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Transcribed Speech of Troyen Brennan

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Transcribed Speech of Troyen Brennan

DR. BRENNAN: [A]lthough I teach health law at the Harvard Law School, I am not really a health law expert, I would not say. I am really a practicing internist and I run a small medical group at our hospital, the Brigham and Women's Hospital. I am interested in health policy and did some teaching in health policy, so my presentation will be a relatively broad look at things.

First, I will go over the major problems in health care policy today. You are going to see that I think the major issues are around cost. [T]hen what I would like to do is sort of just travel very briefly through a number of areas where there is a reasonable amount of litigation, looking at sort of the litigation side of health law, to find out whether or not the health law, as we understand it, can really help us in these issues. I will leave regulation per se off to the side and instead look at the way in which courts address things. [This is] the outline: key issues in health policy; a look at some of the primary impetus in health care law; and then try to answer the question about whether it really helps bring about rational reform.

I have already said that I am not an expert in these areas and my conclusions may be very different than yours and hopefully those things will come out in the discussion.

[W]hen I talk to law students and public health and medical students about health care policy, you can trace everything through three issues: cost, quality, and access. There is really nothing else. I’m going to say cost is the overriding issue in quality. There is always a lot of talk about quality. [T]he problem is that cost is directly related to access. So, the train wreck is higher cost, much less access. Nothing in health policy or health law really addresses those issues.

[L]ooking at the GDP and healthcare spending, what we see is [that] health care spending, which is the spending by median income, tracks along with lack of insurance. The more money we put into health care, the more people we leave behind, and that is the major issue for us. So, cost and access are going to be very closely related. The more resources you’ve got in the system the more people we leave on the sidelines. Most of the uninsured increase comes from premium growth. We can draw that out from a policy point of view. So, I will take that as a given in the rest of the talk.

[T]hese are the facts that I’ve seen: [The] population is aging and that is
going to drive cost. The working population is shrinking. There is not enough money. Doctors and hospitals are going to continue to import technology because we make money on that and my business plan for my $400 million medical group is all about import of technology. All of that is going to negatively impact quality and access. So, cost, quality, and access are really going to be tied up together.

Demographics are the best way to sort of look at things when you are trying to be a futurist. The demographics here are disturbing. The population is aging and the number of people who are supporting the elderly shrinks dramatically over the course of the next 15 years. John had a nice slide about the number of hospital beds in the United States. Chicago, for example, is way under-bedded for the amount of care that's going to need to be provided as the population ages.

The next slide just shows what the projections are in the Medicare spending. Just suffice it to say that this would be the numbers as the budget office put them together in 2000. They are already out of date. The blue part was supposed to be what the additional spending was going to be on the Modernization Act for prescription drugs. That has now tripled. So this whole thing is unsustainable. Everybody in the federal government is looking at it right now – unsustainable increases in Medicare. So every state, I imagine Illinois, is looking at ways to cut its Medicaid budget and we are going to see what you do about those things.

The next slide shows changes in health insurance premiums. This is from Hewitt. The most interesting thing is the percentage of the average family's income going toward health insurance. By 2010, it will be about thirty-five percent, which is an enormous number. So how do we do cost control? I was trying to break the health care system down in terms of cost, quality, and access. What do you do about cost? What we do about cost basically boils down to these four things and really not much more: you can manage care, you can restrict technology, you can underinsure, or you can do pay for performance. Managed care is doctor-based rationing; restricting technology is system-based rationing; underinsurance is patient-based rationing; and pay for performance is really sort of a watered-down form of doctor-based rationing.

I am going to argue that we are moving in this direction and if I had time to argue the ethics and the laws of policy, I would say that is the exact wrong way to go because the patients are poorly situated in order to ration their care. In fact, most ration received is due to underinsurance; but, alas, that is where we are headed. Managed care did work. Managed care is just

1. See Appendix A.
2. See Appendix B.
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bringing market incentives to the doctor-patient relationship and there was a tremendous backlash against it. Here, law really did play a role – a relatively negative role, from my point of view - in terms of eliminating managed care, but it appears to have worked in terms of cost in the mid-1990s.

