

ALASKA LEGISLATURE COMMITTEE FILES 1997-1998 00/2

9315 HOUSE LABOR & COMMERCE

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GROUP I: ADDITIONAL SUGGESTED DATA ELEMENTS FOR THE RECORDER'S OFFICE DATABASE					
a.	Name of Agent/Attorney Involved	<p>Costly and labor intensive to identify and include in the existing indexing system. Would require recording staff to read and interpret the document for applicable information. Consistency in such a process extremely difficult to establish. Possible negative impact to Agent/Attorney if indexed as a grantor/grantee on a lien document.</p> <p>ACTION PLAN: Work with users to clarify this request and the documents it would affect.</p>	Agent/Attorney could be keyed as a grantor/grantee under existing system format	Additional staff to perform data entry.	Yes, without additional indexing or document review. Customer could immediately review document image for information they desire without recording staff involvement. Search capabilities would also allow for identification of one or more document parameters for tailored customer search capability as broad or as narrow as you desire.
b.	Marital Status of Grantor/Grantee	<p>Requires additional staff time to key information, relies on staff ability to key in and verify accurately, information not used consistently on all documents, no system ability to cross check accuracy.</p> <p>ACTION PLAN: Work with users to clarify this request and the documents it would affect.</p>	None. No existing fields could be utilized except the comments field which is not searchable.	Program revision. Addle data entry staff	Yes, without additional indexing or document review. Customer could immediately review document image for information they desire without recording staff involvement. Search capabilities would also allow for identification of one or more document parameters for tailored customer search capability as broad or as narrow as you desire.
c.	Interest Information (% fractions)	<p>Costly and labor intensive to identify and include in the existing indexing system. Would require recording staff to read and interpret the document for applicable information. Consistency in such a process extremely difficult to establish.</p> <p>ACTION PLAN: Work with users to determine how to implement and whether a searchable field is required.</p>	None. No existing fields could be utilized except the comments field which is not searchable	Program revision. Addle data entry staff	Yes, without additional indexing or document review. Customer could immediately review document image for information they desire without recording staff involvement. Search capabilities would also allow for identification of one or more document parameters for tailored customer search capability as broad or as narrow as you desire.
d.	Estate File Number (court file #)	<p>Requires additional staff time to key information, relies on staff ability to key in and verify accurately, information not used consistently on all documents, no system ability to cross check accuracy.</p> <p>ACTION PLAN: Work with users to determine whether a searchable field is required and which document types would be affected.</p>	None. No existing fields could be utilized except the comments field which is not searchable	Program revision. Addle data entry staff	Yes, without additional indexing or document review. Customer could immediately review document image for information they desire without recording staff involvement. Search capabilities would also allow for identification of one or more document parameters for tailored customer search capability as broad or as narrow as you desire.
e.	Deed Restrictions/Limitations	<p>Impractical to try and identify and enter into one dedicated searchable field. Information will vary from document to document.</p> <p>ACTION PLAN: Work with users to clarify this request and the scope of information it would cover.</p>	None. No existing fields could be utilized except the comments field which is not searchable	Program revision. Addle data entry staff	Yes, without additional indexing or document review. Customer could immediately review document image for information they desire without recording staff involvement. Search capabilities would also allow for identification of one or more document parameters for tailored customer search capability as broad or as narrow as you desire.
f.	Power of Attorney Agent/Backup	<p>Costly and labor intensive to identify and include in the existing indexing system. Would require recording staff to read and interpret the document for applicable information. Consistency in such a process extremely difficult to establish. Possible negative impact to Attorney Agent/Backup if indexed as a grantor/grantee on a lien document</p> <p>ACTION PLAN: Work with users to clarify this request and the documents it would affect.</p>	Attorney Agent/Backup could be keyed as a grantor/grantee under existing system format or as a nonsearchable comment	Program revision and/or additional data entry staff	Yes, without additional indexing or document review. Customer could immediately review document image for information they desire without recording staff involvement. Search capabilities would also allow for identification of one or more document parameters for tailored customer search capability as broad or as narrow as you desire.
