Proceedings of the 15th Annual Managed Healthcare Symposium

MOVEMENTS IN HEALTHCARE LEGISLATION:
An Interactive Town Hall

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CONTINUING EDUCATION CREDIT FOR PHARMACISTS AND PHYSICIANS
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WELCOME MESSAGE

DAVID BRENNAN
President and Chief Executive Officer
AstraZeneca Pharmaceuticals LP

MARION E. MCCOURT
Vice President, Managed Care
AstraZeneca Pharmaceuticals LP

Winds of Political Change Blowing Through Healthcare

We appreciate your interest in the 15th Annual Managed Healthcare Symposium, “Movements in Healthcare Legislation: An Interactive Town Hall.” At the 2002 Symposium, held in San Diego, some of the most knowledgeable experts in the United States were invited to lecture, debate, and explore how the healthcare industry will be affected by current and emerging legislative and regulatory issues. These experts agreed that the outcomes of the 2002 elections would be significant in terms of addressing issues of patient privacy, safety, and access to care.

As the title of this program implies, attendees were encouraged to engage the faculty in discussion of how these issues might affect their own organizations. In this special continuing education supplement to MANAGED CARE, you will have the opportunity to share in these insights. James Carville and Sean Hannity, two highly provocative political consultants, debate current healthcare issues in Washington, while Timothy Trysla, policy advisor at the Centers for Medicare and Medicaid Services, outlines new and proposed regulations and their implications for Medicare reform. The conversation then shifts to a pair of panel discussions intended to clarify the effects of national healthcare policy at the local and organizational levels. James Canton, PhD, a healthcare futurist, talks about the role that technology can play in reducing costs through improving communication between payers, providers, and patients. Finally, a cross-section of thought leaders tackle the complexities of consumer-centric healthcare models.

AstraZeneca, a pharmaceutical leader, is committed to supporting valuable educational programs that provide insights and solutions to meet your organization’s strategic goals. Each session has been developed with your educational needs in mind. We hope the ideas presented here will spur innovative thought in your organization.
This MANAGED CARE continuing education supplement is based on information presented at "Movements in Healthcare Legislation: An Interactive Town Hall," a symposium in San Diego, Oct. 24-27, 2002, and attended by health plan medical and pharmacy directors, pharmacy benefit manager executives, physicians, pharmacists, employers, and representatives of the pharmaceutical industry.

The opinions expressed herein are those of the symposium faculty, and do not necessarily reflect the views of AstraZeneca, The Chatham Institute, or the publisher, editor, or editorial board of MANAGED CARE.

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This supplement is supported by an educational grant from AstraZeneca.

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When healthcare costs spike, government steps in. That has been the pattern since the 1960s (see Figure on page 3), when an abrupt increase in per capita private healthcare spending led to the establishment of Medicare. In the late 1960s, states countered cost increases with rate regulation. Congress responded to the next spike by enacting the HMO Act of 1973. President Clinton’s ill-fated Health Security Plan of 1993 was yet another government reaction to rising costs. In the current environment of double-digit premium inflation, a federal remedy seems possible. This time, though, it’s not clear what government can or should do — if anything at all — to make it better.

Opening statement by James Carville

In 1991, when I managed the Weicker campaign, healthcare was more of an accessibility issue than anything else. The commercial we ran said the Constitution gives a criminal the right to a lawyer, so why shouldn’t a working person have the right to see a doctor? This issue is coming back with ferocity, but it is going to be couched more in terms of affordability instead of access. Healthcare premiums have gone up about 14 percent a year, which means that 5 years from now, we will spend twice as much as we do today, assuming inflation of 1½ to 2 percent a year. That rate of increase is unsustainable. The largest impediment to business expansion is healthcare costs. Frankly, we’re going to have to rethink the way that we deliver healthcare in the United States. Most Americans receive their coverage from em-
Employers, who are increasingly dissatisfied with it. We’ll probably have to go to either a straight voucher or a single payer.

**Opening statement by Sean Hannity**

James and I will disagree on the size and scope and influence of government in people’s lives. When you compare our health system to what other countries have, it is second to none. We have a segment of society that thinks the government can fix the healthcare system, but I would argue that there are alternatives. The best proposal, I think, is the medical savings account. People would pay into that account, and if they don’t tap into it, then at some point that money can go back to them and their families.

My brother-in-law is a radiologist who gets less than 50 percent of what he bills and has to deal with a government telling him what he can charge for an MRI, a government that is regulating him to death, a government that does not provide incentives for him to increase the size of his business. Government is a detriment to the healthcare industry, and the idea that the government is going to solve its problems is a fantasy.

**Carville’s rebuttal**

There’s only one health statistic that the United States leads the world in: life expectancy after 65. And where do people 65 and older get their healthcare? The government. So if anybody thinks that Medicare is unpopular, I’d say get out there and run against it. Say we’re going to abolish the whole damn thing!

There are only three entities that pay for healthcare: the employer, the people, and the government. We’re probably moving toward a system that entails some combination of the three. The amount of time and money and energy that employers allocate to healthcare is enormous. That is going to double in 5 years.

Oh, and the government probably doesn’t tell your brother-in-law how much he can charge for an MRI — it just tells him how much it’s going to pay him for it. He can charge what he wants, but it’s going to pay him a set amount.

**Hannity’s rebuttal**

We’ve got to ask ourselves why people flock to the United States of America for their healthcare. When people in Canada need bypass operations and are put on a 6-month to 1-year waiting list, why do they mortgage their homes to come here for care? The free market brought us a medical system that is the envy of the world.

Now, put the government in that system. If you don’t think the quality of care is going to go down, if you don’t think that advancements in life-saving technology will decline, you’ve got another think coming. Government is not the answer. The first thing we can do is to avoid putting the tax burden on business, so that business has the money to afford health coverage for employees.
**SUE BAILEY, MD:** Where should government get involved — at the local or the federal level?

**CARVILLE:** The challenge we face is the 44 million people who are uninsured. These tend to be people who work, and a lot of them have a choice between working and not having health insurance or quitting and having some form of insurance, which is kind of a cockamamie system. We should reward work, but for these people to obtain some form of coverage, the temptation is not to work. Now, if costs and the number of uninsured keep going up, there will be some pretty radical proposals coming forth. My point is that there will be some serious rethinking of this issue, and those of you in the middle had better come up with ideas and participate in this process.

**HANNITY:** Look, I’m not saying the government doesn’t have a role to play. The problem has been in the way we help people. Local and federal governments have created programs that foster dependence on them. That is not working. I urge you to look at where the government has been actively involved. These programs have been a failure. The former Soviet Union had guaranteed healthcare. The quality wasn’t very good, but it had it. And it had a standard of living that was not the envy of the world. Locally and federally, there are roles we can play, but the best thing we can do is to keep the economy running so that jobs and opportunities exist and so that people can be more independent. Our founding fathers warned about relying on government for every aspect of your life. These guys in Washington and at the local level will never give you the answers they promise. I guarantee it.

**DAVID CHIN, MD, MBA:** The central question, under either the right or left scenarios, is, “Who is going to pay?”

**HANNITY:** Who is going to pay? Who is going to provide for your housing? Doesn’t everybody need a home? Who’s going to buy your breakfast this morning? Who’s going to pay for your car and your gas? At what point do we say this ends? I don’t understand the mindset. If we want a long-term solution that doesn’t reduce the level of care or the pace of technological advancement, we have to encourage a system that relies on the individual. If you’re not paying for your own healthcare, you are more likely to access the system. If you have a back problem, you go to the chiropractor again and again, even though you may not necessarily need it. Shouldn’t people be rewarded if they don’t tap into the system?

**CARVILLE:** Say you’re here, at this hotel, and you enjoy a nice breakfast of fresh fruit and beautiful pastries and made-to-order omelettes. Later, you’re by the pool, and the contract employee who’s watering the plants sits down and eats a bologna sandwich. That doesn’t bother us. We are willing to accept this sort of disparity. But if that guy drops to his knees with a heart attack, we are not willing to let him sit there. We will put him in the car, take him to the closest hospital, and make damn sure he gets the best care he can get. Somebody’s got to pay for it! If a kid walks in with a cleft palate, we don’t say, “You don’t have health insurance, so you’re not going to get any help.” If a pregnant woman is overweight and has diabetes and high blood pressure, we are not going to accept second-class care for her, no matter who she is. All of these costs add up. That hospital has to recoup that by charging the government — or getting higher premiums from people like you.

**HANNITY:** James is right, we’re not going to let that guy die. But the system we have already takes that into account. If you are having a heart attack, there’s not a hospital in America that is allowed to turn you away. But when we go from the emo-
tional to the implementation of what James is saying — if the government gets involved — then look at the current models. It’s not better in Canada or England.

**Question-and-answer period**

**QUESTION:** What is your take on the statement that every system the government is involved in is in horrendous chaos and has been an appalling disaster?

**CARVILLE:** I would suggest that Medicare is hardly a complete fiasco. I would not agree that the national parks are in meltdown. Nor is the military. I would remind you that we reduced the poverty rate among the elderly by more than two thirds, that we have made significant advances in environmental protection, and that the government funded the polio vaccine. In my home town of Carville, La., the federal government ran the center for the treatment of Hansen’s disease, where surgery to treat this problem was developed and is still used today. Does the government do some things badly? Sure. Does it do some things well? Sure. But to suggest that the government has never done anything right is absolutely ludicrous.

**HANNITY:** What wasn’t brought up is the burden on American families. You all know what it’s like. You work 5½ months a year to pay your tax bill. Whatever government expansion we are talking about is fraught with waste, fraud, and abuse. We have almost complete redistribution of wealth in this country. The top 5 percent of wage earners in America pay 55 percent of the taxes, and the bottom 50 percent of wage earners pay less than 5 percent, according to the latest IRS statistics. There is only so much that the system can take until you reduce incentive and investment; technological decline will follow.

**QUESTION (to Hannity):** Your facts about Canada are wrong. That the United States is perceived to have the best healthcare in the world is wrong. There is no evidence that the United States provides higher-quality care than any Western European country. What concerns me is that both of you have stuck to ideologies that never made progress in solving American healthcare problems.