So, these are the changes in health plans. [When] I started practicing medicine in 1987, almost everything was in conventional insurance. I have a bottom line to meet a budget. I wish I was a health care executive back in 1988 because how could you not make money there? It was all cost-based reimbursement. You can see that is gone. [T]he PPOs have completely overwhelmed any real management of care. [T]hose are fairly striking shifts in the way in which we are paid. It is a completely different situation today than it was fifteen years ago.

This [slide shows] the decrease in health care spending we saw in the heyday of managed care, just after the “Hillary Clinton plans” came through. But you can see it has bounced back up. [It] is much higher than regular background inflation and there is really nothing that is controlling that right now. [Therefore,] health care costs are really out of control at this point because managed care has pretty much gone away. The backlash against the managed care industry was very intense.

One of the reasons why managed care failed is because all care became managed. So, managed care is gone. It looks like it worked, but right now there is very limited managed care going on except for small pockets in California and elsewhere where the funds flow dictates that they manage care.

The second approach is to restrict technology. This is very difficult in the United States. [T]he reason why most of my colleagues travel to Chicago around this time of year is to go to the RSNA [Radiological Society of North America] which meets, I think, in December down at the big convention center on the South Side. Those are the radiology meetings. If you want to understand sort of inflation and health care, what you need to do is go to that meeting and see the kind of stuff that you can buy. I am definitely buying 128 or 256 scanners in the next couple of weeks to be able to put down in sites out in the metropolitan area in Boston because I am going to make a lot of money off of them over the course of the next five to eight years.

We have a very difficult time restricting technology and I would say it is very interesting to see how much money is being spent. I would say, in general, health care is very lightly regulated. [I]n general the laws are pretty weak. This [slide] is something that is put together by the certificate

3. See Appendix C.
of need regulators and it shows the states that have significant certificate of need regulation. You can see that some are in the south and some are in the northeast; but, in general, the important thing about this matrix is that almost every state has enormously diluted its certificate of need oversight. I would say there is probably only two or three states that do anything significant. Almost everybody has moved over to let the market rule rather than having strong determination of need. I know there has been some litigation around those issues in Illinois and I would not be able to address how difficult you all think it is to put new technology in hospitals or shopping centers in Illinois. But, in general, I would say it is not that difficult and, if anything, this is receding.

[What is] the reason why we are interested in this? The whole point here is that there is a great deal of provider-induced demand and that provider-induced demand is generally driven by our access to technology. Where there are more specialists or there are more hospitals, there is more competition, and there tends to be higher costs. That is what we will continue to see. Rationing through doctors is not going to work because managed care has, sort of, gone away. Rationing through the health care system the way that Canada does, where it creates few in order to reduce health care cost, is not going to work because we will not restrict access to technology.

The next step is really to do patient-based rationing; underinsure people and let them decide what health care to use. I may be buying scanners, but the patients may have an insurance plan that does not pay for the entire cost of those scanners, so they will have to pay out of pocket. Maybe they will start rationing themselves. It is okay for the insurance companies because they have a hard time seeing how they are going get sued when a consumer has made the choice that they want that kind of health plan, but it presumes that the patient consumer has real choice. This is the ancient issue in health policy: whether or not health care can be created by an idea similar to, “I’m going to purchase a TV” or “I’m going to get some health care;” whether [health care] is like a real consumer good; or whether there is something that [says] when you are sick, you actually do not think like a consumer. You think like a patient. That is the sort of important fundamental issue underneath patient-based rationing.

It is an easy choice. It is an easy choice for doctors because we do not have to get involved in trying to assess whether or not care is cost effective. It is easy for the insurance companies; it is easy for the employers, so it is an easy choice. We are making a series of easy choices that are nice, lubricating us along to a significant train wreck of a health care system.

4. See Appendix D.
[T]his is what the employers are interested in. They do not want to reduce choice because they do not want to put defined contribution plans in place because they are fearful that their employees do not like that; but they are quite willing to put in cost sharing for medical care and for pharmaceuticals and for medical treatment. So what is happening is, instead of people being fully insured, what we’re doing is sort of carving out their insurance with larger copays and larger deductibles; an even more radical approach.