g.	SSN of Grantor/Grantee	<p>Requires additional staff time to key information, relies on staff ability to key in and verify accurately, information not used consistently on all documents, no system ability to cross check accuracy.</p> <p>ACTION PLAN: Review legal issues, including privacy issues. Determine whether statutory revision is necessary and work with users to determine which document types would be affected if implemented.</p>	None. No existing fields could be utilized except the comments field which is not searchable	Program revision. Addle data entry staff	Yes, without additional indexing or document review. Customer could immediately review document image for information they desire without recording staff involvement. Search capabilities would also allow for identification of one or more document parameters for tailored customer search capability as broad or as narrow as you desire.

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h.	Standardize entry of aliquot parts in the legal description	<p>Can be readily accomplished and is currently being implemented. This change will be on a go forward basis unless data conversion is undertaken to standardize historical information. This change will not make searching the database any easier as there is currently no means to request a description below the section level without program changes.</p> <p>ACTION PLAN: Agency will develop internal procedures to address consistency of aliquot part data entry and implement prior to 1/1/98.</p>	Data entry will be standardized.	Program revision needed to search at aliquot parts level	Yes, without additional indexing or document review. Customer could immediately review document image for information they desire without recording staff involvement. Search capabilities would also allow for identification of one or more document parameters for tailored customer search capability as broad or as narrow as you desire.
i.	MTRS minimum for mining documents. Index creek, stream or river name as necessary.	<p>Meridian Township Range Section is entered on all documents which reflect this information. Current system will not allow partial information to be keyed into searchable fields. If incomplete information is present on the document the partial information is entered into a nonsearchable comments field. Waterways would also have to be entered as a comment.</p> <p>ACTION PLAN: Research need for statutory/regulatory revision to require MTRS on mining documents. Work with users to determine when creek, stream or river names are necessary for indexing and whether a searchable field is needed.</p>	None. No existing fields could be utilized for partial information except the comments field which is not searchable.	Program revision and addle data entry staff	Yes, without additional indexing or document review. Customer could immediately review document image for information they desire without recording staff involvement. Search capabilities would also allow for identification of one or more document parameters for tailored customer search capability as broad or as narrow as you desire. Maps which are included as part of a document would also be displayed as submitted without staff interpretation. Search parameters could stay at the MTRS level or go down to approximately four levels of aliquot parts definition
j.	Require subdivision code and name as part of the legal.	<p>This would require statutory and/or regulatory revision before being implemented. Current system will only accept subdivision codes in the searchable data entry fields and recording staff must manually convert the information presented on the document to the required data entry format. This is a subjective process that is prone to error. Subdivision names can be entered as a comment, but are not retrievable.</p> <p>ACTION PLAN: Work with users to determine if an acceptable method of cross reference for subdivision name and code can be accomplished and made available for use statewide.</p>	None. No existing fields could be utilized except the comments field which is not searchable.	Program revision and addle data entry staff.	Yes, without additional indexing or document review. Customer could immediately review document image for information they desire without recording staff involvement. Search capabilities would also allow for identification of one or more document parameters for tailored customer search capability as broad or as narrow as you desire. Currently available industry software has the ability to cross reference the subdivision name and code, so both pieces of information would not be mandatory. Either would allow the system to perform a full database search.
k.	Stated amount of lien on property	<p>This information has historically been keyed into the system at the end of other dedicated fields where extra space existed or in the comments field. The overall result is inconsistent index creation with no search capability.</p> <p>ACTION PLAN: Work with users to determine whether a separate searchable field is required and which document types would be affected.</p>	None. No existing fields could be utilized except the comments field which is not searchable	Program revision	Yes, without additional indexing or document review. Customer could immediately review document image for information they desire without recording staff involvement. Search capabilities would also allow for identification of one or more document parameters for tailored customer search capability as broad or as narrow as you desire.
