to require nursing homes to participate in collecting and reporting on a state-funded website the results of family and resident satisfaction surveys that measure all aspects of the services in addition to overall satisfaction.

My dad's nursing home is in Ohio. Of the three facilities in his community, his nursing home has the worst record on the Nursing Home Compare website, but by far the highest family satisfaction rating in Ohio's new consumer guide web report. Interestingly, the nursing home that my mom was in had the lowest family satisfaction rating, despite having the fewest inspection issues.

When given a choice, consumers clearly prefer the satisfaction results because they understand them. Nursing home residents are not merely users of services. The nursing home is their home, even their entire world sometimes, a place where relationships and quality of life assume paramount importance.

As a result, the focus of long-term care must not

only be on the nursing care outcomes, it must also include quality of life issues such as respect, dignity, and resident choice.

Research conducted by Dr. Vivian Tellis-Nayak in 1999 analyzed satisfaction survey results of 11,715 families of residents in 504 nursing homes across 26 states. The research shows that family and staff satisfaction are compelling measures of a nursing home's overall quality and performance.

Family satisfaction is a window to that quality of care that residents receive, to the stability and devotion of the staff, to the way state surveys turn out, and to the nursing home's overall operation.

For this reason, AHCA has developed a model to encourage its state affiliates to begin developing a satisfaction-based consumer guide. The model focuses on reporting a nursing home's three-year trend of family satisfaction, family willingness to recommend, and staff willingness to recommend, as well as the inspection data, but presented as a percentage of the 495 standards that each nursing home must meet.

Our profession is committed to quality and is further -- our commitment to quality is further demonstrated by the launching of the Quality First initiative in July 2002. This is a proactive, profession-wide partnership of

AHCA, the American Association of Homes and Services for the Aging, and the Alliance for Quality Nursing Home Care.

The Quality First initiative declares that we are collectively and individually committed to healthy, affordable and ethical long-term care services that are rooted in continuous quality improvement, openness and leadership. An independent national commission is being formed to assess the report to the public -- and report to the public our collective improvement on six important outcomes.

So where does all of this take us? Nursing homes are facing tremendous challenges. We have 52,000 vacancies for certified nursing assistants, the true backbone of the long-term care system and the key to customer satisfaction. The GAO predicts that the overall demand for nurse aide positions in all areas of health care will grow by 38 percent between 1998 and 2008.

Current challenges are compounded by knowing that the number of individuals 85 and older are double from the current -- will double from 3.5 million to 7 million in 2020, and the number will again double to 14 million by 2040.

We are also facing a crisis in funding for Medicare and Medicaid assistance. An analysis by the national accounting firm of BDO Seidman found that Medicaid has underfunded nursing care nationally by nearly $3.5 billion

annually. Many nursing homes are experiencing extensive and significant financial strength.

Long-term care providers are proactively working with the federal and state governments to find solutions to these critical problems. At the same time, we are also actively pursuing ways to provide consumers with the reliable, valid and timely information they need to make informed choices about the type and quality of care of services they need when they need it.

We are intent on hearing the voice of our customers as we continuously improve and design long-term care services for the future. Thank you.

MS. KOHRS: Thank you, Mr. Dana.

Next will be Laura Carabello.

MS. CARABELLO: Good afternoon. I am Laura Carabello, founder and principal owner of CPRi Communications. And I'm located in New Jersey. And when I gave this presentation about a year ago in Texas, the doctors in the audience wanted to know if I was related to the Sopranos. And I am not.

CPRi Communications specializes in the positioning of health care-related business and services, products and a whole host of health care opportunities in the marketplace. We offer a full range of market and communications services, including public relations and media relations, advertising,

online marketing, interactive communications including web and multimedia development, direct mail programs and market research.

We are headquartered in Teterborough, New Jersey. We have a large airport there that serves the DEA extensively. And we have an office in Scottsdale, Arizona. We have clients in 35 states and strategic partners located in London, and we have a global presence and a continuous focus on generating results for our customer base.

I want to commend the Federal Trade Commission on these hearings to address the quality of information provided to consumers through physician advertising and marketing and its impact on the decision-making processes for selecting a provider of health care or financing arrangement. And I can say that I've been involved in this for about 20 years -- actually, 22, 23 years.

And at the time when I started this company, when I founded this company, it was the time frame that coincided with the U.S. Supreme Court decision to grant physicians the right to advertise. And they went at it. And they flexed their marketing muscles to really take on a lot of advertising initiatives that were available to that time. And over the past two decades I have witnessed a dramatic -- I and my colleagues have witnessed a dramatic change in the way that physicians look at the marketplace and the way they

advertise their services.

And several key factors have influenced these changes: obviously, regulatory oversight; guidance and censure from professional trade associations and organizations; increased competition, which is now fierce, particularly for non-covered services classified as out-of-pocket expenditures; the advent of the internet and website communications; the commercialization of medicine; and consumer empowerment.

And I think that all of these areas have had an impact on the way physicians approach the marketplace and the way that their advisors help them to structure their advertising and marketing campaigns.

If you take a look at Yellow Page advertising, for example, and you look back, how many of you in the audience can look back to prior to the 1980s when Yellow Pages, for example, in the Manhattan Yellow Page book revealed doctor listings, including addresses and telephone numbers.

And if you jump ahead from 1980 to 1990, that same section provides small space advertising and full-page promotions in black and white promoting specific services. And by the way, Yellow Page advertising is not inexpensive.

The listings became aggrandized with boxed information as an upcharge, as well as detailed information on practice offerings. And I can tell you that Yellow Page

advertising gets more expensive because the Yellow Pages tells you that you have to be in every single Yellow Page for a particular community, and then they narrow those areas down so that they have to spend more money.

And if you fast forward to the present, not only did the Yellow Pages triple in size with the sheer number of doctors listed, but also the number of color display ads has grown exponentially. And if you look in any Yellow Pages in any city or states, you will see that doctors advertise extensively. And, by the way, the return on investment for Yellow Page advertising is high.

I guesstimate, and I say guesstimate because there's nobody really tracking the number of physicians, but I would say that 95 percent of all physicians engage in some form of paid advertising or marketing. And I will go into that in a few moments because I think that the scope of the opportunity is far greater than we realize.

And about 25 percent -- actually, that's an approximation; it might even be less -- of all physicians opt for public relations activities. When you look at public relations versus advertising, public relations is considered earned media. Advertising is paid media.

And consultants are usually offering a range of both. They're paying for it. They are consulting with them. They are helping them to work with their practices to

generate coverage in local, regional, national print and electronic media, whether it's press releases complimented by outreach to editors, reporters, and producers.

And the results are mentioned in newspaper and magazine articles, appearances on TV and radio, speaking engagements and other venues where the physician is positioned as an authority or thought leader in his or her given field. Many physicians opt for this coverage since it offers an opportunity to share quality information and may be perceived as a third party endorsement. The credibility of public relations versus paid advertising cannot be disputed. Many physicians seek both.

The advent and growth of web-based communications has clearly changed the marketplace. And this is taken from the AMA. Approximately three out of ten, or 29 percent of physicians using the web, currently have a website. And this has been increasing every year and has remained constant over the past few years.

Websites are greatest among physicians in solo or two-physician practices, and lowest among physicians in a hospital-based practice, as you would imagine. And the primary reasons that physicians offer why they have a site on the web is: 43 percent to promote and advertise their practice; 35 percent to provide patient education and information; and 11 percent increase in physicians using the

web to advertise and promote their practice since the year 2000. I think that's pretty impressive in terms of their confidence in web-based communications.

The Federal Trade Commission, which oversees regulation and enforcement of physician advertising, has raised some reg flags of concern regarding substantiation for both the express and implied claims of some of the promotions now being offered. These concerns may be well-founded.

We are seeing a rise in consumer-driven health care which is really taking on a whole new aspect to how consumers access information and obtain health care. They're taking on a greater role in the selection of providers and services. And there is increased physician participation in advertising and marketing venues. And this is likely to continue.

Patients employee comparison shopping techniques, scrutinizing media outlets for information and following up with calls to providers to ascertain coverage options and costs.

And I can tell you, in the thousands of physicians that I have consulted with over the years, and that includes physicians in solo practice, multi-physician practices, IPAs -- they always complain to me that the physicians [sic] call and they want to know, how much am I willing to do it for? How much can they get? So they really do shop around.

In paid advertising, the quality of information is

largely at the discretion of the physician advertiser.

Health care advertising in general, even for the pharmaceutical companies, which are spending a ton of money, is steep. And for physicians engaging in an advertising opportunity, even for public relations, the costs are very, very high. Most advertisers cannot afford to offer detailed, quality information and prefer to tout benefits, if they're real or otherwise.

Some advertising has led to misunderstandings and has resulted in lawsuits involving false, deceptive, or misleading claims. The FTC and others will make even greater demands for competent and reliable scientific evidence as substantiation, a burden that lies with the advertiser and his consultants or her consultants.

Physician advertising, in my estimation, has changed, the regulations now are so complex from state to state. But they are receiving ample guidance for developing and advertising and promotional materials with the FTC, AMA, state legislatures, local and state medical societies, and specialty medical organizations offering regulations, policies, and guidelines.

There is certainly not a shortage of this information. Regulations grant the relevant medical board certain powers to take disciplinary action, which may result in reprimands or lead to licensed suspension or revocation

against a physician whose advertisements violate the applicable regulations.

And I would say for the most part that physicians are concerned. They are nervous. When they call our office and they want to set up an advertising campaign, they say, you know, I know certain of the regulations. So I think there is definitely cognizance of these rules.

And the state attorneys general usually have the authority to seek injunctive relief and civil penalties against individuals or entities that violate general consumer protection laws that prevent deceptive trade practices.

Physicians are urged and directed to avoid deceptive advertising which may mislead consumers. Physicians need not wonder what is allowed or appropriate. State boards of medicine, state laws, and federal law govern advertising by health care providers, with professional organizations providing appropriate verbiage.

Ethical advertising is achievable but not always practiced. And I can tell you that very often, physicians will try to pressure into getting something into an ad that I know in my heart is not right. And I will tell them so.

And I'm just going to go through a little bit of the advertising rules, the FTC. According to the FTC, an advertisement is deceptive under the Federal Trade Commission Act if it contains a material misrepresentation or omission

of fact that is likely to mislead consumers acting reasonably under the circumstances.

I put this ad up because -- and this is not a real ad; obviously, the numbers are made up -- but I happened to see this in the paper a couple of days before I came to this hearing. And is it good taste? Does it give you good information? One of the things that sort of turned me off was the $499 for the first 1,000 eyes. You know, how do you ascertain that you're one of the first 1,000 eyes? That sort of set up a red flag. But the question comes to mind: Is it bad taste? A lot of ophthalmologists I know would say yes, it is in very bad taste and we wouldn't have any part of it. Obviously, there were people that liked it and wanted to use it as their ad.

The AMA also offers policies governing advertising and publicity, offering no restrictions on advertising by physicians except those that can be specifically justified to protect the public from deceptive practices. And it goes on to say a physician may publicize him- or herself as a physician through any commercial publicity or other form of public communication -- newspapers, magazines, telephone directories, radio, television, direct mail. I could go on and on how physicians market their practices.

They do direct mail. They announce when their office is changing. They announce when somebody is joining

the practice. There are lots of ways that they go about it, lots of opportunities to advertise.

When I called the AMA to see how they were tracking physician advertising, the quote from their spokesperson said, "The AMA is a membership organization, not a regulatory body. The FTC put us out of that business in 1980," and had very, very little information to offer, in fact, cut me short.

It is evident, however, from their policies that the organization is concerned about the quality of physician advertising, and throughout the profession, most responsible physicians endeavor to adhere to the guidelines cited.

If you go on the web and you look at all the different states, every state has their own little quirks and their own little tweaks on what is allowed and what is not allowed. So I'll just give you an example here.

North Carolina, Maryland, Virginia, District of Columbia, Illinois. Illinois doesn't allow testimonials or claims of superior quality. A lot of states do not allow testimonials. New York and Texas also preclude the use of testimonials by physicians, but you can see that the trend is that they all agree that you cannot use deceptive practices.