[T]he next slide from the University Hospital Consortium, which is usually a very mild-mannered organization, is actually taken directly from the slide show at their most recent meeting suggesting that these consumers’ health plans are really a smoke screen. There are no real quality measures, or if there are, they are too complex for the average consumer. The risk for inflation is shifting to the consumer.

[T]he next slide [illustrates] a plan that is available in Florida.5 It looks like there is a $100 deductible. eighty percent of services are covered in excess of the deductible, and your maximum out of pocket for covered services is $2000. So, that’s a cheap plan that you can buy. However, if you look at the finer details, the covered services, only $600 per day or $1200 per day in the ICU. For my ICU, if you go to the thirteenth floor of the Brigham and Women’s Hospital and you go into our new ICU there, you’re in for $3200 that day in terms of our costs. [S]o, this [plan] is not going to cover those costs. [This plan] is going to get the insurance company out of it; it is going to get the policy people out of it; it is going to have me as the provider and the patient in it, though, because what I am going to [do] is to try to collect when these limits hit against these individuals. [As part of] a non-profit organization, how hard am I going to be able to go after people in order to pay for these costs? [B]ehind all that is [the idea] that perhaps this will begin to limit our interest, our provider interest, in providing ever more intense care. [T]his is the type of underinsurance that we are going to see is going to lead to patient rationing and, I think a lot of people can look on the other side of that, some provider rationing.

The reason why it does not work is because, although personal income continues to go up over this period of time, that is, from 1980 to the year 2004, savings are way down. People do not have sufficient savings to really be undertaking these kinds of plans when they get really sick, so what we are going to do is basically bankrupt people and, from a provider point of view, not be able to collect against them.

There is a lot more cherry picking and there will continue to be cherry picking because doctors and hospitals are sort of rational, financial players.

5. See Appendix E.
There will be some regulations, but they'll look for the well insured people and try to stay away from the poor or uninsured people. That will lead to quality problems, especially for the poorly insured individuals.

In regard to consumer-driven health plans, people think these consumer-driven health plans are poised for growth and this is what Forrester, at least, is predicting: maybe about a twenty-five percent share for these kinds of consumer-driven health plans where you've got huge deductibles and co-pays and a lot of uncovered services. They hope that by providing these kinds of relatively low cost plans, they will get these small firms. However, you can see they are continuing to lose the small firms and will continue to sort of do so unless there is a pricing mechanism that offers them a low cost plan. But, as I said, that low cost plan is going to be basically an uninsured plan.

That brings us, finally, to pay for performance. It is characterized primarily as a quality issue but, in the future, pay for performance is really going to be more of a cost issue. It will be aligned with these consumer-driven health plans. [T]he question is, who is going to do this sort of management? [C]onsumers are not sensitive to quality information at the present time. [W]e can talk all we want about consumer-driven health plans and pay for performance, but information from Harris Interactive [reports] the number of people who have actually considered changing their health care based on ratings of individual organizations and it is very small. It is something that Tom Lee published in the New England Journal in 2005.

On the other hand, people will forego treatment if it costs them out of pocket. This [slide shows] the number of people who are foregoing treatment because they are in a low deductible plan as opposed to a high deductible plan.\(^6\) So, the consumer-driven part of this will work on the cost side; but, I am not sure if it will work on the quality side.

Then, finally, the last point I would like to make is, if it is going to work on the quality side of pay for performance, who is going to do it? Who are the managers in health care? [Is it] the doctors who will actually step forward on the pay for performance? Most of it is supposed to be the primary care doctors but, as you can see, and this is something I am very concerned about as a former chair of the American Board of Internal Medicine, we are losing our base of general internists and general practitioners. Family medicine, pediatrics, and internal medicine, or general medicine, are fading. [T]here are fewer primary care residents and there are fewer family medicine residents and, generally, internal medicine residents. [W]hat this [slide] shows is how much specialists make as

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6. See Appendix F.
opposed to how much primary care doctors make. You can see significant increases for the specialist, and they are making about double what the primary care doctor does. All the talk about pay for performance welded into some sort of consumer-driven health plan rhetoric is helpful, but there is nobody there who is going to effect those sorts of changes.