**HANNITY:** Some of the countries you mention have a tax burden of 70, 75, 80 percent. I don’t know if that’s the model that you would like America to follow. I certainly don’t. Now, let me just address your challenge that I don’t have my facts correct on Canada. I’ve interviewed Canadians who have had to wait months and months when they needed bypass surgery. Those are facts.

**REPLY FROM QUESTIONER:** Your interviews are not a scientific study. HANNITY: Get a hold of the Detroit Free Press or any border-state newspaper. They have chronicled example after example of why people leave Canada and use their own money to pay for care in the United States. The system there has failed them.

**CARVILLE:** In every satisfaction survey regarding healthcare, Canada beats us substantially. The biggest detriment to economic growth is the rise in healthcare costs.

**QUESTION:** If the government takes over and says, “These are the payment rates,” what is going to happen to medical quality?

**HANNITY:** My brother-in-law advises people not to go into medicine for that reason.

**CARVILLE:** The government is under fiscal pressure, so it says, “We’re going to limit what we’re going to pay for this.” Does anybody think that managed care companies don’t limit what they pay for a procedure? Of course they do! The idea that doctors are quitting medicine because the government doesn’t pay enough for some procedure while the marketplace is letting these guys get what they want is ludicrous. To stay ahead, you must limit what people get and when they get it.

**CHIN:** Please join me in thanking both Sean and Jim for a very entertaining debate.
Continuing Education Section

Continuing education is offered to physicians and pharmacists who read pages 7 through 26 of this publication, complete the self-test on pages 27 and 28, and fill out the appropriate evaluation form on either page 29 or 30.

Course description

This activity is designed to educate healthcare professionals about current and emerging healthcare issues. The narratives in this section are excerpted from presentations and panel discussions on Oct. 24–27, 2002, at the 15th Annual Managed Healthcare Symposium, “Movements in Healthcare Legislation: An Interactive Town Hall,” held in San Diego. The symposium speakers and panel members discussed political issues affecting healthcare, including Medicare reform, prescription drug benefits, Medicaid, and the Centers for Medicare and Medicaid Services’ (CMS) stance on healthcare policies related to various types of healthcare systems.

Educational needs assessment

Healthcare professionals at the senior management level request information about the status of current and emerging healthcare policy and treatment issues, as well as the potential effects of these on their organizations. The symposium agenda was developed on the basis of evaluations of invitees who have attended previous Managed Healthcare Symposia and on faculty perceptions of significant trends or issues.

Target audience

Managed healthcare professionals, including medical directors, pharmacy directors, and other senior managers in managed care organizations.

Educational objectives

After reading this publication, the participant should be able to:

• Explain the politics of healthcare and the effects thereof on the physician, the pharmacist, the employer, the consumer, and his/her organization.

• Define current issues involving Medicare reform, Medicaid policy, access to care, and the effects of these on the healthcare system.

• Describe how the new CMS regulations will influence the delivery of pharmaceuticals.

• Summarize how information technology can improve communication between payers, providers, and patients, thus enabling all parties to meet emerging challenges in healthcare delivery.

• Outline ways in which a healthcare organization can identify Internet business opportunities.

• Elucidate ways in which technological advances can help healthcare entities reduce the cost of care delivery.

Continuing medical education accreditation

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of The Chatham Institute and MediMedia USA.

The Chatham Institute designates this continuing medical education activity for two (2) hours in category 1 credit toward AMA Physician’s Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

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Release date: Feb. 15, 2003, for a period of one (1) year.

Pharmacy accreditation

The Chatham Institute is accredited by the American Council on Pharmaceutical Education (ACPE) as a provider of continuing pharmaceutical education. This program is approved for 2 contact hours (0.2 CEU). Credit will be awarded upon completion of registration form, successful completion of assessment questions, and completion of program evaluation.

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Planning committee members

Arnold Henning Seto, MSc, PharmD, scientific director, The Chatham Institute; Tamar Small, executive director, The Chatham Institute; Timothy P. Search, RPh, group publisher, Managed Care, a division of MediMedia USA; Paul Pinsonault, president, Pinsonault Associates; Christian Pinsonault, managing partner, Pinsonault Associates; Tony Pinsonault, managing partner, Pinsonault Associates; David Quirk, healthcare consultant, Pinsonault Associates; Dawn Fitzpatrick, University of Utah College of Pharmacy; Diana Brixner, RPh, PhD, University of Utah College of Pharmacy.

Conflict-of-interest policy in continuing education and disclosures of significant relationships

The faculty for this activity has disclosed financial interests, arrangements, and/or affiliations with corporate organizations offering financial support or educational grants for continuing medical education activities, as well as those organizations with a direct interest in the subject matter of this activity. The following faculty members have declared that they have no financial interest, arrangement, or affiliation that would constitute a conflict of interest concerning this educational activity: Craig Beam; James Canton, PhD; Ray Hanley; J.D. Kleinke; Jonathan T. Lord, MD; Cynthia Pigg, RPh, MHA; Randall Ricketts, DO.

Content reviewer

Arnold Henning Seto, MSc, PharmD, scientific director, The Chatham Institute.
S\imply overlaying a prescription drug benefit on Medicare doesn’t fit the Bush administration’s vision for the program. Timothy P. Trysla, policy advisor to Centers for Medicare and Medicaid (CMS) Administrator Thomas Scully and leader of the Bush Task Force on the Prescription Discount Card Program, says a prescription drug benefit is part of a larger strategy to reform Medicare.

The 2002 elections were significant. In the last session of Congress, there was deadlock on healthcare issues. Now, with a workable majority, it is the administration’s hope that bills will be passed. Congressional leadership is needed to make this a reality.

In the past couple of years, there has been debate about whether to have a prescription discount card and a prescription drug benefit in Medicare, but there hasn’t been agreement about how to do it. In Washington, it’s not about the money — but it’s always about the money. The amount of relief you are going to give to the elderly is important. But the real key — and this is how healthcare reform actually gets done — is in understanding that Medicare and Medicaid consume $700 billion a year, making them the largest budget in the federal government. When you are dealing with hundreds of billions of dollars, the idea that you are going to make top-down pricing calls represents an exercise in futility. You can say that you are going to work out a fair payment methodology, but it is difficult for a bureaucrat or a member of Congress to determine an appropriate payment rate for a physician who sees a patient in the office. It takes a host of lawyers, economists, and physicians to make those calls correctly.
Republican Rep. Charles Norwood, of Georgia, often talks about a “perfect storm” when referring to all of the issues facing healthcare: the increasing number of people without health insurance, retiring baby boomers being added to federal programs, the fact that Medicaid costs have actually outgrown Medicare costs, and Medicare reform—which Federal Reserve Chairman Alan Greenspan says is going to make Social Security look like a cakewalk. House and Senate Democrats and Republicans are committed to doing something. But what—and how?

For us at CMS, the most significant driver is that 70 to 80 percent of hospital costs are for treatment of chronic conditions. Many of the people attending this conference are responsible for some of the most innovative therapies available today. To these people, whether the structure of a prescription drug benefit provides for the research dollars that will create incentive for innovation is the crux of the debate.

A prescription drug benefit, however, will take time to implement. Our first step, as part of overall Medicare reform, is to stabilize the Medicare+Choice (M+C) program, then get a drug discount card in place, then enact a prescription drug benefit.

**Prescription drugs**

When we talk about Medicare reform, we are talking about a whole host of things. We have a $100 deductible for Part A—which is based on 1965 dollars. We do not have catastrophic coverage. And then there is the drug benefit.

Sixteen percent of Medicare beneficiaries receive prescription drugs through M+C plans. Over a 3- or 4-year period, M+C enrollees have been losing their access to prescription drugs (Table 1). If Congress had realized [when it passed the Balanced Budget Act of 1997] that, in essence, it had voted to take away prescription drug coverage, I don’t think you’d have the current circumstances [where health plans are withdrawing from Medicare] in place. This is why the administration thinks the first step in reforming Medicare is to stabilize and support the M+C plans.

One of the things that the administration is focused on is the educational initiative that has to happen in this country. You may remember that, in 1998, Congress passed a catastrophic healthcare plan for the elderly; it was a pure insurance model. It was repealed in 6 months. The people who had to pay saw the up-front costs but not the benefit. Educating beneficiaries about their benefits, their value, and appropriate utilization will help us avoid the same situation with prescription drugs.

Three years ago, more than three quarters of those enrolled in a M+C plan had a $0 prescription drug copayment in their basic plan (Figure 1). The change in out-of-pocket costs that is occurring is significant. It’s possible that you will see [comprehensive Medicare reform hinge on a cost tradeoff, such as] a $1,000 deductible [for prescription drug coverage] in M+C, in exchange for catastrophic coverage. That’s going to be a significant cost shift to the elderly. And given the fact that a much larger share of people in this country will be over 55 in a few years, maybe that is a good societal answer.

**Discount card**

The basic tenet of our prescription discount program is this: Everybody has the benefit of a negotiated price for a drug. Many health plans have said it will take 5 to 6 years for CMS to implement a prescription drug plan from the day a bill is
passed. If so, then one thing we want to do is to get started on reducing the overall out-of-pocket cost to the elderly by sharing in some of the drug-discount mechanisms now enjoyed by the under-65 market. Pharmacists [the National Association of Chain Drug Stores and the National Community Pharmacists Association] sued us to stop us from implementing our plan, but the entire framework of our benefit program was simply to get a negotiated rate and go for the rebate dollars that large employers get now.

We are trying to organize group-purchasing blocks. A beneficiary would call 1-800-MEDICARE with his ZIP code to get a Medicare-endorsed discount card. The problem with the current market is that people can have five or seven discount cards from different pharmacies. With this, there is one card, one set of rules. These different programs have different rules and systems. Some require that you go back to the doctor every 30 days to get an updated prescription; others limit you to one or two prescriptions. We would enact minimum regulation for the PBM industry, such as uniform enrollment, information, and marketing guidelines.

For the government, there are issues related to implementation: How do we get negotiated prices? How do we administer and run a prescription-discount program? How do we educate the elderly? How do we articulate ways that beneficiaries can piece through all of this and make sound economic and healthcare decisions?