However, advertising is advertising, and they're allowed to do so. And what is the purpose of advertising? It's designed to spark the interest of the health care

consumer and prompt the buyer, the patient, to access or purchase services. In some instances, consumer expectations are elevated, leading to liability for physicians who cannot deliver what they promise.

How do consumers get this access to this information? For those consumers who are employed, information regarding health care financing and doctors is usually provided by their employers. This is a hit-or-miss opportunity at best, depending on the individual employer and its concern to deliver good information.

For employers that are bearing the majority of costs, particularly in the current economic environment, plan selection may largely be a function of price. Large employers usually distribute brochures, which are provided by the plans, and often sponsor health fairs, offering plans the opportunity to provide more information not only about the plan but about the doctors.

Employees have come to count on the fact that their employers have reviewed quality aspects of the plan. I'm an employer, and employees just guess or have enough faith in our power to review these plans, especially since we're in the health care business.

In fact, it's interesting: Because we're in the health care business, I think all of our employers think that we know everything about health care. I can tell you that

people call us all the time for doctor referrals, and I keep saying, we are not a doctor referral agency. We can't give you information. But we must get probably, I would think, 20 to 25 calls a week from consumers.

For small employers, which we are a small employer, this information can be scant, leaving the consumer more dependent upon the recommendation of the employer's insurance broker or suggestions from friends and relatives. In both settings, employees can log onto the plan website for information, benefits, and provider rosters.

And I must say that most plans to have extensive websites offering information about the plan and the doctors. Since this information, however, is largely self-reported, the quality of the information may be driven by marketing objectives to drive enrollment.

Provider selection criteria are more vague. Consumers turn to their health plans for provider bios and don't always get them. And they usually rely upon word of mouth from family and friends regarding quality of care. And the bottom line is people still ask their friends and family about doctors.

Quality indicators, including board certification, may offer some comfort level, but people still don't understand what a board-certified physician is. The bottom line from consumers is often the personal recommendation from

friends or colleagues.

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

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

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

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

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

better information regarding quality. This will put more emphasis on the advertising and marketing and further burden on the providers themselves to establish credibility and substitute claims.

Consumers can access select information regarding provider quality. As noted earlier -- and that should be NCQA; I'm going to have to smack somebody -- URAC, JCAHO accreditations for plans and networks offer benchmarks.

Many, not all, employers utilize accreditation as criteria for offering the plans to their workforce and tout these achievements in a variety of advertising venues. However, employees and consumers do not really have a clue. They really don't understand accreditation, and may not regard this as important to the selection process.

I always am tickled when I ride along the highway and see those kinds of JCAHO accreditations and say, do people really understand what they're talking about? Furthermore, the economics of achieving accreditation or issuing report cards often forces plans to forego the process.

Condition-specific advertising dominates physician advertising and often includes information about the nature of the underlying condition, whether it's chronic or acute. Many advertisers play upon the emotional aspects of the condition, particularly those that represent life-threatening

conditions such as cancer or heart disease.

There is usually a strong call to action with a toll-free number or opportunity to respond. Many physicians who advertise track the overall response and attempt to gauge the return on investment of a particular venue.

Ads may target the impact on a spouse or loved one, or the impact on patient quality of life or appearance. The more responsible physicians do not claim to offer a cure, but may offer diagnostic, treatment, or management options which may be surgical or medical.

How do you communicate quality? The quality and quantity may depend upon the advertising venue. For example, billboards offer up to a two-second opportunity to deliver the message, two to three seconds at the most, leaving little room for information or quality communication. Radio spots usually run 30 to 60 seconds, hardly enough time to cover details. Here we go. That's the end of the billboard. That's as much time as you probably had to get that message.

And what are the effects on the behavior of health care providers? Physicians who advertise often adopt their own marketing persona. For every patient generated -- this is a rule of thumb -- through advertising, four additional patients will be referred by that patient. So they look at it as an opportunity to really drive their practices.

Physicians that make the investment in advertising

must also follow through during the patient encounter to ensure a pleasant experience regardless of the diagnosis. And marketing-oriented physicians often undergo training, not only to prepare them for media interviews but also to deal with patients.

Practice management and public relations counselors advise on a variety of issues impacting multiple aspects of interpersonal relations, from developing appropriate body language to eliminating bad breath.

Physician marketers may encounter some push-back from their colleagues or a drop off in referrals. There's professional jealousy. Their colleagues who do not engage in advertising express disdain by minimizing referrals. For successful marketers, however, these issues are no loner of grave concern.

Physicians who run advertising for elective, out-of-pocket procedures not covered by insurance usually tout benefits, substantiated or otherwise, along with cost-competitive positioning and opportunities to charge your services to a credit card. Plastic surgery, corrective vision procedures, laser hair removal, fertility, and diet plans are among those conditions which fall into this category.

The quality or credentials of the physicians are not a key selling feature. In some of these instances, the

volume of procedures performed or the number of pounds lost are cited. Before and after photos are often featured as the incentive. This hard-sell approach extolls the volume of procedures, not the quality of the outcomes.

Is advertising driving up the cost of care or simply fueling the competitive spirit? Physician reimbursement is established by the government, Medicare and Medicaid, or set by individual health plans. The fees do not change for physicians who advertise. In the area of non-covered benefits, however, physicians can use pricing as a sales tool.

The competition for patients remain fierce and competitive market forces come into play. What forms of advertising are good? Quality pays off in the long term.

As the competitive climate escalates, there is likely to be surge in comparative advertising. And one of the things I want to point out is that a lot of physicians are dying to be featured as the leading doctor, the best doctor, New Jersey Monthly or New York Magazine, U.S. News. But they realize this is a popularity contest unrelated to performance, not a real litmus of quality. Hospitals and health plans also use these ratings.

Marketing quality services and actually delivering quality services are two distinct issues. There are no restrictions, which limit the quality of -- limit the

advertising of health care goods and services based on quality, but there are regulations articulating standards for avoiding advertising claims that are misleading. These standards are widely respected and adhered to by most physician marketers, and coupled with guidelines, they know what to say.

The ability to advertise and market health care services supports a competitive climate and should ultimately drive improved quality. Competition is healthy, even in this delicate market niche. And for those that stray from restrictions and guidelines, however, there should be enforcement that protects consumers. And obviously, selling health care services is different than selling vacuum cleaners.

My final thoughts: When developing and implementing a marketing campaign, it is incumbent upon physicians and their advisors to know and play by the rules? Advertising that is in bad taste is simply distasteful. Advertising that is false or misleading is illegal.

Guarantees are simply not allowed. The objective is to elevate quality of care goals to the same level as financial goals. And advertising that adheres to standards set forth by government and others is mandatory. Advertising that communicates quality and provides information should be the end result. Thank you.

MS. KOHRS: Thanks very much. We'll have Dr. Lee speak.

DR. LEE: I'm Tom Lee. I'm an internist and a cardiologist and the chief medical officer for the network of Partners Health care System in Boston. And I'm speaking today about direct-to-consumer marketing of high-cost radiology tests, at least I will if we can get in slide show mode.

The issue that I'm speaking about are high-cost radiology tests that are being directly marketing to consumers. And I'm really going to focus on two of them, the two most common ones, which are general screening for malignancies, the most common being lung cancer screening with chest CT versus whole body CT, and then a coronary artery disease screening with electron beam CT, EBCT, as it's called. It's technology that I'll talk a little about more on the next slide.

To summarize, you know, these technologies are marvelous. Technologically, they are really incredible if you understand what they're doing, particularly with the EBCT. But just because they're marvelous doesn't mean they actually help anyone, or at least given our current state of medicine. So their value is unproven. They have not been shown to make people live longer or live healthier lives.

In fact, there's concern. There's concern about

the impact of false positive rates, the economic consequences of false positive rates as well as the anxiety, and even the medical consequences of false positive rates.

And there's also concern about whether the advertising is misleading regarding the false negative rates. That is to say, if you have a negative CT of your body looking for cancer, do you really have -- should you really have peace of mind? And as you can probably guess, my answer is no. And as I said, there's no evidence that they improve patient outcome.

The insurance companies are completely correct in not paying for these tests. The evidence doesn't support it, and where there are many things that are supported by evidence that need to be paid for.

As a result, consumers are being asked to pay for these tests out of their pocket. A lot of people would say, well, if they want to pay for it out of their pocket, that's fine. One of my arguments is that we are all paying, however, for the sequelae of these tests being performed.

The sequelae are real, and as evidence I would cite the fact that the tests are sometimes offered at very lost cost or even free by health care organizations, physician groups and other kinds of organizations, with the expectations that the follow-up tests are going to be covered by insurance, and that is where the health care providers

will make their money.

I want to talk first about electron beam CT. I'm not going to give you a lecture. I'm just going to try to give you the bare minimum. It is an incredible technology that was very promising when it was first developed. It can detect calcium deposits in coronary arteries.

And what's remarkable about it is that it takes such a quick image that the heart is essentially holding still. And the heart is always moving, of course, but the image is done so quickly that you can get a picture that allows you to figure out whether or not there are calcium deposits in the walls of the coronary artery.

It's not so sophisticated they can look inside the coronary arteries and tell you whether the artery is narrowed. But it can tell you whether there's calcification. And such calcifications are present in virtually all patients with coronary disease. And there are very good studies showing that the higher your calcium score, the higher your risk for having atherosclerosis and the higher your risk for having a heart attack in the long run.

But tempering these facts which would support the promise of this technology is the fact that the overall risk for asymptomatic people -- that is to say, people who currently feel fine, don't have chest pain or other symptoms of heart disease -- the overall risk for a heart attack in

the next year is very, very low, like in the 1, 2, 3 percent, even if they have coronary artery disease.

And no study has shown that the treatment of high calcium scores improves outcome. There have been studies where they take people who feel fine but have high calcium scores and randomize them to statin therapy versus placebo, and there is no difference in outcome because all of them tend to do very, very well.

There is, however, a very high false alarm rate. Let me give you -- this is what the scans look like. This is, you know, cut through horizontally the top of your heart, and that is like the main artery going down the front of the heart, a little segment of it, the left anterior descending artery. And you see those bright white shadows are calcifications in the wall of the left anterior descending artery. And you would rather not have calcification than have calcification.

This is the kind of image that gets people -- there are some very good people who are very interested in the technology, and this is why they're so interested. You can get an image like that, and you would like to think that would help you take better care of those patients.

However, it hasn't worked out that way, but nevertheless, these are being advertised. You know, Father's Day is Sunday, and you can get both the heart and lung scan

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

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

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

So what are the implications? Most people do not get the reassurance they seek. That's what they're hoping for. They're hoping for this clean bill of health, and most people don't get it. They get this intermediate calcium score. Very few of them get the low calcium score that

they're hoping for.

The result is that many patients can't sleep at night until they get further testing and further treatment. And every cardiologist I know who's active at all has patients at this point who are perfectly fine, got these tests, and it set in motion a series of other interventions -- exercise tests, cardiac catheterizations.

They find some narrowings. They don't know what to do with it. They do an angioplasty or even bypass graft surgery. And some of the celebrities and very wealthy people in our community, in Boston, have had the angioplasties and bypass surgery and they think their lives were saved, but they weren't.

The bottom line is that the American Heart Association and American College of Cardiology do not recommend this test. Nevertheless, a lot of the members of the American College of Cardiology and American Heart Association sell these tests.

Okay. A whole body CT scanning? It's basically the same story. This is from the FDA website, I believe. And you can see the bold print, you know: "At this time, the FDA knows of no data demonstrating that whole body CT screening is effective in detecting any particular disease early enough for the disease to be managed, treated, or cured." And I can tell you that that is the state of the

science. There is no evidence indicating that it is helpful. That doesn't stop other websites from telling you a different story. And, you know, you don't need to read all this, but this is from an organization that's trying to hook people up with getting low-dose spiral CTs looking for lung cancer.