l.	Establish search capability by subdivision name.	<p>The existing system allows you to look up a subdivision name and see all the plat number or subdivision code choices for that name. The plat number or subdivision code must then be entered into the limited search parameters available. You cannot search from the name itself nor will the search function cross reference against subdivision names entered into comments fields.</p> <p>ACTION PLAN: Address this enhancement as a workplan item under the cooperative agreement with the private contractor.</p>	None	Program revision	Yes, without additional indexing or document review. Customer could immediately review document image for information they desire without recording staff involvement. Search capabilities would also allow for identification of one or more document parameters for tailored customer search capability as broad or as narrow as you desire. Searches can be requested against either subdivision names or codes and will pull information from both groups for customer review by utilizing an internal cross reference capability.
m.	Establish potential to identify multiple document functions	<p>The existing system cannot accommodate long document titles nor does it offer a field which would indicate multiple functions to alert the customer. Staff don't have the ability to consistently identify where the title for one function ends and another begins in all document types nor should they be placed in the position of interpreting what information is applicable. Long titles could be continued on a comments line, but would not be searchable.</p> <p>ACTION PLAN: Continue current procedure which defaults to recording and indexing a multi-function document under first function only unless customer instructs otherwise. Work with users to clarify the request and how it would be implemented consistently statewide.</p>	None.	Program revision and addle data entry staff.	Yes, without additional indexing or document review. Customer could immediately review document image for information they desire without recording staff involvement. Search capabilities would also allow for identification of one or more document parameters for tailored customer search capability as broad or as narrow as you desire. Data entry has very few limits on field sizes, so virtually all long titles would be accepted and fully displayed for customer review and interpretation. Additionally, the software would allow recording personnel to designate customized data entry fields not built into the basic package for their immediate use.

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n.	Add a physical address location of property field as a companion to the legal description.	<p>This item represents a significant amount of additional data entry and goes beyond basic index information recording staff have keyed to date. The existing system has no dedicated field for this type of information. The comments field could be used, but the information would not be searchable</p> <p>ACTION PLAN: Work with users to clarify this request and the documents it would affect.</p>	None. No existing fields could be utilized except the comments field which is not searchable.	Program revision and add data entry staff.	Yes, without additional indexing or document review. Customer could immediately review document image for information they desire without recording staff involvement. Search capabilities would also allow for identification of one or more document parameters for tailored customer search capability as broad or as narrow as you desire.
o.	Standardize aliquot parts entry as minimums for legal description.	<p>This would require statutory and/or regulatory change before being implemented. It would also be problematic as documents are recorded which encompass entire sections of land. Current procedure is that aliquot parts are entered as a continuation line for each legal they affect. Current query capabilities do not allow the user to restrict their search criteria to the aliquot parts level so users must pan through voluminous entries against that Meridian Township Range Section entry to look for variations which might be of help to them.</p> <p>ACTION PLAN: Work with users to clarify this request and the documents it would affect.</p>	None.	Program revision	Yes, without additional indexing or document review. Customer could immediately review document image for information they desire without recording staff involvement. Search capabilities would also allow for identification of one or more document parameters for tailored customer search capability as broad or as narrow as you desire. Location query capabilities allow for one or more pieces of search criteria. The system will pull all information against a meridian down through approximately four levels of aliquot parts description. The results are automatically compiled into a reception book type of format at the customers request.

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GROUP II. INCREASED REPORTING INFORMATION SUGGESTIONS					
2 a.	Search capability on Associated Number Field.	Existing system will not allow group reporting on any field except the grantor/grantee and some location text. Associated documents will only be displayed under this format if they reflect one or more of the same names or same property descriptions as the original filing. ACTION PLAN: Work with users to clarify this request and identify whether this capability should be pursued as a workplan item to the existing cooperative agreement with the private contractor.	None. No customized reporting features are available to the Recording database through DNR facilities. The vendor may be able to accommodate for a fee.	Program revision	Yes, without additional indexing or document review. Customer could immediately review document image for information they desire without recording staff involvement. Search capabilities would also allow for identification of one or more document parameters for customized customer search capability as broad or as narrow as you desire. Any query information will generate a list of associated document numbers if they exist. Once these numbers are identified they can be selected to display the document they represent or an image of the same.