We have taken steps through our regulatory authority to make this a reality. We were enjoined to do this by the courts by the pharmacists, but the main thing is that this is an education initiative, to avoid the problems that occurred in 1998 with the catastrophic plan — people not understanding their benefits or how they would be charged for them — and more importantly, to ensure that they are educated about formularies. The elderly are savvy buyers — they know where to shop for groceries or automotive services — but they need a single source of comparative information to help them make healthcare decisions. If the federal government is paying 70 to 80 percent of their hospital costs and about 60 percent of their overall healthcare costs, then we think we have a fundamental role in providing that information.

### Modernizing M+C

One significant thing we are trying to do through regulatory fashion is to bring integrated health systems into a model for managed care. We have learned, through

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<th>Month</th>
<th>Share of enrollees with $0 copayment</th>
<th>Share of enrollees with copayment</th>
<th>M+C enrollees with no prescription drug benefit*</th>
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<td>77.6%</td>
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<td>6.8%</td>
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<td>28.0%</td>
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* In the basic plan.

**FIGURE 1 Prescription drugs: M+C’s disappearing zero copayment**

Source: Centers for Medicare and Medicaid Services, Washington, 2002

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AN INTERACTIVE TOWN HALL / MANAGED CARE
our disease management (DM) demonstrations for diabetes, heart care, and other chronic conditions, how to structure a federal payment system that encourages wellness and crossdisciplinary care. The current Medicare program doesn’t do this, it doesn’t provide the incentives to do it, and it doesn’t necessarily have a patient-focused approach on how to deliver care. This administration is pushing the envelope, trying to take the best ideas in the private sector and use our demonstration authority to offer this type of integrated care — basically, to modernize healthcare. The biggest concern is that everybody wants to modernize this program, but when you are talking about modernization, beauty is in the eye of the beholder.

The most significant thing that we can point to, in terms of how modernization can work, is what’s going on in the current market. In counties where five or more M+C plans compete, competition works (Figure 2). In these markets, there is more extensive drug coverage and other services. To some extent, we have results to show that competition does work if the private market is given the right incentives.

**QUESTION:** A Medicare drug benefit would rely on PBMs and the use of industry to carry us through. One way to get discounts and lower prices is through rebates — yet wouldn’t the CMS guidelines seem to end those kinds of rebates?

TRYSLA: There are guidelines, and there are proposed guidelines. A strict reading of the proposed guidelines would seem to put the PBM industry in a precarious position. My drug card team has the same concerns you have. The delivery of a drug benefit won’t work without the rebate system now in place for the under-65 market.

The Department of Justice is already looking into the PBM industry, and a lot of federal attorneys have tried to enact compliance programs through fraud-and-abuse investigations. My message is to work with the Office of the Inspector General, because it is better than doing this through litigation. Many of the proposed guidelines reflect PBMs’ current practices. Putting these guidelines in place is not so bad if the alternative is litigation or, worse, something purely political that forces you to justify your existence to Congress. We can’t do to the PBM industry what happened to the managed care industry, where court cases have dictated whether we can enact a cost-saving mechanism.

An educated debate will result in reasonable guidelines. Democrats and Republicans are relying on the PBM industry to be the mechanism to save the government money through competition. They have a vested interest in making sure this industry is prosperous, because the government doesn’t have the technology [to implement this program].
QUESTION: Shouldn’t there be some kind of education about appropriate use of medications? Educational programs for providers about antibiotic use in respiratory infections have resulted in a precipitous drop in inappropriate antibiotic prescribing. I see the government doing very little to educate the physician, provider, or patient.

TRYSLA: We have been aggressive in trying to do that on a couple of different fronts. The discount card is an educational initiative designed to do exactly that — talk to Medicare beneficiaries, so as to change not only the behavior of their physicians and pharmacists, but also to educate them about their options and familiarize them with the terminology. We have an incredible Web page, but by and large, the elderly aren’t on the Web. So, we try to do this through our 800 number, individual by individual.

We also are looking at how we can put DM programs in place. These are a panacea to some and a fraud to others, but we think they are a significant way to get multidisciplinary teams in place to look at the whole patient. Hospitals may not accept risk for the entire Medicare population, but if they receive a lump payment for a certain number of heart patients and if we tell them that we would give them a dietician and a physical therapist to work with these patients, they could make a profit. That’s what we are trying in the area of integrated care, though it has been done in a piecemeal way, because we are allowed to change the benefit structure only through demonstration programs. We don’t have any other authority to do DM.

So, to answer your question, we are working with patients and large physician groups and putting incentives in Medicare to do exactly that: educate. It is a huge initiative to understand how beneficiaries make their medical decisions. Largely, they still rely on their doctors’ advice. If you really want to control costs, you have to control how physicians practice medicine. To do that, you either go to the patient and make them ask their doctors, or go straight to the docs. And then, when you go straight to the docs, you get criticized for pushing cookbook medicine.

QUESTION: With the drug-discount plan, I think it is relevant to ask who picks up the difference in cost. Retailers seem united in opposition to this plan, because they think that they are the ones who will absorb the discount. I don’t think the community pharmacist can absorb it. I think you need to rethink that.

TRYSLA: Independent pharmacists will play an important role; we have network-adequacy requirements in rural and urban areas that would require PBMs or whoever sponsors the discount program to enroll a certain number of pharmacists depending on population density. In addition, we would require pharmacists to amend their contracts to name Medicare as handling this book of business. If you are going to use the Medicare name, you are going to have to sign a contract with us and say you will abide by certain rules. We think this is going to bring uniformity.

More important to your basic economic question, the community pharmacists will be able to open up their contracts with PBMs and renegotiate them. We’re not interested setting prices. The big threat to pharmacists is mail order, but we have made a specific attempt to say that if you are a mail order program, you can’t be a Medicare-endorsed program — yet we still want beneficiaries to have access to that. So, it’s a delicate balance. We wanted to be fair and to put independent pharmacists on a level playing field.
Integrating Medicare to provide a drug benefit to the elderly will take the cooperation of government and private sectors. Can the two work together to decide how to implement drug coverage and other reforms without crippling private-sector initiatives? A panel discusses these and other current issues in Medicare as well as how to develop models that can promote reform.

SUE BAILEY, MD: Regarding the quality and cost of government-managed healthcare programs, is failing to prescribe appropriate drug therapy a greater problem than overprescribing drugs?

TIMOTHY P. TRYSLA: Yes. It is important to understand the challenge of structuring incentives for those who make decisions based on cost. Currently, cost analyses are based on viewing a particular price in terms of its effect on a budgetary system. For example, in an outpatient prospective payment system, drugs are either a pass-through expense or priced on an ambulatory patient classification system. Although these are currently the best pricing mechanisms available in government-based programs, they are not necessarily based on sound clinical information.

KATHLEEN E. MEANS: Medicare officials have determined that a medical care package that includes a drug benefit is bound to result in cost savings. There is evidence that appropriate drug therapy can avoid unnecessary or inappropriate hospital admissions. Based on my experience in Congress, I think it is possible to provide quality while promoting cost savings. The United States has enough wealth to provide quality healthcare. The issues that must be addressed are not deductibles and copayments, but the designs of the programs and formularies.

TRYSLA: Seventy to eighty percent of hospital costs are due to treatment of chronic conditions, many of which are being addressed through innovations in the pharmaceutical industry. However, as fundamental inside-the-beltway conservatives, we typically don’t allow for “dynamic scoring” — that is, to consider the achievement of higher economic productivity (lower hospital costs) from a larger investment in preventive measures (coverage of prescription drugs). We might also benefit from putting more money into educating those taking the medications. For example, the elderly cost the healthcare system a large amount through hospitalizations that are a consequence of drug interactions.

CYNTHIA J. PIGG, RPh, MHA: As healthcare administrators, we have a responsibility to educate consumers. For example, if a person smokes, there are consequences — and we should be there to help those people make healthier decisions. While we can’t look over everyone’s shoulder to make sure that they are following our recommendations, we can at least be sure that we have provided the information.
MEANS: While working on the Senate Finance Committee in 2000, I participated in adding explicit authority to the statute enabling the Centers for Medicare and Medicaid Services to carry out disease management (DM) and lifestyle-modification studies. CMS has begun to award contracts to carry out these studies.

TRYSLA: These DM and lifestyle studies will provide a good opportunity to analyze how to structure managed healthcare in the future. Medicare reform is a continuum of finding ways to institute preventive education in the current system. Preventive education is widely available to those under 65, but it is needed the most for those who are 65 and older and to whom healthcare is a primary concern. The current Medicare administration is committed to pushing the envelope on education over the next 3 to 4 years to determine the benefit of integrated healthcare systems for the older adults.

MEANS: The structure of Medicare today does not allow for a patient-oriented, integrated healthcare system. Hospitals, nursing homes, physicians, and other healthcare providers operate independently. A lack of clinical and economic integration makes these systems difficult for patients to navigate.

PIGG: I don’t think this problem of fragmentation exists solely within Medicare; rather, it is endemic throughout the healthcare industry.

MEANS: At present, those dually eligible for Medicare and Medicaid benefits are presented with challenges stemming from the fact that the underlying benefits of these programs are different. To provide lower-income patients with economic relief to bridge the gaps — such as prescription drug coverage — the system must be modified. One of the more interesting proposals to emerge from last year’s Congressional debate on prescription drugs is a stronger commitment to federalizing the dually eligible population. This would mean that Medicare would take complete responsibility, including prescription drug coverage, for this population.

TRYSLA: A major driver behind Medicare reform is the fact that there is a substantial population of retired citizens who receive healthcare coverage through their former employers but receive little to no benefit from Medicare. This places a financial burden on the employers, who may opt to discontinue these benefits. In the proposed system, the retiree benefit from an employer would be changed from its current function as a wrap-around of whatever the federal plan provides. Currently, the government pays a fee akin to a deductible and the employer benefit makes up the difference. In the proposed system, however, the employer would meet a certain amount in the payment of medical benefits, and the government benefit would make up the difference. This proposal may save the existing retiree-benefit system.

BAILEY: On the subject of access, some diagnostic procedures force us to question disparities in healthcare coverage in the United States. For example, a CAT scan will allow a physician to see, in a quick noninvasive procedure, whether there is calcium buildup in the coronary arteries. This can be seen possibly 15 years before a cardiac event, and it allows for intervention with lifestyle changes, surgery, or medication as prevention. The procedure can cost up to $1,000, however, and not all patients have coverage that would allow for this. Is the fact that some patients are able to have such a procedure a case of medical elitism?