I'll just -- the next slide is the bottom part of this. And I just want to highlight for you the third line from the bottom: "Schedule a spiral CT today. It could save your life." Well, maybe it could, but there's no evidence to support that particular claim. That phrase, "It could save your life," appears over and over and over in the advertising for these technologies.

Well, do they save lives? Well, it's not proven in any study. It's very difficult to prove something doesn't save lives. You need huge, huge, huge studies, and no one's got a particular interest in funding them. The government is, in fact, though, funding some good research.

Research in the past has shown that chest x-rays do not prevent death from lung cancer. They just lead to earlier detection. And here's the reason why: Because intuitively, you would expect if you find tumors earlier, you would help save lives.

The problem is this, and it's discouraging -- I wish it wasn't true, but this is the basic science: Tumors have millions of cells by the time that they are one to two

millimeters in diameter. That's the tip of a pencil point. The tip of a pencil point is millions of lung cancer cells.

And there's plenty of good research -- not some, plenty of research -- that indicates that genetic factors have programmed those cells so that the ones who are programmed to metastasize have already metastasized by the time that there's a one- or two-millimeter mass, and the ones that are not going to spread very easily are not going to spread. And they may reach golf ball size, and you can take them out then, and the patient will still have a good prognosis.

So that by the time you can find them on a CT scan, it's -- probably the game is going to be over one way or another anyway. But it's an unanswered question, and at this point I would say somewhere by saying proponents, the optimists, say it would be unethical to ask people to wait while the big studies are done. The opponents say it's unethical to ask people to pay for an unproven technology.

Again, my problem here is the false reassurance issue. A negative CT can easily miss small tumors, and some tumors are just not visible by routine CT unless contrast agents are given. So anyone who's a clinician here knows that you can't find adrenal tumors and renal tumors and many other tumors unless you infuse intravenous contrast, but those contrast agents carry a small, about 1 percent, risk of

reactions and they're also very expensive.

Fortunately, no one out there is doing screening CTs with contrast. They're not that irresponsible. That said, people walk out thinking that they've got a clean bill of health. They may continue smoking because they believe that they are getting away with it.

So, I mean, this -- I put this slide in here just to say that I don't -- I hope I won't sound like a paternalistic physician, but I'm very concerned that patients just can't understand the risk information, at least as it's being portrayed in the kind of marketing materials that I see.

You've got physicians and celebrities advocating testing. And my second bold point in that graph is just to make the point that everyone -- patients, physicians, all human beings -- have difficulty putting risks in perspective.

There is this whole interesting line of work about prospect theory. And some of you may know that prospect theory won the Nobel prize for economics in 2002. It's about why you will drive five miles to save $5 on a $20 purchase, but you won't drive five miles to save $5 on a $1,000 purchase. It's about why people can't be rational about money.

Well, the same is true about health care risk. Something that seems to increase your risk a tiny bit that

you didn't know about before has disproportionate value in your mind, so that you have people smoking cigarettes while worrying about SARS or worrying about, you know, other things that are just not, you know, important.

And, you know, for me the epitome was a car that someone pointed out to me in Boston the other day, a sports car with a bumper sticker saying, "Ban nuclear power," and there was a radar detector in the front. So the chance this person will die from a car accident, of course, is much, much greater than from a nuclear accident. But the prospect of a nuclear accident was much more worrisome. There is this whole line of thinking. The bottom line of it is that we're not rational animals and it's very difficult for us to put risks in perspective.

Well, what do physicians do? These are my last two slides. I did, after being invited to come down here, do an e-mail poll of the internists and the cardiologists of Mass General Hospital and Brigham & Women's Hospital. And I actually got responses from 141 internists, and I asked them, have you undergone a CT to screen yourself for cancer? And then the follow-up question -- and I asked the cardiologists, have you had an EBCT to screen yourself for coronary disease? And then the follow-up question was, if so, did you pay with your own money? And third question was going to be, did you pay with post-tax dollars?

But I never got to the third question because not one internist at the Brigham or Mass General has had a CT scan to screen themselves for lung cancer or other cancers. Two out of the 26 cardiologists have had electron beam CT, but neither paid. One of them indicated that he would have paid, but as my wife said, she'd believe it when she saw it.

So these were some of the comments I got back in the e-mail from the cardiologists on electron beam CT. You know, "I would not have done it even if it was covered by insurance. It's hype. I discourage my patients from having it done if they ask."

"No. I was asked by my wife's rich uncle in Argentina whether he should invest, and I told him if it was a good plan to get in and then make sure there as a good exit strategy once people figured out the limitations."

"No. I can't see use for it save to generate anxiety and more business for the ETT lab" -- exercise test lab -- "which would be good from a purely commercial standpoint."

And the last one is, "Absolutely not. This test is not ready for prime time."

The last comment I'd make is that I wish the medical profession was effective enough in trying to regulate it. When the leaders of cardiology and general medicine don't believe these tests have value, I wish our profession

was effective in keeping physicians from marketing things.

But it's not, and I don't have realistic expectations it will be in the near future. So I'm hoping that these hearings will lead to some other kinds of interventions. Thanks very much.

MS. KOHRS: Thank you, Dr. Lee.

We're going to have Dr. Koch speak next, if I don't have the computer shut down one more time.

DR. KOCH: Thank you very much. It's a pleasure to be here. I was asked to speak because of the notoriety of good and probably a lot bad that ophthalmology has with regard to LASIK advertising and how it tends to dominate the marketplace in terms of the amount of -- proportion of medical ads. And I think that was shown or reflected in Ms. Carabello's talk as well.

I'm from Baylor College of Medicine. I also would like to acknowledge that I've been discussing this with my colleagues at the American Society of Cataract and Refractive Surgery, and as a society, we have a lot of interest in this area and in appropriate mechanisms for informing patients about LASIK surgery.

And I'll start with my recommendations or my thoughts, which are, we'd like to see more stringent and consistent enforcement of FTC regulations for advertising in LASIK. And we would like the FTC to help us to -- you know,

to reach out to our societies and other societies to encourage them to give them a kind of maybe perhaps moral support, and perhaps certainly to be a little bit more public in their encouragement of medical societies to report member violations, and maybe even consider some kind of complaint hotline.

Let me tell you just a brief thing or two about LASIK surgery. It's approved to treat a certain range of nearsightedness, farsightedness, and astigmatism. It is not for everyone. And very careful screening of patients is required in order to maximize the likelihood of good outcomes and to minimize the risk of complications.

It involves making a corneal flap with a device called a microkeratome. Just recently there's a laser device that can also make the flap. This flap is elevated -- the microkeratome, by the way, uses a steel blade, and then the flat is elevated and the XMER beam is then used to reshape the corneal surface in the desired fashion in order to modify the patient's refractive error.

And typical outcomes might include 80 percent of patients seeing 20/20 or better without glasses, with 1 percent losing a certain amount of vision and a very small number of patients losing large amounts of vision. But the results do vary to a great extent by the magnitude of the preoperative refractive error. So low corrections get better

results, as you might logically feel.

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

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

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

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

The fundamental problem is this whole thing about health care and commodities and is LASIK truly a commodity in a free market? Clearly not in the traditional sense, and again, this was alluded to earlier.

You can't test-drive your surgical result. You can't try to remove one spot and see if this cleaner works better than the other cleaner. You have one crack at having surgery on your eyes. And it's difficult to get data regarding quality of surgeons and outcomes.

The ads kind of run the spectrum. There are those that are legal and ethical, those that are legal but we would consider unethical, and then clearly illegal ads. So an ad can be legal but not in the best interests of patients. And we're also worried about the profession and about not only the image of the profession to the public, but about what we try to instill in our colleagues as physicians.

So the advertising can deceive patients in a variety of ways. These are at least four ways that advertising in LASIK surgery can deceive patients, the first one being price.

The classic one was already really shown, the asterisk, which is a bait and switch: 499 for your eye, and all of a sudden you end up using -- the patient realizes that's not the laser they want to have used. There's a limited refractive range, up to myopia, up to minus 2, for

example, a low correction. And no follow-up or retreatments are included. So by the time everything is added in, in fact, the fee is much higher.

I think money-back guarantees are particularly pernicious because there's the implication of reversibility so that 20/20 or your money back. Well, that doesn't help you if you go blind from the operation. Your money back doesn't quite cut it. So that's, I think, a problematic area.

And look what we got here, 299 for the first 1,000 eyes. You're in the wrong market, you know. Your market's overpriced, clearly. Why we have performed more laser -- and this is the top part of the ad. This is in our Sunday paper every Sunday, in the comic page, the head of the comic page, by the way.

And not only do you get, this is all the stuff, oh, you can get Botox, again with the asterisks. And the asterisks start to -- you know, only for the -- they had the VISX laser in the ad, but the low price is actually only for the Nidek laser, et cetera, et cetera. And it goes on from there.

Here's one: "Don't wait because this offer is too good" -- two eyes for the price of one -- "to last." Let's see here. The computer is having a hard time crunching my large files.

Here's one: "LASIK eye surgery for free. I can see clearly now." Their website is seeclearly.com. And again, the implication that everything is clear. "Win a free laser vision correction." These kinds of inducements that are misleading about price. Two-for-one pricing.

This is one of my favorites: "Guess what I won, hon?" And, you know, which media? And you can see, there's your fine print. You'd need LASIK surgery just to read the fine print.

And my favorite of all time, and I want to acknowledge Dr. Terry O'Brien, who sent me some of these: "Kiss a pig and you can win free LASIK vision correction." You know, it's a trivialization. It's a kind of -- the humor in these kinds of approaches kind of minimize the seriousness of the decision that patients make in contemplating this type of surgery.

Well, what about the eligibility criteria? There's the implication that the procedure is for everybody. And I'll give you one example of that. Here's one -- let's see -- "Get rid of your glasses. Cataracts. Nearsigned. Farsightedness." So it doesn't matter what you've got, we can fix you.

And again, it draws patients in. It makes them think that, gee, I must be eligible for this, and makes them less critical in thinking about the applicability of this

procedure for themselves.

Outcome: There's implications of the perfect result, of the permanent results, of no complications. "20/20 for 2995." You can get rid of your contacts for life. "The only laser vision correction facility offering a 20/20 promise." Refund the final fee. "To the best." How do they define "best"? There are the glasses. No more glasses. No more contacts. Things that are clearly not accurate or correct.

"Participate in our free LASIK" -- dah dah dah dah dah -- "seminar." The "get-rid-of-your-reading-glasses" seminar. And learn how it uses -- for the best results. And again, no data to substantiate these claims.

Other claims from recent ads: "Quick and pain-free way to eliminate your way for corrective lenses." "The world's most advanced ophthalmic lasers." "The only 3-D eye tracker." "To treat a lifetime of nearsightedness, farsightedness, and astigmatism." The eye tracker doesn't even do the treatment. There's one who -- this physician is referred to as an "opinion leader" here in the Washington area. Nobody really knows who she is.

Fear: Fear of complications, and building on fear. I actually object to this probably least because at least it makes patients think about the seriousness of it. But it's still obviously an issue.

This surgeon no longer does LASIK. He does laser on the surface, so he shows a razor blade and, "No blade used. Safer than LASIK. Better quality and quantity of vision." No proof for that. "Greater long-term comfort." No proof of that. In fact, there's proof to the contrary of that. "Don't subject your eyes to the risks," et cetera. But he does himself one better. A box-cutter. So again, you know, that's the kind of material that's out there being viewed by our patients.

Other claims: "Can virtually eliminate potential complications." "Ask about our no-glare, no-halo technology." Nobody has no-glare, no-halo technology. There's proven. CK, which is another operation, "is a non-invasive procedure." CK involves putting a needle about two-thirds of the way through the cornea and applying a current to it and causing a little burn in the cornea. To me, if you're sticking a needle in somebody's eye, that has a kind of invasive feel to me.

"No hassles, just crisp, clear vision." So again, the issue with testimonials is that again it implies that patients are eligible; that the outcomes, you know, incorporate safety components, and obviously ignores whatever this person giving the testimonial often is paid. We see baseball players, movie stars, et cetera.