We have a health care system that is primarily a problem with cost, but what we are relying on is underinsurance or probably uninsurance to deal with those cost issues. We are expecting individual patients, sick people, to be able to manage that, and we are not expecting anybody else, such as the insurance company, the government, or the physicians, or the hospitals, to manage that. What we are doing is creating a situation in which we are going to have unalloyed increase in cost for the smaller and smaller group of people who are going to be able to pay for it. Meanwhile, the population ages and more and more people go into a Medicare system which is impoverishing.

I cannot make out a good situation here. I cannot make out a good situation for 2015. I think everything sort of points in the wrong direction. I think it is relatively irresponsible for us from a policy point of view. Having said that, let's see what the law can do about it.

Switching over now, to talk a little bit about some cases and a little bit about health law. Can health law help out? Is there a threat to federal enforcement? Do private litigators in some way effect change which is going to be helpful? I think that antitrust is mostly a cost containment issue. If you look at the sort of legal issues, now, these are what any of us would teach when we teach a health law class. Most of it is going to be right here; it is going to be antitrust law, non-profit law, fraud and abuse, torts and contracts, and technology regulation. If you thought about what they were aimed at in terms of quality, cost, and access, this is how I would say that they line up: antitrust and cost containment; non-profit law and access and quality; fraud and abuse and cost containment; and the like.

These are the problems that I have identified in that race through health policy: demographic driven changes in health care; big time cost increases; crippled managed care; a lack of technology control; a hospital financial situation which is going to deteriorate, [and] quality is going to suffer; access being reduced by underinsurance; and over-promised hope for pay for performance. Here in the law—antitrust law, fraud and abuse, torts and contracts, and non-profit law—would we expect these issues to be addressed? You would at least hope that the impulse of various areas of health law would be able to help address some of these problems as [one] disaggregates the problems of this headed-for-a-train-wreck health care

7. See Appendices G and H.

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system; but, let’s see what they actually do.

[Antitrust law, from my point of view, is looking pretty settled over the last 15 years. Not much going on with the hospital side. The last case was the ACA case in 1985 on the hospital side. [There has been] pretty strong activity against the doctors since Arizona v. Maricopa County [457 U.S. 332 (1982)]. It is pretty clear that we are not going to be very active on the hospital side in terms of enforcing lack of concentration in hospital markets.

[We have to note that there is a lot of FTC rhetoric, but I do not see a lot of FTC action. [That big report came out last summer from the FTC about what they were planning to do, but so far I am sort of looking for the next steps and not finding them.

[In the meantime, you do have to say that there are a lot of providers who have become clear that they can get aggressive as the dominant hospitals are demanding higher and higher premiums in their pricing. [Now things have been turned on their head a little bit. Really two things are of interest. One, is this Evanston Northwestern business that you all know much more about than I do. [They back into our health policy position. Suddenly, everything is turned on its head by Med South and Evanston Northwestern.

The Med South [case] is perhaps the more interesting one [In re Med South, Inc. (2002)]. The doctors are such active players in the policy area. What do I want to do as a doctor? What I want to do as a doctor [is] exert market influence. [I want] to not be charged by the antitrust laws, but get the insurance company to pay me more. That is what I want to do. I could come up with some socially progressive reasons on that, but that is basically how I keep a job.

The interesting thing about Med South is that it was a decision [that] was a ghost IPA in a PPO world. When the whole world goes to PPO, you are no longer managing care and the whole network falls apart. We are going to contract together, but we are going to contract together and we are going to do clinical integration. We are going to set up electronic medical records, we are going to have guidelines, we are going to provide better medical care. Do we let them act as a cartel and hope that we get the benefits of health care behind that? Will the rates be outweighed by the cost savings?