PIGG: Medical elitism has caused us to be fixated on the idea that more-expensive medicine is better-quality medicine.
forms that include coverage for everyone. I have not read any studies that indicate that a CAT scan to detect calcium buildup can predict cardiac outcomes, so I can’t begin to argue that this expensive diagnostic test could prevent catastrophic costly events. Perhaps managed healthcare companies can decrease elitism by more uniformly determining which procedures or treatments are covered and base those decisions on scientific data.

**MEANS:** There certainly are procedures, however, such as a colonoscopy or bone-density testing, that have scientific merit and data to support their use but still provoke questions as to whether they should be covered. What is needed is not a debate over who gets what, but a deeper political discussion on the design of Medicare. The Bipartisan Commission on Medicare Reform suggested that, over a 10-year span, Medicare be remodeled on the Federal Employees Health Benefits Plan. The concept is that the government would contract on behalf of beneficiaries with national and regional health plans. It would not be like Medicare+Choice, where plans set market-based premiums; rather, plans would negotiate prices with providers on a range of services. The government would step back from implementing pricing systems like the Diagnosis-Related Group (DRG) system for hospitals or the Resource-Based Relative Value Schedule (RBRVS) for physicians. So, instead of the government directly regulating prices, the plans would develop their own schedules based on the benefit package being offered. This has been a difficult political debate. The pharmacy benefit management model being discussed in Congress is a retreat from this idea. The PBM model does not turn Medicare into an integrated benefit package. Instead, the drug benefit becomes a silo isolated from the rest of the program.

**TRYSLA:** In the current system, the silo-based payment methodology has no incentives or cross-disciplinary interaction to look at the whole patient. A good deal of money can be made from Medicare from fraudulent practices because of the lack of integration.

**MEANS:** When I was working with the Senate Finance Committee, many members of the committee expressed enormous anger and frustration at having to make decisions on fee schedules, dispute resolution, new benefits, hospice payments, and the like every year. One very prominent member of the Senate threw a fit and said, “This is not what I was elected to the United States Senate to do. These are important issues that need to be addressed, but not by United States Senators — because what do we know about health care?” And he was right. None of those senators had any medical background whatsoever. What they are struggling for is a model in which the government provides the underlying financing for benefit decisions to be carried out. This is a major reason that the government is interested in changing the way it interacts with healthcare plans. Medicare+Choice plans are every bit as much under an administered pricing system as are hospitals with DRGs and physicians with a fee schedule. This net-premium system has broken down, and this has damaged the capacity of these plans to operate within the framework of Medicare.

**TRYSLA:** It’s interesting that when you gather together a group of individuals who work in healthcare, it is usually the government official who is the least educated in the room, and this panel discussion is no exception. To have members of Congress deciding whether a mother stays in a hospital for 48 hours after childbirth is a ridiculous way of providing healthcare. The real debate that is going on in Congress is, “Is the system working for the 80-year-old widow?” The administration is committed to making these reforms so that the private sector still has the ability to provide the benefits, with incentives to base the benefits on clinical research. The question is how to create incentives that won’t cripple what is currently being done in the private sector.

**MEANS:** It’s exciting to hear managed care principles being extolled by the administration. I hope that we can assist you in the challenge to tackle these issues and let the market forces work.

**BAILEY:** Thank you, panelists.
How are states adopting managed care concepts? Can state programs continue to evolve along a budget-neutral path while adopting these concepts? The panelists review the past and present to determine how government-funded healthcare can serve beneficiaries — and stay afloat.

DAVID CHIN, MD, MBA: I’ll ask each of you to share your perspective on this topic. Ray?

RAY HANLEY: I began my work in Medicaid for the state of Arkansas, in 1984, when I had a budget of $200 million for drugs, nursing homes, and hospitals. In 2002, my budget approached $2.5 billion. Medicaid began as an afterthought to Medicare, as a program for extremely poor women and children. Since then, the number of people who receive Medicaid benefits has risen significantly. In Arkansas, 47 percent of obstetric care, 75 percent of nursing home care, 40 percent of pediatric care, and 80 percent of mental healthcare is paid by Medicaid. While patients on Medicaid receive full reimbursement for inpatient and outpatient costs, as a group these people are the sickest and the most frail in the state. Most would never qualify for paid insurance, simply because of the risks they present.

Over the last few years, states have taken measures, such as using their Medicaid programs, to reach out to the uninsured. However, Medicaid is a leaky boat. As the economy has suffered and people have been bumped off of employer health plans, the number of recipients of government health benefits has risen. Many states face an impending fiscal train wreck; 41 states are in deficit. The year 2003 will be worse, because there is no renewal of revenue to support one-time funds that were established to get states through 2002. In the private sector, insurance premiums are, in some cases, rising 30 or 40 percent, employers are dropping benefits or taking dependents off of them, and many who fall victim to these cuts are coming to Medicaid for help. Cost containment is bound to fail when enrollment is rising.

DAN MENDELSON: One way states can adopt managed care principles is by using the increased flexibility being granted by the current presidential administration to spread health benefits to more people. For example, a waiver was recently approved for Oregon to reduce Medicaid coverage by approximately 25 percent for certain populations to cover an additional 60,000 people. States can also implement disease management (DM) techniques. Finally, many states have patients who are eligible for both Medicare and Medicaid, increasing the cost burden. The issues inherent with these “dual eligibles” can be addressed with an integrated healthcare plan, though that would require more flexibility in program design.

Many states have a limit on how many brand-name drugs Medicaid will cover per patient. For example, if a state will cover four brand-name drugs and the patient...
needs five, he or she will not get the fifth. I do not see this as applying managed care concepts, but as using blunt instruments for cost containment. It could be argued that such lack of access violates the Early and Periodic Screening, Diagnostics, and Treatment (EPSDT) statute that entitles certain populations to care. DM is an important principle of managed care that must be applied to Medicaid if states are determined to limit the number of drugs that can be prescribed.

HANLEY: The Medicaid population has every chronic illness and diagnosis known to science, so applying disease management can be challenging. At present, we have a wealth of information about patients who receive Medicaid benefits. However, we don’t have the resources to work with patients and physicians to develop a DM strategy. Asthma is a good example. Asthma is the primary reason children visit the ER and are admitted to the hospital. It has been found that many children and their parents don’t know how to use inhalers and medications properly. DM techniques would help those working with Medicaid families to teach them how to use medication and devices to control this disease.

About 40 percent of the United States population is overweight and at risk for diabetes, yet only 15 percent of American healthcare dollars go to diabetes education and management. When looking at the underlying factors and causes of diabetes, whether it is diet, lack of exercise, ignorance about how to check blood-glucose levels, or underdiagnosis, it becomes apparent that there is no chronic disease more ripe for management and positive intervention, with great potential for saving money.

STEPHEN E. CHIES: While prevention is undoubtedly a good strategy, who will pay for these programs? This is the same struggle that HMOs face. How do you make the case to senior management that an investment of $100,000 or $300,000 for education will pay back 10- to 20-fold in 5, 10, or 15 years? Ray’s problem is that he’s got a legislature that doesn’t want to hear about spending on preventive measures, but about how to reduce Medicaid expenditures.

MENDELSON: We must establish systems that influence providers to do the right thing.

HANLEY: Give the states more control over patients who are dually eligible for Medicare and Medicaid, so that we can lock them into a managed care system with a formulary. If we are going to take on a pharmacy program to extend coverage to beneficiaries, then allow states to claim the savings required to prove cost neutrality stemming from reductions in Medicare hospital and physician costs. Under existing rules, states must demonstrate cost neutrality in the waiver application, but can’t claim credit for the savings that will accrue to Medicare. This is ridiculous. If granting a drug benefit to the elderly will improve their health, it makes no sense to not claim that savings. If the administration doesn’t want to change these rules and would rather put them into Medicare than granting Medicaid more power to handle dual eligibles, then fine. The administration can show that it worries far more about the under-65 population than older Americans.

CHIES: If I had the ear of President Bush, I would tell him that the plan in place is ineffective and contrary to the direction in which we should be headed. We should give the responsibility for the under-65 population to individual states and the responsibility for the 65-and-over population to the federal government. I would advise that the government roll back some barriers in place for Medicare benefits: the 3-day hospital stay limit, the overly strict skilled-nursing definition, and the $100 copayment for skilled-nursing benefits. I would then advise the start of a massive public education campaign to inform families and the elderly about the effects of chronic illness.

MENDELSON: Every state in the nation is in dire circumstances; there are going to be enormous fiscal problems across the board if the president doesn’t loosen up on federal matching rates. I would like to see more generous Medicaid payments for DM programs, even if these payments were at the expense of other programs. Sadly, the best advice I can give the president about Medicare is to sit tight for a few years. I don’t see much political payoff for the president in Medicare.
QUESTION: What is the future of capitated Medicaid programs?

HANLEY: Arkansas doesn’t have a capitated program. We have a successful primary care model, under which 2,000 physicians participate and are asking for four times the number of patients we can provide. It has cut emergency room use by 60 percent. I think capitation has lost the ability it once had. The California Public Employees’ Retirement System, which covers 1.2 million people in the state on a capitated basis, had to absorb a 25-percent rate hike this year. This is a scary example of the financial problems that can occur with capitated programs.

MENDELSON: One area that may benefit from federal capitation is the dual-eligible population. Currently, funding is fragmented and is going to many different providers. Some payments are made by Medicaid, some by Medicare, but no one can isolate how much is coming from where. Moving these individuals to a more tightly managed, capitated environment would be positive from a care-continuity perspective.

HANLEY: More than 25 percent of Arkansas’s drug budget for Medicaid pays for dual eligibles. Many of the drugs prescribed for this group are antidepressants and antipsychotics. We have taken profiles from some of our nursing home patients and presented them to the American College of Psychiatry for analysis. The results indicate that the drugs that are prescribed are either inappropriate or are used improperly. Part of this can be attributed to the fact that few psychiatrists actually prescribe therapy for mental illness. In rural Arkansas, most nursing home patients are treated by general practitioners who may not know how to use antidepressants or antipsychotics.