So false advertising deceives patients. It fosters

poor patient decisions regarding undergoing a procedure. It demeans the profession, and is a violation of the implied pact between physician and patient.

As part of this survey, we found that dissatisfied patients after LASIK surgery were less likely to know what procedure they had -- they didn't even know if they had LASIK or another procedure -- or to be knowledgeable about the benefits, risks, and expected amount of visual improvement that could occur with the surgery. And they were more likely to note advertising as a source of information about LASIK surgery.

So how can we better protect our patients? We have to provide better information. That falls upon the medical profession to do that. And I think tighter scrutiny in advertising is important.

Now, at the American Society of Cataract and Refractive Surgery, we've developed the Eye Surgery Education Council, and that has a website that has a range of materials, including very detailed LASIK patient-screening guidelines that are designed really to stimulate patients to think about all aspects of what LASIK surgery involves and whether they might be a candidate, and provide them with a list of questions they can ask physicians.

We have guidelines for refractive surgery advertising, and FTC was very helpful in this, actually. And

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

So what we'd like to have is stronger enforcement of the guidelines. And are there other things that -- maybe some ideas about how we as professional organizations can oversee our members without subjecting ourselves to these threats of litigation.

We believe that if we work together, we can improve our patients' welfare, and that FTC enforcement of current regulations will bolster professional societies' self-policing and make it easier for societies to enforce the guidelines that FTC has worked with to create.

So we'd like to see this more stringent enforcement, further working with our societies, dialogue about this, public announcements of this, and consider maybe even a hotline of some sort as a way of promoting or making it easier to report these sorts of things.

And again, I appreciate the opportunity of being with you this afternoon.

MS. KOHRS: Actually, our next speaker is going to

be -- sorry. It's going to be Richard Kelly from the Federal Trade Commission.

MR. KELLY: Good afternoon. I think the presentations so far have really been excellent. Given me a lot to think about even before I walked up here.

It reminds me of the story of why lab technicians prefer lawyers to white rats for their laboratory experiments. And maybe you've heard this story before, but I think it's an interesting one.

One of them, of course, is there are just much more lawyers than white rats. And the second reason is that the lab technicians don't get attached to those lawyers. And the third one, of course, is that there are just some things you can't get a white rat to do.

So, you know, here I am today, listening to these presentations and desires for the agency to do more. And certainly we're listening and we want to respond.

And what I wanted to do today was to talk a little bit about the FTC's experience with LASIK, but also to give you a little background in case you don't know a little bit about what this agency is about and the kinds of things we do.

It's probably useful for this slide to be up there in terms of the value, the positive value, of advertising. Because inherently, we're going to hear about some negative

things. These ads are deceptive. These ads have misrepresented this or that. These ads lead people down the wrong path.

And I think Laura had mentioned the Supreme Court's intervention in the area to open up the doors to advertising by health care professionals several decades ago. And that was certainly over First Amendment concerns, but it's also a recognition that advertising, if done well and right, can help the marketplace.

Obviously, it can do all of those things that are on that slide. You yourselves can think of experiences where advertising has helped you make a choice or a selection or become aware of something new that you just didn't know was out in the marketplace. But that last point, that last point on that slide, is of course essential. But of course it must be truthful and non-misleading.

You know, it's interesting: When I hear the discussions about the FTC, I mean, and all the things that we might do or could do, today, right now, we're in court today, not on a case involving physician advertising, but we're in a court today, right now, seeking a temporary restraining order against a marketer of a product called coral calcium.

And coral calcium was being marketed as to treat or cure cancer and other diseases such as multiple sclerosis and heart disease. Very widely promoted on television. So we're

in court today challenging that.

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

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

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

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

It turned out that Gutbuster really didn't do anything to tighten your stomach. So those claims were deceptive. But the other concern -- and this is a Gutbuster -- the other concern about the Gutbuster was that it could break upon use and maybe actually bust that gut by piercing it or hurting some other part of the body. That part of the advertising was unfair because it would cause injury that consumers could not reasonably expect or avoid, simply by using the product.

Core advertising principles: I don't think anybody could disagree with any of these. Obviously, tell the truth. But that's an important point, too: Tell all the truth. Don't omit information that's needed to keep what's being said in an ad from being deceptive. And, of course, to make sure it's the truth, which is a core, very significant approach that the Commission takes, and is certainly very vital for any health care advertising.

The concept is, is before an advertiser makes a claim in their ads, they'd better have a basis, a reason, to believe that in fact that product or service will do what's being said. And this standard, which we call the substantiation standard as it says here, is flexible. It depends on the claim.

So if you say in an ad, four clinical studies show that this does this, well, then, you'd better have four

clinical studies that show that. If you say in an ad that 98 percent of our customers or our patients or the consumers taking this product achieve this result, that certainly is an implication that you've done some kind of study or follow-up with your patients to demonstrate that that's true.

But the point is that the standard is also flexible so that if something new has been developed, some new technology is being developed that information can get out in an advertising about this technology so that there isn't some absolute bar that you must have at this point this amount of evidence before you can say anything, but still if you do choose to do that you've got to present it in a fair and reasonable way that consumers would understand what that evidence means and what it doesn't mean. And of course, it requires competent and reliable, and in the health care area scientific, evidence, evidence that an expert would say is needed.

A little concept here about ad meaning. When you look at those ads that were being put up on the board before, advertisers are certainly responsible for any express statement they make in the ad, but also for ones that are reasonably implied by the express statements they make.

The net impression of the ad -- we always look at everything. Take a look at a couple of the other slides I gave you, which are sort of interesting. Because they get

into some of the issues that we might address in FTC cases.

This ad here, the one that has this big, blown up, "A 1994 contemporary pediatrics recommendation study found that 88 percent of pediatricians who recommend baby food recommended this particular product."

Now, that's not what the -- that was a small fine print disclaimer or disclosure at the bottom of the ad. The ad actually looked more like this. I know you can't all see it, but it was in bold print. "Four out of five pediatricians recommend Gerber." Okay? Then they had put this disclaimer that you see blown up.

Now, the facts are, and the Commission brought this case in part because of these facts, there was in fact a survey done of physicians. And they surveyed 562 docs. And these were pediatricians. And 408 responded to the survey that, yes, we recommend baby food. But almost all of them, 82 percent, said, but we don't recommend any specific brand.

So there were in fact 76 out of that original 562 that did recommend a specific brand. Now, there the company was absolutely right. Of that 76 who recommended a specific brand, 67, about 88 percent, recommended that product.

But it's still a sign that, you know, again, the banner headline was, "Four out of five." Then there's a disclaimer or an asterisk or an explanation in sort of fine print. Then you hear the rest of the story and you go, is

this exactly -- you know, this doesn't make sense.

The other ad is also interesting as well. This is for a product that was being promoted as being 93 percent fat-free. Now, I could take a survey in the audience here and ask you, all right, how many grams of fat do you think would have been in a serving of that product that was 93 percent fat-free? The answer is ten grams of fat. And about 14 percent of the product was actually fat.

Apparently where most of the fat was coming from was not the light version of the ice cream. It was the chocolate covering that was on the ice cream bar. And the other fact that the commission noted in its complaint was that the amount of calories in that product was very little or hardly at all different from the calories that were in the non-light version of this product. Most of the calorie saving was because the product was smaller in size. So you got less ice cream; therefore, you got less fat.

We've got this four-piece placement/proximity/prominence/presentation. I think we saw some of those examples by some of the ads that have already been put up. But we look at issues like, is the disclaimer big enough for people to notice? Is it easy to understand? Is it where consumers might look? And is it near the claim that it qualifies?

We had a little discussion about consumers

testimonials. It's worth pointing out that you can't say -- basic rule: An advertiser cannot say in a testimonial what they couldn't otherwise say in an ad. So just because someone who has gone through a particular procedure or bought the product had this particular result, if the advertiser felt, I couldn't say that because I don't have substantiation for that, I don't think that's true, just because some consumer says it is, you couldn't use it in the ad.

And testimonials can often contain claims that are basically statements of efficacy. We can see it in the area of LASIK. We see it in many, many other areas, where that testimonial is making some kind of statement that, you know, basically says, this product will do this. It did it for me and it will do it for you. And, of course, such claims need to be supported.

Let's talk a little bit about LASIK. We've been interested, involved, working with others in this area for a number of years. And it seems like some of the issues continue to be the issues that have been from day one: Throw away, eliminate the need for glasses or contacts, has certainly been a major question, a major issue. Misrepresentations being made about the safety of the procedure are certainly of issue. And concerns raised about making comparisons.

And what our approach has been to date has sort of

been this multi-faceted approach combining not just one area exclusively, but looking at others. So we're going to do education, we're going to encourage self-regulation, and where needed, going to do law enforcement.

So we have over the years been working with a number of groups, and again trying to come together. Absolutely right, we did help and assist in the development of guidelines. We have been in discussions and had meetings with the various professional groups. We've talked with the state medical boards. Again, where we have found examples of advertising that have been questionable, we have tried to get someone interested in going after it.

That last point: Bring cases where necessary. And -- did I jump ahead? Well, let's go right there. Recent Commission cases: We just announced two cases in March against national advertisers, and they focus again on some of these claims that people have been concerned about for a number of years.

Eliminate glasses and contacts for life. Eliminate the need for reading glasses. Risk of glare and halo. Significantly less risk than contacts or glasses. It really seemed to be an inappropriate thing to be comparing the risks of going through a LASIK procedure with what might happen if you put a contact on your eye or a pair of glasses on your nose. They were really speaking to very different issues,

and so we challenged that.

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

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

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

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

MS. KOHRS: Thanks, Dick.

And I'm very grateful to Mr. Sfikas, who's next, because I don't have to worry about his PowerPoint presentation because he doesn't have one. Mr. Sfikas argued an advertising case a while ago before the Supreme Court, California Dental, which was brought by the Federal Trade Commission. Mr. Sfikas? Thanks for joining us today.

MR. SFIKAS: I would like to thank the Justice Department and the Federal Trade Commission for inviting me as a representative of the American Dental Association to speak to you today.

As it was indicated, I did represent the California Dental Association in a case that went to the United States Supreme Court and thereafter was remanded to the Ninth Circuit Court of Appeals.

In that case, the California Dental Association, with reference to quality advertising, took the position that in order for a dentist in California who was a member of the association -- in order for that member to advertise quality claims, the claims had to be verifiable.

The FTC took the position that that was a restraint of trade, interfering with both the consumer's right to hear that information and the dentist's right to utilize that sort of information. The case ended up that the California Dental Association prevailed and the case was dismissed against the California Dental Association.

Now, I'd like to give you a little bit of background, and then I will try to answer some of the questions that appeared on the FTC website relating to quality advertising.

Quality advertising is considered by many inherently deceptive because it cannot be verified and it cannot be precisely measured. The rationale for this statement is the striking disparity between the knowledge on the other hand of the professional and the knowledge of the consumer.

Professionals, obviously, supplying information have far greater knowledge regarding the quality than the individual consumer who is buying that service. Thus, it is extremely difficult for a patient to discern whether he or she has had, let's say in this case, good dentistry.

If there is an individual who goes into a dentist and has a tooth filled, it is very difficult for the patient to determine whether or not that restoration was a good restoration. The same is obviously true for medicine and the other health care professionals that we saw with their presentations today.

The quality of professional services tend to resist evaluation by patients in part, as noted above, because of the specialized knowledge, but also with reference to whether or not that service was the type of outcome that was expected

as a result of what the health care professional did to the patient.

Many economists in this area and other experts have come to the conclusion that the lay public is totally incapable of evaluating the quality of medical services. A patient's loyalty to his or her dentist also complicates the effectiveness of quality advertising.

In other words, there are bonds between patients and dentists and patients and various physicians so that irrespective of how you might rate that physician or dentist, they will continue to go to that dentist because they have a relationship with the dentist or the other health care professional.

Now, as a result, the Supreme Court determined that these various significant challenges to informed decision-making by the customers for professional services suggest that advertising restrictions arguably protecting the patient -- this is the requirement for verification of the quality advertising -- could not be looked upon in the rather cursory manner that the Federal Trade Commission had in determining that there was an antitrust violation.