Here I have to sort of dip into the legal literature a little bit. I find this sort of a charming little backwater here. [This [data] is from the Annals of Health Law and it is an article that was written by a student of mine at Harvard [Andrew S. Oldham].

argument using Oliver Williamson’s antitrust theory. He was trying to look at what Med South did. This is the average cost at time A, and time B, at time 0, and time 1. [T]his is the quantity of services that were provided at time 0 and time 1; and this was the pricing at time 0 and time 1. [H]e follow[s] these relatively straightforward theories. He defines this as the benefits and this as the cost associated with it and then, you have got to love sort of the law and economics approach, he goes through a couple of formulas on the next two pages. [H]ere is a nice formula that he puts together, which I know you will want to study in depth. It is in the 2005 Annals of Health Law.

[H]e goes through the whole demand curve with constant elasticity. If the doctors get 20% increase in cost – in the price they are being paid, that is okay as long as they develop a .024% decrease in the overall. It works in this formula, but then when I got him to sort of apply it to the real world and try to find what overall costs were, that was where the problem [came] from. What are we actually talking about in terms of the cost of care for a group of patients, especially in a non-managed world? I am not sure antitrust enforcers are ever going to really figure out what this formula should look like. I think that the individual doctors and individual doctor groups will figure out how to profit from it. As a result, I do not see how antitrust changes the antitrust laws along the lines of Med South can really reduce the cost of law.

If you combine that with the California Dental Association case, a real backing away from the Goldfarb and the National Society of Professional Engineers, which was hostile towards professionals, instead we have seen the Supreme Court showing greater deference to professionals. All of that is going to lead to doctors who are going to put together ways to collaborate together to get higher pricing from the insurance companies but not, I do not think, an improvement on quality.

[O]n the other side of it, on the hospital side of it, what we see is the Evanston Northwestern case. I was stunned by this. You all know about it [but] I do not. From my point of view, it looks like a relatively narrow little market area that they are defining as the market and the analysis of the market share in this case. [The opinion] is 200 pages. I did read through it and I still could not find a good way to fit it with previous thinking about hospital markets. [T]his suggests a much more stringent approach than what we had seen in the past. I would submit to you that if there is a reasonable place to put responsibility in the health care system, I think you are better relying on the hospitals than the doctor. [This case] is interesting in that it is hostile towards merging hospitals in the same way that Med

9. Id. at 169-170.
South is kind of coddling merging doctors and I do not think that is a good way to do it. I cannot make hide nor hair of it. It does not seem to be moving in the right direction, though.

There has not been much since Ocean State and Marshfield Clinic. This is going to be a critical issue going forward: how the provider-insurer relationship plays in the antitrust; but we don’t have enough time to go into that.

I want to just talk about non-profit law because I think that is the other major area we can look at. Will non-profit law act in a way in which we can bring about a better health care system? The impulse of non-profit law conflicts with the pro-competition rhetoric of the FTC. It is much more of a regulatory approach. It is a peculiar mix of aggressive attorney generals and, sometimes, federal policy. So let’s look at some of the recent developments of non-profit law to see how it’s affecting things.

The latest challenge is the so-called Scruggs litigation, [named] after the lawyer Richard Scruggs, who is a famous class action lawyer in Mississippi and who initiated this. [T]here are large groups of plaintiffs’ attorneys who come together to work on these kinds of issues. [T]he problem with the Scruggs litigation is that they had a real problem with standing and it’s not surprising. Jim Blunking, who is a law professor down at Vanderbilt, identified this as an issue 30 years ago in the Eastern Kentucky Welfare Rights Organization, a case the Supreme Court decided. [The plaintiffs’ attorneys in the Scruggs litigation] have been turned away in terms of standing and are seeking to penetrate the state court.

What are they doing in the Scruggs litigation? Well, they wanted standing to certify the class, which they did not get. They wanted to be a third-party beneficiary of the contract created by the tax exempt status. They analogized themselves to the Hill Burton litigation. Then they saw a breach of EMTALA, which is always a stretch, especially the way EMTALA’s been constructed over the last eight or ten years. [T]hen finally they are trying to use acceptance of 501(3)(c) as creating a charitable trust. Courts have rejected each of these grounds. [What is] the impulse here? Try to get the hospitals to be more open toward taking care of patients who are underinsured or lacking in insurance, try to get them to act as real non-profit organizations.