To combat this problem, we have begun to try to get funding from pharmaceutical companies to create a team effort to consult with doctors who treat patients in nursing homes where we have identified problems. Changing the prescribing patterns of attending physicians is one area where we could cut the drain on Medicaid funds. We have had some success with this, but not nearly enough, due to lack of interest on the part of physicians and medical directors.

CHIES: While I think you are taking pot shots at medical directors, I don’t completely disagree with you. Doctors don’t have the same incentives to work with agencies in long-term care settings as they do in acute-care settings. In long-term care, patients often don’t get better, and doctors are not fond of this type of practice. To solve the problems that exist in long-term care, a peer-to-peer discussion is needed with physicians, pharmacists, nurses, survey agencies, and Medicaid administrators to discuss the approach for delivery and payment of services.

HANLEY: If disease management is done correctly and efficiently, then more money would be spent on drugs. A perfect example of where we need disease management principles is for those who have diabetes but who are undiagnosed. These people need medication but they’re not getting it. Meanwhile, we are wasting money on duplicate and triplicate therapy in mental health. So we have to solve these problems before we can find the funds to practice disease management in other areas of medicine that warrant attention.

CHIN: I would like to thank the panelists for sharing their thoughts on how managed care concepts can be used to improve government-funded healthcare.
TOWN HALL

Healthcare’s Future
Consumer-Centric Models

THE FACULTY

MODERATORS

David Chin, MD, MBA
Principal, Healthcare Consulting Practice
PriceWaterhouseCoopers

Sue Bailey, MD
Former Assistant Secretary of Defense for Health Affairs
Analyst, NBC News

PANELISTS

Craig Beam
Chairman
American Heart Association

Jack Bruner
National Health Care Practice Leader
Hewitt Associates

J.D. Kleinke
President
Health Strategies Network

Jonathan T. Lord, MD
Senior Vice President and Chief Innovation Officer
Humana

Randall Ricketts, DO
Family Practitioner
Monarch Health Care IPA

LORD (second from left): People who are involved in the decision-making process have lower rates of resource consumption and better outcomes. From left; Bruner, Lord, Kleinke, Beam, and Ricketts.

SHOULD PATIENTS HAVE MORE RESPONSIBILITY FOR THE FINANCIAL ASPECTS OF THEIR HEALTHCARE? A group of managed healthcare experts focuses on this question and its relation to unnecessary healthcare spending. A spirited discussion supporting, doubting, and debating the merits of consumer-driven healthcare follows.

DAVID CHIN, MD, MBA: In the United States, we claim to have private healthcare, but in the typical definition of a private market, there is a buyer and a seller. Under this definition, the patient would be the buyer and the physician the seller, and a financial transaction would take place between the two parties. In healthcare, however, the patient exchanges little or no money with the physician. Would creating a higher level of financial responsibility for consumers make sense?

JACK BRUNER: Yes. A recent Hewitt survey of 550 major employers in the United States revealed wide variation among companies in terms of the level of cost sharing with employees, selections for dependent coverage, the plans that individuals choose, the providers that individuals choose, the pharmaceutical remedies that are prescribed, and the providers’ participation in disease management (DM).

These decisions are personal and emotional, and many health plans that previously drove the answers to these questions are now reluctant to do so because
of a severe backlash against the managed care industry. When we asked employers about whether they would be willing to step into the role of the decision maker, the majority said no. Based on these results, we perceive consumerism to be the next wave in healthcare. This is not because consumers want it this way, but because they are the only entity in this process that can’t be sued for making those decisions.

**Jonathan T. Lord, MD:** Consumerism is the future of healthcare coverage. In the current system, we have masked healthcare costs from most of the people who use the system. Engaging consumers and getting them to think about their choices is critical to fixing the problems that exist.

There is no true healthcare “system” today. Variations of systems, driven by practice patterns, exist. However, to expect healthcare providers to change methods that they have been using for the past 50 years is unreasonable. Improving healthcare is not only about improving the design of the benefits, but also about including an element of education, engagement, and awareness for the average person. People need and want choice. They want access to information and to be able to make decisions independently.

**J.D. Kleinke:** I disagree. I have studied this issue extensively, and I have come to some hard conclusions. The problem with this argument is that it makes the presumption that the consumer of healthcare is always rational. This may be true for such circumstances as buying a car or real estate, but when the consumer has just been diagnosed with cancer, rationality often goes out the window. These patients become desperate and, in essence, tear up the contracts they had signed during open enrollment.

**Craig Beam:** The American Heart Association embarked on a project approximately 7 years ago to build an Internet-based, highly interactive preventive model. We spent $20 million — and it was a complete failure. No one showed any interest in accessing preventive advice over the Internet. Six years later, the AHA launched a second model titled “Heart Profilers.” This translated the science into sixth-grade language so that people could easily understand it, and it provided guidelines for those who have experienced an episodic cardiac event. “Heart Profilers” has been a wild success, so we recently launched a cholesterol model that has 80 questions for users to answer. The completion rate in answering the questionnaire on this site is 92 percent.

What we have learned from this is that while preventive models may be successful in the future, people currently are interested in their health only after they have experienced an episodic event. In general, as long as people feel healthy, they are largely unmotivated to take control of their healthcare.

**Randall V. Ricketts, DO:** My opinion is that physicians have been so demoralized by managed care that although we want to help patients take control of their healthcare, we don’t have the time. Many of my patients have a $5 copayment — their employers pay for the rest — so patients think, “It only costs $5 to see Dr. Ricketts.” Now, I have more patients who come in for trivial matters that don’t require a doctor’s attention.

I am aware that health plans often compete on the basis of copayments. I’m not a businessman, so I don’t understand how the difference between a $3 and $5 copayment will help to sell a health plan, but, apparently, it does. However, from the physician’s perspective, these lower prices hurt our practices — some copayments are $0. If managed care companies would raise copayments even to $10, this would make a significant difference in how patients perceive the value of an office visit.

When I first became involved in managed care 10 years ago, the statistics provided to me said that the average patient sees his doctor 1.8 times per year. I don’t see how this is possible. Doctors are supposed to provide preventive care to patients, perform well-woman exams, and talk to patients about topics that range from knowing their cholesterol levels to wearing a bicycle helmet.

I believe that most patients are out of the loop when they should be more involved with the costs that are associated with care. If patients become more involved, they would value the care they receive more than they do now. For example, if a patient had to pay more of the cost of expensive testing, he or she would be more likely to think about whether to undergo the test, possibility eliminating some costs associated with unnecessary procedures.
BRUNER: The reality is that as long as managed care companies pay the vast majority of costs, people will take full advantage of the benefit. Does that mean they value the benefit less than if they had to pay more for it? It’s fascinating that in plans where the patient is directly responsible for paying for the office visit, people place a higher value on the care that they receive. For example, we hear questions such as, “What’s the quality rating for this physician?” When a price differential enters the picture, these decisions seem to be made more carefully than ever.

LORD: There has been a great deal of research on how to provide people with the facts they need to change their decision-making behavior. Many studies have found that people who have been more involved in the decision-making process had lower rates of resource consumption and better healthcare outcomes. Healthcare companies have provided consumers with overly filtered information. More information is better, because it helps people to understand the healthcare they receive.

BRUNER: In my business, we track data on approximately 15 million people for 400 employers. We have seen dramatic variations in costs relating to at least three factors in decision making: participation in DM, evaluation of hospital cost efficiency, and evaluation of the costs of pharmaceuticals.

Approximately 10 percent of the population we track accounts for roughly 70 percent of healthcare costs. Much of this is affected by whether they participate in DM programs. Employers must understand that individuals who have chronic conditions can prove costly if they are not in a DM program.

In stratifying all the hospitals in California, we found a large cost difference between hospitals for identical procedures. If employers moved their employees to the hospitals that are the most cost efficient for the same procedures at the same level of quality, I’d estimate that a 30-percent reduction in hospital costs can be achieved.

Finally, the differences in costs among pharmaceuticals are clear. Where consumers are in tiered pharmacy-benefit plans, we must engage the consumer in deciding which tier is most cost effective. This is an area that has been driven largely by pharmacy benefit managers. I think we are about to see that change.

KLEINKE: The results of a recent study, based on several years’ data on tiering, showed that 20 to 30 percent of people put in a tiered program switched to a product in a less-costly tier. What about the other 70 to 80 percent of people? When confronted with the decision to choose a third-tier drug instead of a second- or first-tier product, they chose the more expensive option. It is unclear as to why, but it may have to do with outside influences.

LORD: The three- or four-tier benefit designs have simply spread the ingredient costs out among the tiers. The newer concept of the therapeutic map is different in that it puts drugs into different categories based on their effectiveness against some time line. For example, cholesterol-lowering drugs would be categorized as “investment” medications, and antihistamines would be considered “lifestyle” medications. Reclassifying and understanding the dynamics of medical and pharmaceutical expenses is critical, and it will have an impact on both PBM and integrated-benefit designs.

KLEINKE: If the people in this audience were the CEOs of small businesses buying health care, would they understand that? Part of the problem — and this where consumerism is on the wrong track — is that we have immediately made it as complex as all other concepts in managed care. Some of these consumer-directed plans have payments and benefits that are too difficult for the average consumer to understand. How do we find a simple solution to the managed healthcare
industry’s economic deficit? Health insurance should be just that — health insurance. In 1950, when health insurance had a deductible of $200, women who were pregnant and had normal deliveries stayed in the hospital 5 days and paid $190 out of pocket without exhausting the deductible. The problem was that people had to pay with post-tax dollars, so we ended up with this convoluted complex system that people don’t understand. If I could control the healthcare system, the CEO of a small business would set aside $4,000 for a family’s healthcare. Half of that would pay insurance premiums, and the other half would pay front-end costs. The individual would choose and pay for their own drugs on a pre-tax basis, and there would be no complicated benefits. It costs so much money just to manage healthcare! If we simplify the system, it would allow that front-end amount of $2,000 to be spent on medical care — instead of management.

LORD: There’s no question that managed care has done a lousy job of explaining benefits and delivering services in an efficient way. However, the phrase “health insurance” is a misnomer because we provide care and insure a “product” against a catastrophic event. In auto insurance, the consumer insures his car for protection against some type of catastrophic event. The gas is not prepaid, nor are oil changes or any other item that may not actually be used. In managed care, we are forcing some people to prepay for services they may never use. In managed care, we are forcing some people to prepay for services they may never use. We need a model that allows us to estimate what a person’s healthcare needs will be over the course of a year. Then we can determine how consumers want to finance it.