The Bates case has been mentioned by a couple of speakers now, and that was the case that first introduced advertising to the professions. But even in the Bates case, although it said advertising for routine services was fine --

and that was not an antitrust case; it was basically a First Amendment case -- nevertheless, the Chief Justice at the time, who wrote the opinion, also noted that: "Claims relating to the quality of legal services probably are not susceptible of precise measurement or verification, and under some circumstances might well be deceptive or misleading to the public or even false."

Now, with this background, I'd like to try to answer some of the questions that were posed on the website in introducing this hearing this afternoon.

What information regarding quality is available to consumers? Well, of course, there is quality advertising. However, we have all the cautions that not only I've raised here in the background but that the other speakers in showing various forms of advertising that were troubling.

But let me give you an illustration with reference to dentistry. Let us suppose that Jane Jones, DDS, who practices in the State of California, advertises herself as the best dentist in the West. Is this misleading? Is it verifiable?

Well, in California and as a result of this Supreme Court decision, Jane Jones would have to try to show that she is the best dentist in the West or she would not be permitted, if she were a member of the association, to run this ad.

Now, how are the ways that Jane Jones can show that she is the best dentist in the West? I suppose if something like a magazine like Consumers Union did a study and determined that she was the best dentist or among the very best dentists, that would probably satisfy the fact that this advertisement had been verifiable.

What are the problems that might arise if this type of advertising is permitted? Well, a patient may go to Jane Jones, believing that she is the best dentist in the State of California, and Jane Jones may not be the best dentist in the state and may, as a result, leave the patient with lips that are sore and a mouth that is sore as a result of this. Well, certainly this patient will not return to Jane Jones. She will go on and look at other dentists, and it may be trial and error before she finds a dentist who she considers is best for her.

Well, that trial and error constitutes search costs, which would therefore interfere with the delivery of services. And one of the arguments in the California Dental Association case was that the elimination of those search costs meant that this type of advertising would be pro-competitive and, in fact, the Ninth Circuit Court of Appeals found that to be the case.

What is the difference -- here's another question -- what is the difference between dentists who

advertise and those who do not advertise quality services? Well, there may be no difference between them in terms of training and skill. It's simply one is advertising that she is the best, and the other is not advertising. So it would appear as if the advertisement might give the dentist who was advertising sort of the ability to say that they are superior to the other dentists in the community.

What role does comparative advertising play in dental advertising? There is almost no comparative advertising; at least, I've never come across comparative advertising in dentistry.

Are there governmental and association limitations on advertising? And yes, as you saw with Mr. Kelly speaking, the advertisement does have to be truthful. And in the case of the California Dental Association, it also has to be verifiable.

And the question then is, is that -- what effect is that on the marketplace? In my judgment, that's a salutary effect on the marketplace because consumers in California, for example, can rely on the fact that the professional association of dentists in that state verify the advertisements that are being run in the Yellow Pages or in newspaper columns or newspapers in general.

There's another question: What empirical evidence supports this justification? Well, I'm really not aware of

any empirical evidence that supports this. However, I suppose one way that you could determine that is to run a study and see whether or not -- let's take California again as the illustration -- whether dentists in California who are not members of the California Dental Association run more quality advertisements than members of the California Dental Association, who cannot run quality advertising unless they're ready to verify those.

As a matter of fact, just as others have said here with various physician-type advertising, advertising among dentists is flourishing. The last time the ADA survey center took a survey on advertising was in 1996 and I'm sure the numbers would be much higher today. But in 1996, 65 percent of all dentists were advertising. Now, that's not to say they were advertising quality, but they were advertising in general.

And the survey further asked those dentists, did they believe that their advertising was worthwhile? And 70 percent of the dentists of that 65 percent stated that the advertising was in fact worthwhile.

Now, the aftermath of the CDA litigation indicates that probably the California victory was a pyrrhic victory because what has happened because of the expense of that litigation, none of the state associations are enforcing advertising principles of ethics.

But it's even more significant: They are so concerned about anything, any enforcement, any disciplinary actions, under the ADA principles of ethics that they are not moving forward to try to obtain discipline for any violation of the principles of ethics.

Now, I'd like to make one other statement for the record. There was a dentist here yesterday, I guess during the Noerr Pennington discussions, whose name -- I'll leave his name out. But he made a statement which I would like to challenge.

His statement was that a dentist may not advertise that he is a mercury-free dentist. And although the ADA Judicial Council has never been called upon to resolve that issue, nor am I aware of any state association ever being called upon to make a determination with reference to this ad, the likelihood is that that ad, without more -- mercury-free dentist, John Smith is a mercury-free dentist -- that would not violate the principles of ethics.

On the other hand, if that dentist went further and stated that he or she were mercury-free dentists because of the toxicity of a certain type of restorative material, that very likely would violate the principles of ethics because that claim is untruthful and it's not verifiable.

In fact, the Food & Drug Administration, Health and Human Services, has an extraordinarily large body of

literature, that supports the notion that that form of restorative is not harmful to patients and, in fact, except for a very small element of the population who may be allergic to that restorative.

But with reference to history, that restorative has been used for 150 years. All the governmental agencies, the scientific bodies, all conclude that it does not harm patients. And therefore, if this dentist were to go further and say he is a mercury-free dentist because of the toxicity of a certain restorative, that probably would violate the principles of ethics.

Let me conclude by telling you a joke that I used to tell all of the dentists when I litigated with the Federal Trade Commission. And that litigation lasted for a number of years. And that was, how many lawyers does it take to screw in a light bulb? And the answer is, as many as you can afford.

And I would tell the dentist that the United States government has many, many lawyers that it affords who work for them in litigation with the FTC. Thank you very much for permitting me to speak to you today about this subject matter.

MS. KOHRS: Thanks, Mr. Sfikas. I think we're just going to take about a ten-minute break to give everybody just a chance to get up and stretch your legs and think a little

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

(A brief recess was taken.)

MS. KOHRS: It's 4:00 here. So I'm going to go ahead and start with our next presenter, who is John Gebhart.

MR. GEBHART: Thank you. Good afternoon, and I'd like to express my appreciation to the FTC and the Department of Justice for inviting me here today. DoctorQuality is a company that perhaps many of you do not know. We serve anonymously or invisibly, in many cases. But I'm interested in giving you some background about what we do. No, I don't see where it fits with the agenda of today's discussions.

First, a word about myself. I'm actually trained as a financial executive, financial and general management, although I've spent about the last 15 years in health services in a variety of different activities.

I've worked in areas that pertain to health care marketing, hospital marketing, demand and disease management, where we've delivered advice directly to consumers; also, in physician referral, physician practice management. I had some brief involvement in providing information services to mental health professionals, and most recently have been focusing on patient safety and physician quality with DoctorQuality.

Earlier this year as well, I had the opportunity to serve on a panel at the NCQA that dealt with the issues of provider referral and what kind of directory information should be available to consumers. So hopefully I have some insights onto some of the issues we're dealing with today.

I'm also going to talk a little bit about the company. We provide a couple services, one of which I think is directly germane to today's discussions. And I would submit the other one is as well, but perhaps not as obvious. And we're going to focus primarily on my Quality Coach, which is a provider service -- or a service that we provide to health plans and large self-insured employers.

DoctorQuality was founded in 1999 during what I'd like to refer to as the apex of the dotcom toga party. I actually represent the second generation of management. The academic physicians who founded the company are back in academic medicine, and doing so, they were able to double their salaries and they now have 401(k) matching, to which I say God bless America.

Even though we have a very -- we're very young and very new on the scene, we do have a very strong customer base made up of some reputable clients who have really helped us shape the platforms that we provide today.

We're also very fortunate to have the guidance of some very prominent individuals on our board of directors.

One is a gentleman named Chuck Buck, who actually is a member of the Institute of Medicine, who published the frame-breaking report in 1999, "To Err Is Human," which really kind of blew the covers off of medical errors. And the other is Dr. David Nash. Dr. Nash heads up the Center for Health Policy and Outcomes Research at Thomas Jefferson University, nationally known as one of the experts in quality and patient safety.

We are a company that uses health care technology to improve quality and safety. We believe in the transparent marketplace. We believe that there's an opportunity to get more information into the right hands as people try to either monitor performance or make critical decisions.

To that end, we have a hospital and physician selection tool that helps consumers choose resources based on performance and quality. We also have a hospital incident and adverse event reporting tool which is used for quality assurance purposes, and from that activity we today house the largest database that we know of -- we've looked everywhere to find anything comparable, and we haven't been able to -- we've got the largest database in existence for medical errors and near-misses. And I'll talk a little bit about that.

The two products that we offer are Risk Prevention and Management, or RPM -- this is the hospital error

collection tool. It's used for quality assurance purposes. And we also have My Quality Coach, and that's the physician and hospital selection tool.

I'd like to emphasize, it's very important as we're trying to provide information to consumers to make informed decisions. You must know that there is an impermeable wall between these two platforms. The information that we collect in the conduct of the RPM program is private, confidential information for quality assurance purposes only.

Frequently I get the question, so you collect hospital error information and tell consumers who makes the most mistakes? That's not the objective of the program, nor will it ever be.

I want to start by talking about the hospital error reduction program. I think it's important -- maybe not directly in the context of today's discussions, but I think it's important in the context of: at some or another every one of us here is going to be a patient or has been a patient.

Between 44,000 and 98,000 people are killed annually in the United States as a result of an unnecessary medical error. Let's put that into context because 98,000 a year is a big number. It's hard to really figure out what that means. I've been given 15 minutes today. Three people will die while I'm up here. And that's a pretty sobering

fact. So it's a very significant problem.

The other thing that's very interesting is of the numerous medical errors that are made, it's been estimated that only about 5 percent are actually reported, reported in the context of trying to analyze why the mistakes happened so preventive measures can be taken.

Not only is it a tragedy, but it costs a lot of money, too. Medical errors cost this country about $140 billion a year, both in terms of repeated procedures and the costs for those procedures, and there's also a growing concern, a crisis in many states, with respect to malpractice insurance. And this is a piece of it.

Now, it's very encouraging to see that many of the states in this country are now requiring some form of mandatory medical error reporting. About 20 states today actually have some legislation on the books requiring error reporting.

I think two in particular are, I think, very near and dear to DoctorQuality's heart. In New York, there's a program called NYPORTS, and it might not be generally known, but every single hospital in New York has a dedicated NYPORTS terminal at which the hospital employees are required to report certain errors to New York State.

Also, in Pennsylvania, I'm very proud to say that yesterday our company submitted the bid to provide error

reporting across the state to a new regulatory agency in Pennsylvania known as the Patient Safety Authority. And Pennsylvania is really going to be the first state of its kind that is going to encourage not only what's known as serious events -- in other words, the things that harm patients -- but Pennsylvania wants to know about the near-misses as well. And I think it's a big step forward in terms of really being able to find ways to be proactive about some of these problems.

The problems that we see here are not necessarily individual acts of negligence or incompetence. The problems that we see, we believe, most often are the result of a system of care.

Here's a very startling statistic: From the time that an individual is admitted to a hospital for what's become a fairly routine procedure, coronary artery bypass -- from the time that person is admitted to the time they're discharged, about 400 people are going to be involved in delivering care to that individual, 400.

Not all of these are going to be hands-on. Some of these people are going to work in the lab, some in the pharmacy, some in the kitchen. Some are going to work in maintenance, and they're going to clean up the operating room after the fact.

But 400 employees of the hospital are involved in

delivering service to one person. If each of them do three things, that's more than a thousand opportunities for an error someplace in the process.

So we believe that it's important to be able to collect data and understand where in the system things break down. And we think this is a function of both variation from accepted medical practices, and it's also an important element in trying to house the right kind of culture in medical institutions.

And this might be the point where the service that we provide internally and the service we provide externally overlap. And this might be the point that has the greatest relevance for today's discussion.