b.	Larger screen fields to view all of legal description data	In order to be accepted by the current system, legal descriptions must be keyed in specific combinations (i.e. lot, block, plat number, section, township, range, meridian). Descriptions which do not fit the required parameters can only be keyed as a comments field which does not report in a location search. Current display screens have insufficient space to see all of the detailed information keyed by staff when the index is created. The user is unable to determine without reviewing every entry, if the item applies to their research or not. ACTION PLAN: Work with users to clarify this request and identify whether this capability should be pursued as a workplan item to the existing cooperative agreement with the private contractor.	None. Existing query features already do not fully utilize the information keyed by staff.	Program revision	Yes, without additional indexing or document review. Customer could immediately review document image for information they desire without recording staff involvement. Search capabilities would also allow for identification of one or more document parameters for customized customer search capability as broad or as narrow as you desire. Location query capabilities allow for one or more pieces of search criteria. The currently available integrated system software can pull all information against a meridian down through approximately four levels of aliquot parts description. The results are automatically compiled into a reception book type of format at the customers request.
c.	Ability to cross reference between DEC and recorder's office database	The ability to establish online linkages with other state agencies is highly desirable from a user standpoint and also represents a significant time savings for numerous state agencies like the Division of Mining, DOT, Child Support Enforcement, etc. in the execution of their regular duties. This does not mean that the databases would be merged, each would remain separate in its own right, but users could travel between different sites easily online. Currently, no such option is available and each of these agencies must pay a subscription fee to review the recording database. ACTION PLAN: Work with users to clarify this request and determine scope of information required.	None.	Program revision, possible telecommunications revisions and establish access agreements with the vendor.	Yes. The desired technology is an open architecture design that will communicate with a variety of systems in use in other locations. Once installed, any user, can access the system via Internet capability or as an additional user on the Wide Area Network.
d.	Search capability by spouse name or business name	Currently, the user must be prepared to identify, enter and search on every variation of the name they are seeking. In the case of individuals this may require knowing the name of both the husband and wife, which can be complicated if divorce or remarriage has occurred. ACTION PLAN: Address this enhancement as a workplan item under the cooperative agreement with the private contractor.	Review all existing index files to identify the husband and wife entries which must be converted from one entry to two. Husbands and wives have been keyed separately since the early 1990's.	Request a program extraction to identify and convert problem entries. This would alleviate the problem of "hidden" names only.	Yes. The currently available software can operate more intuitively to identify and compile a report of entries for user review. Entering one character of information will produce the broadest report of all documents or you can specify a list of criteria to search against, such as document type, time frame, district, etc. Such software is also capable of searching "married" entries using more of a FIND function approach and does not rely on a direct match in order to furnish a report.
e.	Report of Market Share by Title Co., Lending Co., etc.	The existing system can only display all document keyed on a specific name. DNR has no ability to customize any search format to a specific time frame, dollar amount, etc. beyond the three search keys currently available (serial number, grantor/grantee name or location description.). ACTION PLAN: Work with users to clarify this request and determine scope of information required.	None.	Program revisions through the vendor or create a second layer of programs within the department and run two systems.	Yes. This type of capability is part of the basis comprehensive system package that users could access and utilize from their own locations or at any DNR recording facility as a simple search and print feature. It could also be established as a regular report which could be distributed by the recorder's office to regular interested users.
f.	UCC - By week by community	The existing system cannot produce this type of customized report. ACTION PLAN: Work with users to clarify this request and determine scope of information required.	None.	Program revisions through the vendor or create a second layer of programs within the department and run two systems.	Yes. Producing a report of UCC transactions for a specific time frame in a specific district is a standard request capability. To go further within districts to identify communities would require a more refined search ability that could be requested during the bid process.