[Bailey takes a question from a physician in the audience.]

QUESTION: Because health care is widely perceived to be either a benefit or an entitlement, is it economically realistic to return to an insurance model?

BRUNER: I will throw out some statistics. Our surveys indicate that the average premium increase for a large employer is 15 percent. Costs are going to double in the next 10 years. Employers say that 8 percent is the most they can afford, so there is roughly a 45-percent gap between what they say they can handle and what they are facing. If employees pick that up, their expenses triple. That’s not acceptable. When we look at how to solve this though giving consumers a [health-savings-type account, in which they receive first-dollar coverage up to a certain amount — typically, $1,000 to $2,000] coupled with catastrophic coverage, it breaks down pretty quickly from an actuarial perspective, because 80 or 90 percent of the dollars spent are above that $1,000 or $2,000 deductible. So, unless we have some very specific levers in place to get patients with chronic illnesses to work with their physicians to manage those conditions, we are not going to prevent a lot of the high-end claims from taking place. The low-end stuff is driving physicians crazy, and yes, we need to do something about it — but it’s not what’s going to destroy us economically.

LORD: Well, the first piece is to engage people in choice. The typical consumer-driven health plan engages people so that they understand what their health needs are. We tested this concept on our own employee group, and our experience was that approximately 70 percent of employees and their family members spent less that $500 per year on healthcare. So, we created a $500 first-dollar coverage option. With this, people received routine care on a first-dollar basis and had a “risk card,” or deductible [after the first-dollar coverage ran out], between $1,000 and $2,500. The year before we implemented this, our employees paid about 21 percent of the total cost of their health care. When we switched to this model, the employee contribution was 22 percent — so there was no gross cost shift to the employee, yet much more choice and involvement.

We have been trying to understand how people choose their benefit designs. We now have the capability to completely customize benefit design at the individual level, based on income and family size. We use HIPAA-compliant technology to track their choices and to evaluate whether greater consumer involvement affects how they talk to their doctors and whether they are more selective about the services that they receive.

BAILEY: There are some good concepts here to consider when implementing consumerism with the goal of trying to provide better care at a lower price. I would like to thank the panelists for their participation.
The Future of Healthcare In a High-Tech World

JAMES CANTON, PhD

Technology drove medical advances during the last half of the 20th century. James Canton, PhD, chairman and CEO of the San Francisco-based Institute for Global Futures and an advisor to the White House Office of Science and Technology, has published works about how technological innovation will affect business in the 21st century. With respect to medical practice, it will accelerate 10 demographic, business, and societal trends that already challenge American healthcare.

Technological advances are moving much faster than our ability, in terms of government and ethics, to keep up with them. The axiom goes that in the last 50 years, technology has changed our society more than all of the advancements of the previous 25,000 years. Over the next decade, even more radical technologies will change our economy, our lifestyles, and healthcare, and will make those 25,000 years seem small.

Technology will shape the future of our business models in healthcare, as well as healthcare policy. Shortly, we will discuss 10 key trends that will affect healthcare; technology is key to healthcare organizations’ ability to face these challenges. The strategic question is, “Will you be ready?”

What does it mean to be ready? Is it just knowledge of the technologies, or is it the capability to be agile enough to deliver services that consumers will want? One of our key forecasts is that as new technologies start to emerge, they will change the competitive landscape. Just being able to attract the right kind of talent at the enterprise level will be a challenge. On a broader level, will these new technologies en-
able us to tinker with human evolution? I would maintain that they will.

Disruptive innovations that will affect healthcare are emerging. Have you heard, for example, of health tourism? Where do you think the center of health tourism is? It’s Thailand. If you need a little tuck here or an enhancement there, or something as radical as a sex-change operation, the most cost-effective place to have it done — the five-star spa, if you will — is at a place outside of Bangkok. Similar things are happening with genomics in Singapore and Iceland. Have you noticed the ads in Science magazine? Health tourism is the beginning of this global competitive market.

The point is that disruptive innovations will come quickly. This is the quiet before the storm. Who’s going to pay for these enhancements? This is not the same as talking about braces for the kids or hair replacement. We’re talking about, “Who’s interested in living an extra 25 years with the vitality of a 25-year-old?” Everybody.

Imagine that it is the year 2010, and you are planning to have a baby. You are looking at a variety of choices, some of which are legal and others illegal in certain states or countries, and your interest as a parent is to have a smart child with the greatest potential possible. Then you find, through an audit of your genetic makeup, that you have a precursor for a variety of SNPs (single nucleotide polymorphisms, or common DNA-sequence variations among individuals that promise to advance the ability to understand and treat human disease) that aren’t deadly, but aren’t necessarily desirable. These could, for instance, increase the chances of your child being under six feet tall. Or becoming an alcoholic. Or having below-average intelligence. What do you do? We are going to have that information. Does this represent an opportunity — or a disruption? Does this represent a transformational experience that will change the tool set of practitioners and medical centers? Who’s going to want access to this information? Every parent is going to want to understand the implications of their genetic profile. This is beyond issues of social policy or morality. The point is, if they are marketing health tourism in Bangkok, then trust me — somewhere, either globally or domestically, these issues will be addressed.

According to the Centers for Medicare and Medicaid Services, healthcare was the largest industry in the United States — $1.3 trillion — in 2000. We may be looking at $3 trillion by 2007. And yet, there may be as much as $500 billion in waste in healthcare, one of the last industries to be transformed by information technology (IT). Every other major industry — including financial services, manufacturing, and entertainment — has been affected by many of the competitive forces that have created new opportunities in the marketplace. Healthcare has not followed suit. As new technologies provide opportunities, and as new technologies change the way healthcare is delivered, there will be cost increases. If we layer new technologies on top of an industry that is already inefficient due to a lack of investment in IT, you’ll have another set of challenges to complicate the environment.

The bottom line: There are going to be new challenges, driven by new technologies, that will change the way you lead, the way you serve customers, how you change, and how you don’t change.

Leadership styles

There are four leadership styles in healthcare organizations. This goes to the culture of healthcare, and it has to do with medical directors and physicians, and their readiness to deal with new technologies and their effects.

The first group is the traditionalists. Traditionalists tend to be culture-dominated, over-resisters of change. “These things are not going to happen,” they would say.
Or, “Genomics is important, but we are not going to offer these kinds of services. It’s an issue we are not going to navigate.”

The second group is the maintainers. Maintainers are healthcare organizations that tend to be covert resisters. They say yes but mean no. When it comes to the smart-health architecture — where healthcare is starting to adopt real-time IT that can share information — they see the benefit but don’t deploy the resources.

The third group is the adapters. Adapters are organizations that recognize, quite frankly, that they have to change, like it or not. “We have got to deploy new resources to stay on the leading edge, to use the Internet, to try e-learning, and to look at e-procurement.” They set up working groups to be able to map that. They figure these emerging technologies into their strategic planning.

The final group is the innovators, who tend to be the early adopters. These organizations are made of stakeholders who want to be recognized as out in front. Your readiness to invest the kinds of dollars, resources, and vision to plan for the future is one of the critical elements that will determine your ability to survive and to create a sustainable organization.

Ten trends

The top 10 trends that will affect healthcare (see list at right) are important developments that should be factored into your own strategic planning, because these are the trends that will change the game.

Aging baby boomers. There are 78 million boomers, and they will not go down easy. This is the largest concentration of wealth in the United States. Baby boomers want to live forever. They want to have the vitality, the performance, and the ability at age 55, 65, or 75 that they would have if they were 35 or 40. This group makes the largest concentration of investments in plastic surgery, exercise, fitness, and vitamins. They’ve got the bucks. This represents an opportunity.

When you take this group — the most-educated cohort ever — what are the implications for use of new technologies and healthcare demand?

For one thing, we have seen the emergence of “lifestyle” pharmaceuticals. These are the first shots across the bow; they demonstrate that there is a market. We will see a new class of drugs that will be customized to enhance people’s longevity, performance, or sexual and mental abilities. When you marry that to the ability to know one’s own genetic profile, you have a very different notion of what healthcare is about, complete with different consumer expectations.

Nanotechnology. This is going to have the largest impact on medicine, healthcare, and society overall. The result of being able to manipulate matter will be a variety of new materials. This will have dramatic implications for implants and bionics for pacemakers, for instance, or the possibility of being able to embed intelligence so as to enhance people’s performance. I know that may sound abstract, so try this: One in four men will suffer from memory loss and, potentially, Alzheimer’s after age 75. What would you pay to get your memory back, particularly when you are losing it? These will be real issues that consumers will drive in the marketplace.

Genetic discovery. If you take all of human history, the average age humans live to is 18. The human body is not really engineered to live beyond a certain age. Socrates was an old man in his late 20s. At the turn of the last century, life expectancy was 45. Retirement was based on longitudinal studies that determined that people would never live to be 65 — therefore, it was safe to offer retirement benefits at that age.
**Personalized medicine.** This is what we are moving toward: the ability to take one’s personal genomic information and use it to customize treatment to improve health, performance, and longevity — depending on a patient’s goals, age, genetic profile, economic condition, health insurance plan, benefit design, and who pays for it.

**Data privacy.** If we’re going to collect these data, what’s our role in protecting consumers’ privacy? Fast forward to 2008: I am walking into the doctor’s office for a checkup, and I get a genomic swipe on a cotton swab. My profile comes up, and I get a personalized prevention-and-health-promotion plan. There is a whole set of new services I want to pay for — and of course, the boomers will pay for it, because they want to live longer and healthier. Who will protect those data? What if you don’t have the capability to warehouse those data? I view this as a major opportunity.

**Security and biotechnology threats.** How many beds are ready in the United States for this? After Sept. 11, it’s a new game. Your ability to communicate with public agencies and understand the implications on your organization is important.

**Smart health.** On a more positive note, the smart-health IT infrastructure, and being able to utilize some of the best-of-breed IT systems that have provided greater efficiency and productivity in many other industries, is critical.