We start with trying to help our hospital clients get an understanding of their culture, and someone in public relations told me a long time ago, public relations starts at home. You have to understand your own organization's culture if you're going to understand how you want to portray a message or an image publicly.

One of the big problems in health care is that we have not practiced an open and blame-free culture of gathering information about mistakes. Whether if it's for fear of reprimand or whether it's arrogance or something in between, a lot of these mistakes don't happen -- pardon me, they happen; they don't get reported. We'd like to be able

to change that, help our clients change that, and start to gather the information to help them figure out where the problems are.

So we start with culture. We move to data capture. Once we know -- once we have the data, we can start to analyze the data to figure out what the solutions are, implement the solutions. And we find among a lot of our clients, once we've nailed down one solution, another one pops up. Health care technology changes constantly. Or once you've solved a problem on the surface, it might expose several other problems underneath.

So we believe that it's important at every level, and I think in particular with respect to health care policy, legislative policy, something has to be done to really evolve the culture of health care.

I mentioned a little bit earlier the database that we have. Earlier this week we crossed the line. We now have a little more than 80,000 medical errors. Next week, it will be more than 81,000, collected from more than 150 health care facilities across the country.

You'll see that about two-thirds fall into either the adverse clinical or medication areas. And I think the statistics on the right-hand side are pretty telling as well. The one I like the most is that of all the items that are reported to us, 43 percent involve a near-miss.

You know, this might be a situation where in the middle of the night you see the nurse come into your hospital room and say, "It's time for your pill," and she hands you a yellow pill. And maybe you're going to be awake enough to say, "Wait a second. Mine is blue." That's a near-miss. It was caught in time. And there could be about 15 people someplace in the chain that somehow put a yellow pill on that tray for you instead of your blue one.

We've seen numerous cases where our clients being able to quantify the recurrence of near-misses has led to some very significant improvements in their procedures. And we were able to prevent similar recurrences in the future.

I'm just going to say one more thing about the medical error situation before we roll into the physician and provider selection tool that we provide. But I get a lot of questions very frequently about why should anyone really want to report a medical error?

The first one, you know, why should you want to do it? Well, I believe that doctors went to medical school to learn how to do a good job. And there's a little bit of a Pollyanna in me about that. I don't believe doctors go to medical school so they can golf on Wednesday. There are cheaper ways to golf on Wednesday.

I think that health care professionals try very hard to do a good job, and I think it's harder and harder to

do a good job. And what we provide is an improvement tool that helps people understand where their weaknesses are and be able to react to them.

Next question: Won't error reporting lead to lawsuits? A very, very common misperception. And the answer is, in 49 states, no. In 49 states, any information that's collected as part of a quality improvement is protected by the peer review statutes, which means you cannot subpoena it. I'm sure that will be challenged, and it's probably a question that we're going to have to wrestle for a long time. But I'm very pleased to say that at a policy level, in 49 states the answer is no. This does not lead to lawsuits. This leads to better health care.

Who would want to report on a coworker? Well, let me tell you about one of the programs that one of our clients has in place, which I think is just the perfect embrace of the kind of culture that we hope our clients are promoting. We have a client who has a program called the Plant a Flag program, and what happens is the hospital gives lapel pins and collar pins to the doctors and nurses that report an error.

They take the attitude that the errors are like potholes in the road. If you stepped in the pothole, please plant a flag so that your coworkers don't step into the same pothole. And we see hospitals give out gift certificates for

cookies in the cafeteria, movie tickets, anything to promote a culture of blame-free reporting.

And does this offend doctors? Well, it doesn't offend doctors if they've embraced this culture of blame-free reporting. It's very important that we look at error collection data in a non-punitive fashion. And I go back to my first point: 98,000 people die because of medical errors. It seems pretty apparent to me that blame has not worked. We need to try something else.

Let me turn to our second product, My Quality Coach, which is an online consumer decision support system whereby consumers can choose physicians and hospitals based on quality and satisfaction data. With this program, we encourage consumers to log on and prepare ratings on their doctors. And we also invite doctors and hospitals to present certain information about themselves.

Now, this information, we think, is pretty important in the context of how resources are chosen, VHA did -- the Voluntary Hospital Association, that is, did a study last year and it seems pretty clear that health care is becoming more consumer-centric. I won't go ahead and read all those, but you can probably them.

But in other words, this slide makes the point that consumers are interested in finding out quality information. They would be very pleased to make decisions based on the

standards of performance and the quality of care that's delivered.

It's also becoming an increasing trend that employers are very interested in this as well. It doesn't cost more -- in fact, it actually costs less -- for the employees to go to better quality doctors and better quality hospitals. And to the extent that this both is a way to reduce health care cost and to bolster employee satisfaction, this is something that large employers in particular are increasingly becoming very interested in.

This last point on the slide: Network size is taking a back seat to network quality. Actually, that's backwards, and the person who drafted that is going to be in big trouble tomorrow morning when I get back to the office.

Network quality -- no. I'm sorry. I'm backwards. Start again. Network size is taking a back seat to network quality. It used to be that when you'd get into a health plan, you'd look at the book and say, is my doctor in here? Well, now people are increasingly trying to figure out, is the good doctor in here?

Just a snippet from the Philadelphia Business Journal, where last year the Blue Cross organization in town has actually developed an incentive program based on quality. If institutions are delivering certain quality metrics, they're paying bonuses, cash from a health plan, for doing a

good job.

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

My Quality Coach has information on about 750,000 physicians and all of the hospitals in the country. And it's available via a secure password-protected site.

We offer our members an opportunity to rate physicians. This is my -- one of my customs is to put up on slide that's just not legible. This is it. But you can see that there is a questionnaire that you can fill out, and immediately upon completing the questionnaire, you can see satisfaction rankings for your physician compared to other physicians in the plan and other physicians in that same specialty.

We, in addition to providing access to information about how to find the best qualified physician and hospital, provide some personal health information tools, health risk assessments and health guides, that can help you better understand your circumstances and prepare for your interactions with the system.

Time is very short, so I'm going to go ahead and skip over a couple of these. And I want to jump to, at the

very end here, a couple of things on -- the impact of this kind of information on the providers and the hospitals themselves.

We work very closely with the Pennsylvania Health Care Cost Containment Council, or PHC[4]. And they have published a number of studies over the years. They got a lot of attention in 1998 around a study regarding coronary artery bypasses in Pennsylvania and the associated report cards that emanated from that study.

David Nash, prior to the formation of our company, was quoted in the Wall Street Journal pointing out that the great thing about the report cards is it tells institutions where to start looking. It's a place to start looking at performance and what to do about it. One of the surgeons at Lehigh Valley Hospital admits that they're under a microscope, and says it's a good thing. It's causing them to move forward.

In the interest of time, we'll jump over these statistics. But I do want to point out that the public dissemination of performance data has had a very positive impact in Pennsylvania. You can see that in the ten years concluding in the year 2000, there's been a pretty dramatic decrease in mortality surrounding coronary artery bypasses.

This has also been demonstrated in other disease states and other procedures, where the impact of revealing

this performance data has had a very positive impact on the actual performance of the physicians themselves.

And I'll end with the last one from a fellow you might know of, Dan Rather. "When it comes to choosing a heart surgeon, Pennsylvania is on the cutting edge in helping consumers pick the right one."

So we like the idea of making information available. We think it has a good impact on the institutions themselves. And we think it's a trend that consumers are continuing to demand. Thank you very much.

MS. KOHRS: Thank you, John.

I'll ask all of the panelists to come up. Helen, you're going to speak. You don't have a PowerPoint, but everyone else can come up and have a seat. You can choose to speak from your seat or from the podium, whichever you would prefer. Helen has been here all day.

MS. DARLING: I just -- obviously, the satisfaction of what I have to say will be inversely related to how long it takes me to say it. So I will try to make it as fast as I can.

I'd like to mention that two of our Washington Business Group on Health public policy goals, two of our highest, are to increase transparency in the system -- and there is a report out there; if you haven't gotten it, I hope you will read it. It talks a lot about what's now available.

I think for anybody who hasn't worked in this field recently doesn't really appreciate how much incredible information, DoctorQuality.com being one of the best examples, is available to especially companies. I know one of the companies that uses them is G.E. And they are a very demanding purchaser and very sophisticated purchasers.

So they have a product. Others have products. The interesting thing is how many are emerging, how all of them are getting better, how -- I mean, they have data and tools that would just make us salivate even as recently as five years ago.

And the ability -- it's probably one of ours, too -- but the ability to put in something like your personal zip code, and say you want a hospital within ten or fifteen miles, and these are the things you care about, like complication rates and things like that, it will create its own report for you, ranking all the hospitals in your immediate area.

And again, if you're not familiar with that, what's amazing is what's available and how critical it is that we keep moving. They're now using data that I hear now, but we're not going to have more data unless we have more pressure to have more data.

We certainly think as an organization that advertising can be fine, and we certainly wouldn't want to

squelch that, whether it's First Amendment or not. But we do think that the role of FTC -- and the FDA, by the way, and we met with the Commissioner the other day about the role they can play from where they have authority to try to drive the system to more fact-based information, and also, obviously, certainly no deceptive advertising.

If anybody has -- you should see Tom Lee's letter in the -- article in the New England Journal of Medicine on the topic, the best I've ever seen about how you don't get peace of mind. For us, it's hard to believe that anyone can even today run an ad and say that if you get this scan, you can be assured and have peace of mind. I mean, if that's not deceptive advertising, I don't know what is.

In the past, critics have said -- a lot of people who are scornful of some of these things have said, neither consumers nor purchasers use quality information. Well, that is not true any more. And usually that was said based on surveys at a time when we didn't have information, so you did a survey with a two-year look-back and say, do you use quality information? They'd say, no, they don't. Well, they didn't have it. It wasn't available to anybody.

And in many instances now, it's available. Also, in other instances, a lot of useful information is tucked away in places like state health departments and quality improvement organizations and that sort of thing.

So one of the things we'd like to see in every piece of legislation that goes through any time in the next two years are requirements around reporting. At a minimum, of all currently publicly reported information, that such reporting would be easily accessible to consumers. But we'd like to go further and eventually have even better information.

There is evidence, as we just heard from John a minute ago, that public disclosure of provider performance is resulting in clinical quality improvement, in Pennsylvania but also in New York. In fact, in every state that has such information available, we are seeing improvements and people do pay attention. The interesting thing is that providers pay attention because they don't like looking bad, and for obvious reasons.

We also know that consumer information needs to move beyond hospital quality report cards, not because they're not wonderful, but because the information has to get much more complicated because we're going to have tiered networks and they're going to be often by specialty and that sort of thing. So the kind of drill-down detail will be more important.

I would just say, just to end, really, we hope the FTC and the FDA will be very aggressive in stopping all deceptive and misleading advertising; that they will see

protecting the consumer, especially in these complex areas, at a time when consumers, employees will have much more of a role to play, whether they want it or not; they will be playing a much bigger role, and they're going to have to have information. And the only way they're going to have it is if we keep the pressure on. Thank you.

MS. KOHRS: Thank you very much, Helen.

It's sort of the policy here to give the first half of the panel an opportunity to respond to some of the things that were said after they spoke. To make things a little bit easier for me and to move these things a little bit easier, if you're interested in speaking, just tilt your name tent on its side so that I can see. If it's tilted like that, I'll know that you want to participate and ask a question.

So we'll go ahead and just start down the line, if you want to just make a comment briefly. Bernie Dana had to leave, so we have a fill-in. Ms. Condeelis?

CHRIS CONDEELIS: Thank you. I guess one of the things that I'd just like to share, a couple points, is that I think with the panelists today, we do in long-term care share some things in common, in that our residents, our consumers, come to us with a very critical need. We are not an elective care service.

The fact that 75 percent of our customers are coming to our homes and their payments are capped does have a

very specific influence on the way we provide our services that is -- you know, it kind of caps competitiveness. And I think that's different from the other panelists.

We do for our consumers have quality measures. There is difference in the marketplace about how good those measures are, but I think that as a profession, we have pioneered the consumer satisfaction data that is then allowing us to give yet another indicator of quality to those that are seeking our services.