The Kolar v. New York Presbyterian case is typical in that plaintiffs have lost their way. They need to consult a map, or compass, or [the] Constitution, because plaintiffs have come to the judicial branch for relief that may only be granted by the legislative branch. That is the bottom line in regard to the federal government’s approach. [T]he federal government does not really want anything to do with this. Instead it is going to be [turned] over to the States.
Turning over to the states in the non-profit area, there has been some very interesting activity by the Attorney General Elliot Spitzer, who is so very active, brought litigation. This is the Manhattan Eye, Ear, and Throat Hospital litigation. [W]hat Spitzer did in that case was that he forced them to reconsider a plan which they were going to, basically, sell their plant and then set up a series of ambulatory centers throughout the metropolitan area. [Spitzer] said no, that was not going to support the health care system. [H]e was successful in that litigation.

In the Littauer litigation, two hospitals merged, a Jewish hospital and a Catholic hospital. [I]n the merge, the family planning services went away. Spitzer thought that that was bad, so he tried to break up that merger again based on his authority as the Attorney General overseeing non-profit institutions. Spitzer [was] trying to make policy, but he ended up losing in the Littauer case.

If this is what we are going to depend on, individual attorney generals who are always running for governor – that’s what they do; they run for governor – trying to make policy through enforcement of the non-profit law, I am not sure that works.

In Re Allina, this was a really interesting case. You can get on the Minnesota Attorney General’s website and it will take you to the evidence that they put together around Allina. [I]t makes great reading because they examined what Allina was spending money on. They found that they were buying golf memberships and that the people were traveling to all of these places having room service and breakfast. It was very expensive and they detailed all the spending there. This was right after the AHERP collapse in Pennsylvania. [T]he Attorney General wanted to step in but the result was that they forced Allina to spin-off the HMO. It does not make much sense. In many ways, it could be considered rational, [having] the HMO there in with the health care system leads to some sort of integration. [Y]ou have to ask yourself, is the Attorneys General’s Office really the place where you want policy being made?

Fraud and abuse is a very active place for health lawyers; but, from my point of view as a health care executive, I have to spend a lot on attorneys, but it does not have to do with anything I want that looks like it is going to be profitable.

There has been muted success, if we look through the Greber and Hanlester cases up through McClatchey, but the major metaphor is, “Tell me how I can get this done.” The other thing I have to say about fraud and abuse is that it does inhibit collaboration between hospitals and doctors. Our business as hospitals is to try to get business in the door; get patients in the door. Fraud and abuse says you cannot do that in a way that other businesses certainly can. [I]nsofar as it creates a sort of wall between
collaboration, I think it cannot be good. I really believe that gainsharing makes good sense from an efficiency point of view.

In terms of torts and contracts, I feel that [area] is a place where we are not spending money well. I do want to make one more point. [I]f you look at ERISA litigation and what it did to managed care, it was striking in terms of its elimination of managed care, but it is emblematic of what is going on in the Supreme Court. Go to the Supreme Court and ask, “What sort of advice are you getting about health law?” [A]ll we know is Travelers reduces the scope it relates to. Pegram, coming out of Illinois, endorses this sort of notion of eligibility and mixed decision-making – quality as opposed to eligibility – and really opens up things from an ERISA point of view. [T]hen, [in] Rush Prudential, [the Court] expand[s] the savings clause. It looks like the Supreme Court has completely gone on its head from where they were surrounding ERISA in the early 1990s to really allow more litigation.

So everything gets turned on its head by Aetna v. Davila, which is the Texas Health Care Liability Act litigation. A unanimous Supreme Court said that ERISA is broad. [Aetna] closes the Pegram loophole around mixed decisions and really limits the savings clause as it was used in Rush Prudential. [I]t looks like the Supreme Court is saying, “We don’t know where to go with this. This is not our decision to make. We thought maybe we were causing problems with health policy when we had ERISA preempted with fraud. So we narrowed it. [N]ow we narrowed it too far and we’re going to open it back up.” You cannot look to [the Court] for guidance in this area.