**Cost containment.** This will continue to be an issue, and in some ways, it goes together with smart-health systems. The whole conversation about cost containment should not be about pushing costs onto consumers — why should we ask them to pay more for the healthcare industry’s inability to manage costs effectively? Don’t attempt to do strategic cost containment without looking at the efficiencies that could be available through smart health IT. It’s just not going to happen. Healthcare in the United States is an unsustainable model. Do the math, then look at those numbers’ impact on quality and care efficiency. It’s going to change with leaders who see the value of technology.

**Telehealth services.** Healthcare is being transformed by an emerging electronic supply chain that looks for greater efficacy and competitiveness. Could I serve patients in this environment? Could I migrate staff education to that kind of a model? Could that be distributed in a wireless environment or over the Internet? Absolutely.

**The shift from a disease-centric model of care to a health-centric, promotion-and-prevention model.** New technologies will give us the ability to screen for genetic information and, therefore, create personalized approaches to healthcare. In our surveys, we ask consumers, “If you know that you will have a particular health problem in the future, would you be willing to change health behavior?” There has been a body of research around this for a long time. In the 1980s, it was popularly known as wellness and health promotion, but it waned because of issues of trying to motivate people to change. Now, you have undeniable data sets that will be relevant for Jim and Sarah and Bill, and it becomes a public-health issue. The cost of having that information and not integrating it into healthcare practice is very high.

**Putting it together**

When you weave together these emerging issues, you get a future that is very different from the past. What follows will transform healthcare in the 21st century.

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**Top 10 trends that will affect healthcare**

- Aging baby boomers
- Nanotechnology
- Genetic discovery
- Personalized medicine
- Data privacy
- Security and biothreats
- Smart-health IT infrastructure
- Cost containment
- Telehealth services
- Shift to health-centric model of care
Too many of us are moving paper, as opposed to bits. In healthcare, there is tremendous cultural resistance to moving to new platforms, but the architecture of the health plan of the future is IT-enabled — whether you are talking about a patient’s medical record, patient education, who is moving and recording what, or levels of efficiency and effectiveness. The question is, can we get the funds and the leadership to build this next-generation healthcare organization?

In many regards, we are still waiting for disease to show up before we deal with it. Nanotechnology gives us a visibility level that is much deeper. Disease starts between DNA and the atomic level. We don’t have the tools, the genetic information, yet to be able to see the causality. But we will. The implication of having to rethink medicine this way is a healthier population, which will give us a better return on investment in healthcare management.

Genomic medicine will empower consumers. There are issues yet to be settled about who gets to use what data. There is, already, some genetic testing occurring. How much information do we share? Ultimately, every individual will want some kind of human enhancement. My mother, who is 70-something, recently got a titanium hip. Now she can play golf and has a certain degree of mobility. My aunt, on the other hand, died 40 years ago, when none of that technology existed. She loved to travel. What would she have paid for that titanium hip? Everything she had.

But there’s a flip side to that: We are going to have a lot more genetic information than ability to do something with it. Knowledge management is going to be hampered by the capability set, and the expectations of consumers in the marketplace will make it difficult to reconcile that. The health-enhancement market, led by baby boomers, will become the largest market in the 21st century.

Human longevity is an interesting thing. Whether it is Ponce de León looking for the Fountain of Youth — which is what brought him to the New World — or genetic medicine, this has been a primal urge for human beings for centuries. People want to live longer. They want to be healthy as they live longer. They want to be vital. And if they’ve got the chance to do that, they will. If they need a procedure and can’t get it here, they will go to Bangkok. Singapore is setting itself up as a leader in genomics for this reason. It is attracting scientific talent. Canada is trying to seduce researchers in stem-cell work because of our policies here.

By 2006, personalized medicine — customized pharmaceuticals and the plotting of people’s genetic future — will be a $5 billion business. How we deal with it ethically, morally, and socially, has yet to be determined. Right now, I can screen everybody in this room and identify who has the SNP for cardiac blockage. The question is, what do we do with that? Do practitioners have a responsibility to provide that information to patients? As a consumer, I’m willing to pay for it. There will be new businesses around this to help people live healthier lifestyles. Considering the final trend mentioned earlier — moving healthcare organizations from a disease-centric to a health-centric focus — this represents a key opportunity in the future.

In summary, disruptive innovations will come faster than ever. A lot of these innovations will be convergent, such as health informatics and genetic pharmaceuticals. Nanotechnology, which will give us the ability to see disease precursors and then plot a course of treatment, will spawn nanodrugs and genomically inspired devices. It will be a brave new world.

The hacking of the genome is only the beginning. Opportunities exist in personalized medicine. Are you and your organization change-ready? Will you be able to lead change? Will you develop a capacity to anticipate the future? It’s in your hands.

I do not have all the answers. I am only suggesting that these are big issues.
CONTINUING EDUCATION QUESTIONS

Directions: Please tear out the combined answer sheet/assessment form on page 29 (physicians) or page 30 (pharmacists). On the answer sheet, place an X through the box of the letter corresponding with the correct response for each question. There is only one correct answer to each question.

1. In 2002, ____ percent of Medicare+Choice enrollees had prescription drug coverage:
   a. 84.
   b. 82.
   c. 72.
   d. 32.

2. One proposal debated in Congress during the recent Medicare-reform discussion would attempt to improve coordination of care for “dual eligibles” — the population eligible for Medicare and Medicaid benefits. This would:
   a. Give Medicare (the federal government) complete responsibility (including drug benefits) for this population.
   b. Give states complete responsibility for this population.
   c. Give this population a standard Medicare benefit set, but give states the option to add drug coverage at shared expense with the federal government.
   d. Give this population a standard Medicare benefit set, but give states the option to add medical and/or drug benefits at state expense.

3. Which of the following reflect some of the financial challenges that state Medicaid programs currently face?
   a. People who have been laid off or otherwise lost their health benefits recently have been turning to Medicaid for health coverage.
   b. Disease management programs could result in increased pharmaceutical expenditures.
   c. Most states are running deficits, and legislatures are looking to cut Medicaid spending.
   d. All the above.
   e. Answers A and C only.

4. Which of the following is/are among the top 10 challenges Canton identifies as having the greatest effect on healthcare?
   a. Aging baby boomers.
   b. Nanotechnology.
   c. Genetic discovery.
   d. Personalized medicine.
   e. All the above.

5. The American Heart Association’s efforts to provide the public with health information over the Internet led AHA officials to believe that:
   a. Consumers are most interested in using such information to take control of their health after age 40.
   b. Consumers are most interested in using such information to take control of their health after a major medical event.
   c. Females are far more interested than males in accessing health information online.
   d. People are generally uninterested in receiving health information online at all.

6. The framework for the development of CMS’s prescription-discount program would:
   a. Allow the government to obtain a negotiated purchase price for pharmaceuticals, thus gaining access to rebate dollars that commercial plans and large employers currently enjoy.
   b. Give the government the authority to regulate prescription drug prices.
   c. Split the cost of discounts between the government and pharmacists.
   d. Decrease hospitalization costs through greater use of prescription drugs.

7. How would the Bush administration’s Medicare-reform proposals change the employer retirement-benefit system?
   a. The government would pay a fee, akin to a deductible, to the employer and then expect the employer to make up any difference in the cost of providing a benefit package to retirees.
   b. The employer would pay a predetermined amount to the government, which would administer the employer’s specific benefit set.
   c. Neither of the above; the administration’s proposals do not address the private retiree-benefit system.

Self-test continues on next page.
8. Which of the following reflect some of the difficulties that states face in implementing managed care principles in Medicaid?
   a. States have a good deal of information about Medicaid beneficiaries but do not have the resources to work with physicians to develop disease management strategies.
   b. Continuity of care is poor for dual eligibles (Medicare and Medicaid).
   c. Rules for applying for waivers to create managed care-style incentives can be cumbersome.
   d. All the above.

9. According to Canton, the most effective method of achieving cost containment in healthcare in the 21st century will be to pass a greater share of expenses on to consumers.
   a. True.
   b. False.

10. Which of the following is not a major factor in determining overall healthcare costs, according to Hewitt Associates’ utilization-tracking data?
    a. Patients’ participation in disease management.
    b. Hospitals’ cost efficiency.
    c. Patients’ selection of their physicians.
    d. Pharmacy utilization.

11. CMS has structured payment systems that encourage wellness and crossdisciplinary care through demonstration programs for:
    a. Diabetes.
    b. Heart care.
    c. Pneumonia.
    d. Answers A and B.

12. The Bipartisan Commission on Medicare Reform suggested remodeling Medicare in the likeness of the Federal Employees Health Benefits Plan. This would mean that:
    a. The government would contract, on behalf of Medicare beneficiaries, with national and regional health plans.
    b. The government would abandon such pricing systems as the Diagnosis-Related Group (DRG) or the Resource-Based Relative Value Schedule (RBRVS).
    c. Health plans would develop their own pricing schedules, based on the benefit package being offered.
    d. All the above.

13. Oregon provides an example of how federal waivers have allowed states to modify Medicaid programs to serve more beneficiaries. What did Oregon do?
    a. Reduced benefits to some beneficiaries to provide a drug benefit to the elderly.
    b. Reduced benefits to some beneficiaries to provide new benefits to additional populations.
    c. Increased employer taxes to provide Medicaid benefits to the working uninsured population.
    d. Implemented a disease management program for patients with asthma, and used the savings to fund new benefits for the previously uninsured.

14. Health care was a $1.3 trillion industry in the United States in 2000. The Institute for Global Futures predicts that, by 2007, healthcare expenditures will rise to:
    a. $2 trillion.
    b. $2.5 trillion.
    c. $3 trillion.
    d. $5 trillion.

15. When Humana tested a “consumer-driven” health plan model, it based the benefit design on which of the following assumptions?
    a. Seventy percent of consumers spend less than $500 a year on healthcare.
    b. Greater consumer involvement in making healthcare decisions leads to lower rates of resource consumption and better outcomes.
    c. Consumers would value the opportunity to customize benefit design at the individual level, based on income and family size.
    d. All the above.
CONTINUING EDUCATION ANSWER SHEET/CERTIFICATE REQUEST
Movements in Healthcare Legislation: An Interactive Town Hall

CME Credit for PHYSICIANS

Sponsored by The Chatham Institute

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Physician — Maximum of 2 hours in category 1 credit. This learning module may be used for category 1 credit through Feb. 15, 2004.