MS. KOHRS: Great. Laura?

MS. CARABELLO: If we are to insist upon getting quality information out to the consumer, what is going to be the best way to get it out there? Whose responsibility is it to do so? Is it incumbent upon the physician himself? Is it the organization? Who's going to take on that job? Is it going to be the FTC to help out?

Getting out information is not inexpensive. There's a big price tag to it. And the fact that the quality website is up there for getting quality information, if you're not a member of G.E., does that mean you can't get the information? Who is going to take that responsibility to get that information, for example, that a body CT scan is not advisable? Whose responsibility is it and who's going to pay for it?

MS. KOHRS: Well, I think she's thrown that out

generally. Helen, you look like you're --

MS. DARLING: Well, I can always answer a question. I think on that one, it's a good example of where the complex system that we have will govern. That is, all purchasers should make certain that it's available to the people they purchase for -- Medicare to its beneficiaries, the states for their Medicaid beneficiaries, and private purchaser employers for their employees.

And many of the companies, as you saw, some of the insurance companies that provide coverage for lots of middle-sized and small employers, provide these tools as well. So that is who's paying should pay for it.

Now, in a way, it isn't expensive. That is, we already spend billions of dollars reporting information, and you could go on and on on that. We have a lot of information, but much of which isn't nearly as useful as it could be.

It's already -- we have built into the system the expenses of collecting that information. In fact, they estimate, I guess -- some people estimate about 20 percent of health care costs are the transactions that we have in our system in contrast to other countries. So we've got a lot of money already in the system. We simply need to use it differently.

MS. KOHRS: Okay. Dr. Lee?

DR. LEE: You know, I would actually add that I think the professional societies, they should be challenged more by the business community and by others to pick up the role and really show some leadership in this area about making even stronger statements about what is and isn't supported by evidence.

And I actually think they're ready for it. I mean, I do a lot of stuff with the American College of Cardiology, and I think they're primed. They're actively discussing having -- you know, taking stands on -- you know, to try to reduce waste. Because frankly, they know they need to. You know, providers need to show that they are also trying to make the system work because they haven't been doing that much thus far.

I'd also that, you know, people don't usually think of physicians being in synch with the business community. But I would say that in general, our physician -- at least our leadership is very much in synch with what Helen said on both counts, in that first, we would be very supportive of strong action to try to reduce, you know, misleading advertising that generates demand where there isn't really need, and we'd do everything we could to try to support that with our, you know, experts and so on.

And then the second half, which is that how do physicians feel about public disclosure of data related to

quality, and there's certainly a bit more neurosis and ambivalence about that. But I would say that times have changed, and that many of our physician leaders accept it and are for it. They think that it's -- you know, it's like having your teeth cleaned. It's, you know, uncomfortable, it draws some blood, but it's good for you.

And then there are others who just understand that it's going to be this way, and they're not going to resist it any more. So I actually think that there's enough people who understand that it's a tremendous driver for improvement, and that wherever something isn't -- wherever we are against data being made public, we'd better have a good internal sense of accountability. And that's sort of where we've arrived in our system.

So I actually think the providers are in synch on both counts: better quality data being released to the -- made available to the public, while a reduction in the poor, misleading information that makes up a lot of advertising.

MS. KOHRS: Dr. Koch?

DR. KOCH: I think consistent with that, in terms of elective procedures, if we get after something like LASIK surgery, the manufacturers, industry and medicine, both want procedures like this to be successful, to work, to give good outcomes, because that's what drives it forward.

And so false advertising, patients who have the

surgery who shouldn't have it, spoil it for everybody. In addition, of course, to the primary problem, which is those patients, you know, end up with an outcome that they weren't expecting.

So I think that in general, really consistent with what you're saying, there's a feeling about wanting to move ahead. As far as the societies becoming involved, I think Mr. Sfikas has given us a good feeling for what the down side of societies becoming involved is in terms of the costs. And that's always a problem.

I mean, what does a society do? Do you just -- do you do the bully pulpit and just talk, talk, talk, because if you proceed and try and get to any level of enforcement, then the restraint of trade issues come up and it becomes extremely expensive, time-consuming, and everybody washes their hands of the next case.

MS. KOHRS: After the encouragement of Drs. Lee and Koch about the FTC's involvement, I think it sort of leads me to ask a question of Mr. Sfikas. I'm going to quote from the Cal Dental decision. The concern -- the decision says that there were many instances in which the dental association suppressed such advertising claims as, "We guarantee all dental work for one year," "Latest in cosmetic dentistry," and, "Gentle dentistry in a caring environment." And I'm wondering if the California Dental Association has changed

its perspective, whether those types of claims would be allowed now.

And you said that there was a reticence on the part of the California Dental Association, or indeed any dental association, to pursue any types of claims. How do we encourage them to get involved in the process, as Drs. Lee and Koch would want an association to be involved, without causing anticompetitive problems?

MR. SFIKAS: Well, it's a real irony because, of course, we prevailed in the California Dental Association case. We won. The Court said that it was not an antitrust violation.

I think you've heard that in the case of guarantees, that they're really not a solution. If someone is injured, the mere fact that they get the cost of the dental services back is not really anything that's extremely helpful.

How do you encourage the associations to get involved? I think if the FTC -- I think from the standpoint of the dental profession, it would be very helpful -- and there's really no way to do this, I mean, because the principles of ethics are already out there. But it would be very helpful if we could present the principles of ethics to the FTC where they would say, excluding the advertising -- we wouldn't give those to you because we've already won that, in

our opinion -- but if we gave everything else to you and you said, you know, none of these would raise antitrust concerns -- and many of these certainly would not raise antitrust concerns.

For example, some of the things that are not being done today, in the case of peer review, peer review was always used as an alternative dispute resolution mechanism. A patient comes forward, says they're unhappy with what the dentist did. They don't like the procedure that was done. The association hears it, often agrees with the patient, would make the dentist reimburse the patient.

Now, because it's no longer obligatory since it's not being enforced, the patient is left to file a lawsuit, which is not a good way out of that. Consultation and referral, when it is in the best interests of the patient, certainly that doesn't raise any antitrust issues. This is the dentist determining that the dentist ought to refer, more likely than not, to a specialist. That's not being enforced.

And even a very recent one, the dentist should avoid interpersonal relations that could impair personal judgment, sort of something on the order of sexual harassment. None of those are being enforced, and I'm sure that we could agree that none of those would raise antitrust issues.

So it's a real irony. It's the expense of the

California Dental Association having to litigate that case, first before the administrative law judge, then before the Federal Trade Commission, then in the Ninth Circuit Court of Appeals; then, because the first time, as you know, the Ninth Circuit Court of Appeals ruled for the Commission, a two-to-one decision, then the Supreme Court takes the case. The Supreme Court reverses, and then sends it back down to the Ninth Circuit Court of Appeals before that litigation came to an end.

Well, the other state associations, not as large as the California Dental Association, are saying, we just don't want to get into that. So there is a great reluctance to enforcing not only the advertising restrictions in the principles of ethics, but other provisions as well.

MS. KOHRS: Go ahead. Dick?

MR. KELLY: Yes. I'm not an antitrust lawyer. I'm not in the Bureau of Competition. So to directly respond to some of those issues would be foolhardy on my part.

Clearly, in the California Dental case, there was a debate as well as to what kind of record needed to be in evidence to justify or not justify those restrictions. And ultimately, that case, at least, turned in significant part on what approach was being used. There's something called a per se approach to evaluating restrictions, and then there's a truncated rule of reason. And the Court was saying the

Commission picked the wrong one, and sent it back.

The Commission at the time it dismissed that case did say that it was concerned, and continued to be concerned, about restrictions that would be in place that would needlessly, in essence, restrict truthful or nondeceptive advertising. And that discussion, I think, continues today.

On the consumer protection side, I mean, we worked with AAO in adopting -- in their adoption of some guidelines for advertising in 1997, I believe. We have been reached out to by those groups as well as state medical boards to look at and evaluate specific complaints.

And there is clearly agreement, at least in part, on a number of things. I think everyone agrees, everyone agrees, that false and deceptive advertising should not be allowed. And what I think sometimes the debate turns on as well: What methods can you use to prevent false and deceptive advertising? How far can you go in adopting restrictions?

The Commission, on the consumer protection side, generally proceeds on a case-by-case basis. We look at the record in a particular case. We look at the evidence in support for a particular claim, and make a judgment whether that advertiser at that time was engaged in deception.

And that is a contrast to adopting board rules that seek to prevent -- prohibit broad categories of speech. I

think one of the ones that went up there was prohibition on using testimonials in advertising, for example. And that's where I think the debate has been, at least in major part, over these decades about this issue.

It seems to me that it is important to deal with all of these issues that have been raised today and, of course, are raised in other forums on other days on similar kinds of problems. It requires a joint tri-part, multi-part approach from the role of a consumer of having easy ways to complain if they feel they've been taken and deceived, and encouraged to come forward and complain so that people can get access to that information.

It requires, on the part of responsive professional groups that oversee that, to, in fact, be forthcoming if they see problems or abuses within their industry; to try to find a way to present them to the Commission in some sense in which way some things were being presented today.

It requires a response on the part of government to look at that and to evaluate that information, and if there is a strong case being made, to proceed. I mean, we at the FTC, like everyone else, have to have priorities.

I mean, we've been involved for a number of years in looking at claims on the internet, health care claims, not necessarily by doctors but health care claims. And there's a huge number -- as you know, just filled with claims. So

where do you draw the line? What do you focus on? And we try to focus on claims that are making representations about curing dread diseases, for example. And that's where our focus is.

So it requires consumers, it requires the groups, it requires government, in some sense working together to try to address some of these problems as best as possible. And, you know, I remain hopeful.

In the coral calcium case I mentioned today, one of the things we're doing at the same time we were going into court seeking this temporary restraining order, the FTC and the FDA were together sending out letters to marketers on the web, trying to get them to stop making similar claims for coral calcium products.

So, you know, there is hope. There is approaches that can be taken. And, you know, hopefully we're all willing to try to work together to achieve that.

MS. KOHRS: And speaking of things going on on the web, John, you have dealt with the gamut of physicians and consumers and various entities. Can you talk a little bit about what that experience has been like? Do you have a minimum pool of doctors? If I wanted to look up my doctor, John Smith, and I see that 100 percent of the comments have been negative and I click on it, does it tell me that there's only been one comment made, something like that? How do you

assess -- how does a consumer assess the data?

MR. GEBHART: We try to make everything as transparent as possible. So if one person has submitted the rating, it will say one. You know, whatever the number of ratings have been, that's obvious to the consumer when they're using our site.

Some of our clients have actually asked us to suppress any rating information until 30 ratings are submitted, so at least there can be some semblance of an average. Now, of course, you get into a little bit of a Catch-22 game when that happens because if you submit a rating but you can't see the results right away, then it's not a very satisfying experience for the consumer.

So we've really encouraged keeping the information as open as possible, not really trying to take sides, but really just in trying to encourage more ratings.

MS. KOHRS: And what's the response been from the physicians?

MR. GEBHART: Initially, physicians have been pretty much against it, pretty much against it. And I can certainly appreciate that. There's a lot of fear of the unknown. There's a fear that they might have one bad case and that person will continue to rate and tell all their friends to rate.

And we actually have some safeguards for that as

well. But this is a new territory, and obviously it's going to be a little awkward and a little intimidating until there's more trial in what we do.

I guess -- I'm not letting the social issues slow us down here. I take the attitude that, you know, myself and the rest of the baby boomers are really hitting our health care consumption prime right now. And we're the ones that fired a president 30 years ago, and getting health care information is just another one of the things we're going to solve.

MS. KOHRS: One of the issues that I wanted to ask about with regard to LASIK is one of the concerns is that there are a lot of consumers who are getting a great deal of information about LASIK from the media, but they're not really talking to a physician about it until they come in and say, I want to have this procedure done.

How does that affect informed consent? Do you have consumers who come in and say, I want this, and they will not -- they just want to have the surgery, they want you to go forward with it?