I think that an even better statement is the case of PhRMA v. Walsh, which had to do with a Medicaid drug coverage. [T]his [case] was about a very complex issue of state-negotiated rebates for non-Medicaid patients. The circuit court reversed the granted injunction that PhRMA had managed to get in this program and the Supreme Court affirmed. Maine was regulating out-of-state transactions. [I]f you look at the decision, the judges had a great variety of views of the Medicaid purpose, even on the fact surrounding Medicaid. The striking thing is [that the justices] came together to say, “It’s too complicated. DHHS has to decide. The courts should not be involved here.”

If I had to summarize, we see a health care system that is not doing well. [E]verything you can predict about it says it is going to do worse in terms of good quality, lower cost, and greater access during the course of the next ten years. [L]ooking over both state and federal litigation, in particular federal litigation, you do not get any sense that the judges have any purpose on these issues, whatsoever. In fact, the high court is really saying, we should not be involved in this. This is a policy issue for the policymakers.
I have to summarize by saying that it is a relatively ugly diagnosis for the health care system looking forward, but I do not see that there is much hope for therapy out of the private litigation. We are going to have to have policy analysts and policymakers come together to set up a more rational form than we would get out of the system of litigation.

Thank you very much.
Projected Medicare Spending under Bush Administration Budget, FY 2001-2011

Billions of Dollars

- Additional Spending for Medicare Modernization/Prescription Drugs (~$110 billion, 2005-2011)
- Baseline Spending
  (Projected annual increase of 6.6%)

Note: Numbers for proposed reform do not add to $110 billion due to rounding.

Appendix A
Increases in Health Insurance Premiums Compared to Other Indicators, 1988-2002


Note: Data on premium increases reflect the cost of health insurance premiums for a family of four.

Appendix C
New Arrival: "Underinsurance Plans"

Increasingly common benefit plans that look normal on the surface, but have extraordinarily low internal limits that expose covered individuals to catastrophic losses

From Florida:

Nominal Benefit Provisions (on the surface)
- $100 deductible
- 80% of "covered services" in excess of deductible
- Maximum out-of-pocket for "covered services" = $2,000/year

Internal Limits (the fine print)

"Covered Services" Limits
- $600/day inpatient R&B
- $1,200/day ICU R&B
- $2,000/year everything else

Patient is uninsured for hospital costs in excess of R & B per diem plus $2,000/year for all other charges

Appendix E
<table>
<thead>
<tr>
<th>Condition for Which Medication Was Prescribed</th>
<th>Patients Enrolled in Non-High Deductible Plan</th>
<th>Patients Enrolled in High-Deductible Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>13</td>
<td>28</td>
</tr>
<tr>
<td>Diabetes</td>
<td>15</td>
<td>24</td>
</tr>
<tr>
<td>Depression</td>
<td>9</td>
<td>30</td>
</tr>
<tr>
<td>Arthritis</td>
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<td>16</td>
</tr>
<tr>
<td>Chronic pain</td>
<td>9</td>
<td>23</td>
</tr>
<tr>
<td>Heart disease or hypertension</td>
<td>8</td>
<td>18</td>
</tr>
<tr>
<td>Allergies</td>
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<td>23</td>
</tr>
<tr>
<td>Asthma</td>
<td>9</td>
<td>23</td>
</tr>
<tr>
<td>High cholesterol</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td>Other chronic condition</td>
<td>17</td>
<td>25</td>
</tr>
</tbody>
</table>

Appendix F
All primary care residents

1995-96
43,760 total

64.3%

2004-05
44,668 total

58.7%

5.6% decrease

Appendix G
Family medicine residents

1995-96
9,261 total
74.2%
22.5% decrease

2004-05
9,373 total
51.7%

Internal medicine residents

1995-96
21,071 total
53.1%
0.3% decrease

2004-05
21,332 total
52.8%

Appendix H