Complete answer sheet/evaluation form and mail to:
Office of Continuing Education
The Chatham Institute
26 Main Street, 3rd Floor
Chatham, NJ 07928

Credit will be awarded upon successful completion of assessment questions (80 percent or better) and completion of program evaluation. If a score of 80 percent or better is not achieved, no credit will be awarded and the registrant will be notified.

Please allow up to 6 weeks for processing.

The cost of this activity is provided at no charge to the participant through an educational grant by AstraZeneca.

EXAMINATION: Place an X through the box of the letter that represents the best answer to each question on pages 27 and 28. There is only ONE answer per question. Place all answers on this answer form:

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PROGRAM EVALUATION
So that we may assess the value of this self-study program, we ask that you please fill out this evaluation form.

Overall activity rating
Excellent Very good Good Fair Poor
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Were the educational objectives met?
A great deal Not at all
5 4 3 2 1

Will this activity benefit you and improve patient care?
Very much Very little
5 4 3 2 1

What other topics would you like to see addressed?
________________________________________________
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Give an example of what you will do differently in your practice as a result of participating in this activity:
________________________________________________
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Did you detect any bias in this presentation?
Yes ____ No ____ If yes, please explain: ______________________________________________________________________________________________

Comments:
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CONTINUING EDUCATION ANSWER SHEET/REQUEST FOR STATEMENT OF CREDIT
Movements in Healthcare Legislation: An Interactive Town Hall

CE Credit for PHARMACISTS

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Pharmacist — This program is approved for 2 contact hours (0.2 CEU).

ACPE program number: 812-000-03-002-H04
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EXAMINATION: Place an X through the box of the letter that represents the best answer to each question on pages 27 and 28. There is only ONE answer per question. Place all answers on this answer form:

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PROGRAM EVALUATION

To receive continuing education credit, please answer all information requested below. This assures prompt and accurate issuance of your continuing education certificate.

Please rate this program as follows:

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How long did it take you to complete this continuing education activity?
Hours ___ Minutes ___

Requested topics/skills to address in future programs:

________________________________________________________

Did you detect any bias in this presentation?
Yes ____ No ____  If yes, please explain: ________________

Comments: ________________________________________________________________________________________________
Flags of Our Fathers

JAMES BRADLEY

It is the most reproduced photograph ever: the one depicting six United States Marines raising the American flag during the Battle of Iwo Jima. Flags of Our Fathers author James Bradley always wondered why his father — the second Marine from the right in that photo — never talked about the photo or World War II. After his father died in 1994, Bradley learned that his dad had been awarded the Navy Cross for heroism at Iwo Jima. It was the first of many discoveries Bradley would make about his father, the other men in the photo, and himself — and about achieving the impossible.

A few weeks after my dad’s funeral, my brother found three cardboard boxes stuffed with Iwo Jima memories. There were letters from every president and a letter from John Wayne requesting my dad’s autograph. At the bottom of one box was a letter my father wrote, three days after the flag-raising, to his mom and dad. “I had a little to do with raising the American flag,” he wrote, “and it was the happiest moment of my life.”

Iwo Jima is a trivial scab far out in the Pacific, only five miles long. The name means sulfur island, for all the sulfur pits there that smell like rotten eggs. We sent 110,000 American boys in an armada of 880 ships to conquer that island. The Battle of Iwo Jima is still the worst battle in the history of the United States Marine Corps.

Iwo Jima was so important because the Japanese had a radar station there that could warn that our B-29s were coming to bomb Japan. They had fighter planes based there that could pick off the lumbering B-29s. So, the strategy was that we were going to obliterate everything and everyone on the island. It was a great strategy, except for one problem. The Japanese were not on Iwo Jima. They were in Iwo Jima.

The 22,000 Japanese troops on Iwo lived in an underground city with 16 miles of tunnels that connected 1,500 rooms. Seventy-two days before the battle began, the Air Force started dropping bombs on the island. Three days before the battle,
the Navy started lobbing shells the weight of Volkswagons onto the island.

How was this impossible battle against an unseen enemy won? America stamped out more medals for bravery during the month these guys spent on Iwo Jima than in any other month in its history. That’s what it took.

When this photo appeared in the United States, these guys were automatically famous, but at first, nobody knew who they were. Today, there is a statue of this photo in almost every state. The tallest is the Marine Corps Memorial in Arlington, Va. But the flag-raisers’ names are not on the marble base.

That was my problem. I couldn’t find out who these guys were. Were they buddies? Did they have nicknames? I knew zilch. I called sheriffs’ departments and mayors’ offices across the United States, searching for relatives. I thought their sons or brothers would shut me out as they had shut out the press for a half century, but they saw me as a family member, told me stories, and gave me documents that had never left the family. The result was *Flags of Our Fathers*, about six boys I would like to introduce to you.

**This is who we are**

Six boys raised that flag. Three died on Iwo Jima.

Behind my dad is the helmet of Rene Gagnon, from Manchester, N.H. If you took off Renee’s helmet at the moment that photo was taken, you would find a picture of Rene’s girlfriend there. Rene put it there because he felt he needed protection. Rene was scared. Rene was 19. He died in 1979.

Another boy in the background, whom you can’t see, is Sgt. Mike Strank. Mike’s left hand is on the pole. Three months before the battle, his captain tried to promote him. Mike turned the promotion down. He said, “I promised my boys I would be there for them.” Mike died on Iwo Jima.

The last guy to the left, whose hands do not reach the pole, is Ira Hayes, a proud Pima Indian from Arizona. President Truman called Ira a hero to his face in the Oval Office. Ira didn’t see it that way. He later said, “How can I feel like a hero when 250 of my buddies hit the beach with me and only 27 of us walked off alive?” A half century later, we recognize these as the words of a post-traumatic stress sufferer. Ira died when he was 32, face down, dead drunk — almost 10 years to the day this photo was taken.

The next guy to the right is Franklin Sousley, a fun-lovin’ hillbilly from Hilltop, Ky. Three days after the flag raising, Franklin wrote a letter home and said, “Dear Momma: Look for me in the papers, because I helped put up a flag.” Well, his mother, Goldie, and Hilltop were elated. Franklin would come back a hero. It almost worked out that way — until two days before the end of the battle, when Franklin got a bullet in the back. He was buried, along with 6,824 other American boys, on Iwo Jima.

This photo was taken on Feb. 23, 1945. Two days later, Army Air Corps Lt. Ed Block was visiting his mom and dad in Texas. He was looking at the local newspaper when his mother, Belle, looked over his shoulder, put her finger on the guy putting the pole in the ground and said, “Lookit there, Junior! There’s your brother, Harlon.” Ed looked at her and said, “Momma, we don’t even know if Harlon is on Iwo Jima. You can’t tell who that is.” Belle said, “That’s definitely Harlon, I know my boy.”

Two months later, the government identified the guy putting the pole in the ground as Hank Hansen, from Boston, a Marine who died on Iwo Jima. Mr. Block brought the newspaper to his wife. She said, “I don’t care what the government says. Honey, I changed so many diapers on that boy’s butt, I know it’s my boy.”

In 1947, there was a Congressional investigation — instigated by a crazy mother.
in Texas who wouldn’t be quiet — to find out who was at the base of the pole. Finally, Congress confirmed it: Belle knew her boy. Harlon died on Iwo Jima.

**It’s all in how you look at things**

When I look at this photo, I think of the concept of doing the impossible. Amphibious assaults are the most dangerous operation in all of warfare. In World War I, the Allies tried to get into Turkey and were shot down at the water’s edge. All the geniuses said that with machine guns, amphibious assaults would no longer be possible.

In the early 1920s, a young Marine captain named Howlin’ Mad Smith conceived the idea that the Marines had to become the world’s experts at amphibious assault. He got his best and brightest together and said to them, “We are going to do the impossible, and we are going to do it well.” In that meeting, the Pacific War was won.

That mindset was repeated many times during the war. There were things that “could not be done” that had to be done, and people took the attitude of challenging the impossible to make it possible. It was all in how they looked at it.

Consider the “impossible” in your own life. Many of us have a dream and don’t try to move toward that dream because we think it’s impossible. But maybe, the difference between getting it done and not getting it done is simply how we look at it.

When I realized that these guys were in the Pacific doing what had been considered impossible, I knew I had to get these stories into a book. I had never written a book, but I thought, “My dad’s going to be on the cover. I might as well write a *New York Times* number 1 best seller.” So, I cold-called agents: “My name is James Bradley. My dad helped raise the flag on Iwo Jima. I’m the only one with the stories. It’s going to be a *New York Times* number 1 best seller.” They hung up as quickly as they could.

I cold-called 66 of them before I got an agent who felt sorry for me. The book proposal went out to three publishers. It took 18 months to get 27 “Nos.” Finally, we got a small contract, and the book came out. The first week the *New York Times* measured a full week of sales, it was the best selling book in the United States. Three weeks after the book was out, Steven Spielberg bought the movie rights. Maybe the difference between what is possible and impossible is just the way we look at things.

After my dad died, my father’s captain on Iwo Jima telephoned my mom and told her that her husband had been awarded the Navy Cross for heroism on Iwo Jima. She said, “What is a Navy Cross?” The Navy Cross is the nation’s number 2 award for valor, following the Medal of Honor.

Now I know why my dad didn’t talk. He was a medical officer. He held 200 guys in his arms as they died, screaming for their mothers. What is there to talk about?

This is what he kept from us: My dad’s company was 300 yards from Mt. Suribachi. The Japanese had taken the face off the mountain and backed in tanks and antiaircraft guns, then put on seven feet of cement and left the barrels sticking out.

The American boys got the order to go. It was a massacre. In that sea of blood and screams, my dad saw a Marine fall wounded, 30 yards away. His citation says he ran through 30 yards of Japanese gunfire and dragged him back, with bullets ping- ing off the rocks at his feet. Guys who saw this cried. One guy who was on Iwo Jima said, “Running through those bullets and not getting hit was like running through rain and not getting wet.” My dad was doing the impossible out there.

Write down that dream. Put it in your pocket. Maybe later, you’ll have the guts to show it to somebody. And if they laugh at you and your dream like they laughed at me, I have a suggestion: Read a good book about six boys who fought a terrible battle in the Pacific. They did the impossible, and they did the impossible well.