DR. KOCH: Well, I think that's true of all these elective procedures. You've got people who are just convinced they're going to have it done, whether it's a facelift or LASIK or whatever. And they come in and they're totally focused upon having that procedure done.

And we just have to try to pull them back, you know, show them the informational video. We give them the informed consent. We tell them explicitly that there are these risks of complications, and you do the very best job possible.

And at the extreme, if you're cautious as a physician, you will actually reject patients who clearly do not appreciate that there is the risk of complications because of the concern about what would happen both to the patient and to yourself were there a bad outcome.

I don't know that the majority of -- probably the majority of physicians do that, but there's certainly a minority that do not.

MS. KOHRS: And as you said, they can't -- getting your money back after a bad outcome is not going to do the patient any good. But is there some kind of mechanism we could use that would brand the doctor as being a more capable provider, that there's some kind of way he can identify himself as being somehow better, a safer risk, if you will?

DR. KOCH: Well, it gets into the whole issue of self-reporting of results. And I have a colleague in my community who reports that 98 percent of his patients see 20/20 after LASIK surgery, or some such statistic, and yet I continue to see complications from his office drift into my office and they are not in that 20/20 category.

So you're at risk. We keep our own data, for example, and for a while we used to put it up on the website. But no matter whatever number we put up, the next person down the street somehow had a number that was a little bit better. And so unless you have some kind of an external, objective measure of quality, either in terms of results or risks or incidence of complications, it's a difficult problem. And it's particularly difficult when you're not in a hospital or other type of setting where you have other people overseeing and monitoring your outcomes.

DR. LEE: You know, it's a very tough area and I think you have to have realistic expectations about what you can do. I mean, another area where a lot of numbers get thrown around is prostate surgery for prostate cancer, and what's the risk that someone is going to have incontinence? What's the risk that they're going -- what's the chance that they're going to have sexual function afterwards?

And you don't see this advertised on billboards or in the newspaper, but believe me, when the patient gets in the door, a lot of numbers are thrown around. And the patients either are not sophisticated enough or they don't even want to find out what's really behind the numbers. They hear 99 percent, and they want to believe that the surgeon they're talking to is great.

So I just don't know how -- I think that this is

not an area where investment in energy and time is going to have a great return. I mean, I'm not against going in there, but I would be realistic.

One thing that ran through my mind that I -- you know, this is going to sound like a, you know, like a physician-like, Taliban-like perspective on things. But I think that in the interests of promoting fair competition in the health care marketplace, I think a number of my colleagues would be -- they would support a ban of advertising of anything which required a physician decision, that is to say, a prescription being written, a test being ordered, with the logic being that if the decision-making is supposed to be restricted to a physician, then the lay public doesn't have the expertise to judge their need for it. And this obviously would limit all direct-to-consumer advertising in pharmacy.

And I think that that kind of thing does provide -- have some small benefit. I think it creates much more demand where there isn't much need. You know, the ratio, you know, of that to good is not a good ratio.

And I think that people should compete, but they should compete fairly with people who can judge things appropriately. I think physicians have the training. So this is kind of a paternalistic point of view. I don't think it's politically feasible. But I think that physicians would

support a movement in that direction, which I know would be not easy for you. But physicians would be right behind you.

MS. KOHRS: Well, our advertising specialist, who assures us she's not related to the Sopranos, is behind you chuckling. So Laura, do you want to weigh in on this one?

MS. CARABELLO: Well, I think it's unrealistic to assume that we're going to turn back the clock at this point on the pharmaceutical industry or on the physician industry, or on the hospital industry, for that matter.

Hospitals are the ones who are driving the marketing engine more than anybody else with issuing all kinds of not only quality reports, but investing fortunes -- and I have to say that over the years, I have handled many, many marketing projects for hospitals where they want to get out to the community.

My concern is this, and it comes down to: How does the consumer -- and I've marketed products; I've marketed physician services, disease management companies, and you name it across the board in the health care spectrum -- how does the consumer, who doesn't have access to the internet -- we talk about all these websites -- who doesn't have access to newsletters, who is the run-of-the-mill -- or who might get his or her information at the beauty parlor or at the barber shop, going to be able to judge quality? And is that quality information simply going to come to them on a

billboard that they may be able to read or not because it wasn't in their language?

Are they going to get it from, you know, the health club? Are they going to get it from some other source? Or have they lost total confidence in the quality components of advertising?

MS. KOHRS: Dr. Lee?

DR. LEE: My response is that I'm not really worrying that much, actually, whether the consumer really understands it. I think that if solid quality measures get put out there, it produces the desired effect, which is it makes consumers like, you know, me in my day job, you know, sweat bullets and try to create systems to make it better.

So that it will be great if the consumers understand it, but to me it doesn't really matter if your goal is to actually improve care.

MS. KOHRS: Well, going back again to that Cal Dental decision, when "gentle dentistry in a caring environment" was seen as a quality assessment that Cal Dental was not willing to allow dentists to advertise, how would you assess what quality advertisement really is? Do you have a -- can you give us a sense of what that might be?

MS. CARABELLO: Well, in my mind, anything that flies in the face of the regulations is not quality. So that has to be the first benchmark, whether it's the state

regulation or it's the FTC or it's your association or some guideline that you're following, as long as you're in the guidelines.

It's a question of good taste versus bad taste. I mean, there are doctors who are advertising regularly who are advertising in good taste and promoting quality. And I think quality wins no matter what. That's the bottom line.

And I somewhat take issue with the fact that, do we care whether the consumer gets it? I think we have to care whether the consumer gets it because ultimately, when they get the right information, they take better care of themselves, the outcomes are better, and it costs the system less money.

So I think it is incumbent upon those who are on leadership decisions, and certainly I take my responsibilities very seriously when I work with clients, to make sure that they are promoting quality. Because ultimately, if we don't -- and the employer. And one thing that Helen said about those who pay for the health care are responsible for providing the information. And I think that's true.

I think if an employer is going to recommend a particular panel or endorse -- and by offering it, they're really endorsing a particular PPO or HMO or whatever it is they're offering as a health care option -- they should get

behind giving that information.

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

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

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

MS. KOHRS: Helen?

MS. DARLING: Well, I think we have a lot more positive experience than the tone of this conversation is headed. A number of people have been working on HEDIS measures of health plans for, now, about ten years. In fact, Tom and I co-chair the committee that oversees that evolution.

And one of the things that's been very

interesting -- because we've got about seven years' experience now -- is that the health plans that allowed their information to be reported publicly initially got better and better; that the ones who were doing -- basically, people who did a good job and made it available did better in lots of ways. They got better.

The plans themselves in many instances, we know from reports that if they didn't do well one year on something inside the plan, then a lot of things happened. A lot of steps were taken to improve it.

We do know that there are companies that pay a differential and provide information. When I managed health care at Xerox, we actually provided data from the HEDIS report, and we had an allowance, and our employees had numerous options. And they migrated to the better plans.

And this goes back several years, before we even had the kinds of tools that DoctorQuality has. So now we've got much richer tools. We already have evidence going back as far as about eight years, as the data began to become available for health plans in particular and then later hospitals, that when people see it, they do pay attention.

And you can -- I don't know whether I'd want to see ads doing this; I don't know that I really care -- but you do have hospitals now advertising that they were, you know, number one in a certain geographic area, with a little

footnote and everything.

We have -- we know that health plans do that, that they advertise in their markets around open enrollment season. You know, they have 99 percent of all people who had a heart attack got a beta blocker in our health plan, and all women got mammograms, and things like that.

So there is a pretty rich area of information and experience already that data move people. Measures, especially those that are seen as quality, and which have a certain either face validity or intuitive appeal, that people know it's a good thing. They do pay attention. And they will do even more so if we give them that information in an easily understandable form.

MS. KOHRS: One of the other issues that we've seen come up in the information and advertising area is a question about providing adequate information to various cultural groups. Have you seen anything like that, John, on DoctorQuality? Any requests for other languages or are you just seeing the traditional health care user?

MR. GEBHART: I have not seen it at DoctorQuality, but at other companies, multilingual capability in particular. And for that matter, not just different nationalities, but any demographic sort -- you know, age-specific services as well, I think, are very important.

I mean, when you take a look at health care

decisions and interactions with the system, they're very personal, very intimate interactions. And I think to the extent that different age groups and different cultures have different needs, we think one expression of quality is that the services are appropriate for the individual circumstances, not just their diagnosis.

So I think it's a very important component of it. It hasn't been demanded of us yet at DoctorQuality, but, you know, sure enough, it will be coming.

MS. KOHRS: Helen?

MS. DARLING: Actually, it's become the hot topic. And cultural competence is the current language on this. It's actually a big issue and very important, and large employers who especially -- like the hotel industry, the hospitality industry, companies that have a lot of people in places like California and New York where you have large immigrant populations with many languages.

I know, for example, not too long ago I was at a meeting with some people from Oxford Health Plans and, you know, they actually have to cover 14 languages. And that's just one where they have a lot of people. That's not counting all the other dialects.

So this is because our workforce has become so much more diverse and we have a lot of large employers -- again, Marriott is the best example, probably -- where basically all

the HR material is done in Spanish or -- you know, they are particularly good on, if you will, the easier languages for us now as a country, where we have a lot of people speaking that language in a lot of different places. It's easy to get the resources.

But they're recognizing that there are many, many categories of people from different cultures. It's going to be very expensive, though, to deal with it. But employers really think this is extremely important.

MS. KOHRS: Dr. Koch?

DR. KOCH: I want to just touch base again on this issue of doctor quality and quality health care provision. And I'm very intrigued by your website and what's occurring, and also a little concerned about the possibility that, you know, unhappy patients can try to get in multiple ways. And certainly in the LASIK world, there are whole websites devoted to complications, and then certain physicians will be spoken of, you know, based on one case.

And when we try to think about who is best capable of evaluating quality of care, it's really our peers, our peers in our specialty and, to a certain extent, peers not in our specialty.

And I guess maybe my request for your next project is, why not have doctors evaluate doctors? Don't do it through the best doctors of America, which is one way to do

it, but why not have doctors evaluate doctors and have those ratings become available? I know that's all the competitive and all that sort of issues, but who else better than those in their own peer group?

MR. GEBHART: I think that's a very valid observation. And let me respond to that a couple of ways. And I failed to mention this earlier.

It's interesting: We do not have enough ratings to really see what the true pattern is going to be yet. But the overwhelming majority of ratings that we have are quite favorable. So we find there's probably a greater propensity for people to get online and help their doctor out with, you know, thank you for a good experience.

Having any kind of a peer review function, it would be great to be able to present it. My immediate reaction was to try to figure out how to organize it, and that would take a little bit of work. But what we do provide is a survey that both the doctor and the patient can use that for any given condition displays what the evidence-based standard of care is. And an evidence-based standard of care is prepared by peers.

The doctor is able to get online and indicate whether or not they follow that standard, and then that standard is displayed to the member, to the user, so they can determine if what's happening in the process is indeed in

accordance with that standard.

So, you know, whether or not your doctor has a nice office staff and free parking and things like that, that's good to know. Whether or not you're actually going to get the treatment you need and they're going to follow a pattern that's been proven to be effective in the past, that's really where the rubber meets the road. And we try to help people with that as well.

MS. KOHRS: Well, I'm afraid that that's going to have to be our last word on the topic today. I'd like to thank everyone who was able to come and be a part of this panel, and I'd like to ask everybody to join in a round of applause at this point. Thanks very much.

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

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

DOCKET/FILE NUMBER: P022106

CASE TITLE: HEALTH CARE AND COMPETITION LAW AND POLICY

DATE: JUNE 12, 2003

I HEREBY CERTIFY that the transcript contained herein is a full and accurate transcript of the tapes transcribed by me on the above cause before the FEDERAL TRADE COMMISSION to the best of my knowledge and belief.

DATED: JUNE 11, 2003

LISA SIRARD

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

I HEREBY CERTIFY that I proofread the transcript for accuracy in spelling, hyphenation, punctuation and format.

SARA J. VANCE