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g.	Corporate computer online search of UCC database by debtor.	<p>The recorder's office supports this type of remote access, but is currently prohibited from offering this option under terms of the cooperative agreement with the private vendor who maintains the indexing system.</p> <p>ACTION PLAN: Work with users to define the scope of request and possible future options to provide broader dissemination of public information.</p>	None.	Modify agreement with private vendor, develop state programs/network to accommodate. Additional funding to cover increased chargeback costs.	Yes. Utilizing remote Internet access is a basic feature of currently available software. Customers can pay for the service via pre-defined account numbers or they can furnish credit card information when they are reviewing online.
h.	Ability to print single page or selected pages from corporate computer	<p>The recorder's office supports this type of remote access, but is currently prohibited from offering this option under terms of the cooperative agreement with the private vendor who maintains the indexing system. The existing index can only be used to identify the film location of specific documents. The film must then be retrieved and a copy made. Adding this service under the current agreement would negatively impact operations by adding yet another processing layer</p> <p>ACTION PLAN: Work with users to define the scope of request and possible future options to provide broader dissemination of public information.</p>	None.	Modify agreement with private vendor, negotiate program revisions, purchase equipment, upgrade network to support image transfer and add staff.	Yes. Documents taken on a daily basis would be scanned into the system and would be available for public review immediately or on a short delay basis from any location in the state. Once the image is available, users can either establish accounts or provide credit information to print document copies in their own locations.

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GROUP III:		OTHER ISSUES			
a.	File UCC transactions with UCC Central only.	<p>The recorder's office is in favor of simplifying the UCC filing process for the users and staff. Statutory and regulatory change would be required in order to go forward with this item.</p> <p>ACTION PLAN: Research UCC programs in other jurisdictions, communicate with Uniform Laws Commission on the status of proposed national code revisions. Work with users to define the scope of request and evaluate user support for legislative change.</p>	None.	User study group and input into the drafting process of the statutory and regulatory language package	The currently available industry package software is capable of supporting any type of UCC filing structure including electronic filings if desired. Conversion to electronic filing has been implemented in numerous jurisdictions nationwide.
b.	Include the public in the change process for the recorder's office.	<p>The recorder's office regularly seeks public input with regard to issues involving statewide changes with public impact.</p> <p>ACTION PLAN: Continue to work with users on desired changes in the recording system.</p>	The stakeholder process was the first step in what we hope will be ongoing public participation in improving recording/filing services offered statewide.	Public participation in statutory/regulatory processes and ongoing meetings with users to identify and clarify changes requested.	Public participation would be critical in planning technological improvements.
c.	Problems with accuracy of data entry.	<p>As noted in the stakeholder meetings, database errors can result from errors in the source document as well as errors in the input process. Recording staff are not at liberty to make assumptions about the accuracy of what is submitted on the source document. Effort is made to check and recheck the data which is added to the permanent database, but existing system limitations result in relying on virtually a manual item by item checking process which is extremely labor intensive and costly.</p> <p>ACTION PLAN: Utilize a re-verification process and work with user groups to explore alternative means of presenting index information. Address this enhancement as a workplan item to identify errors in frequently misspelled common words.</p>	The recorder's office has implemented ongoing periodic re-verification processes to identify and correct data entry errors not contained within the source document.	Program revisions to provide spell check capability on common words such as National, First, Bank, Mortgage, etc. would provide partial relief and some improvement in database accuracy.	Not 100%, but the intelligence of the currently available software would allow for a dramatic reduction in the number of errors which would get through. Examples include having currently available software compare the data entry of the input operator with the verifier's data
d.	Return of original documents is too slow	<p>Before the original documents can be released, recording staff must be certain acceptable archival film quality is captured. Documents are routinely ready for return approximately 3 weeks after recording, but they are frequently held longer because incoming daily work must take priority over processed document mailback. This perpetual backlog situation is one of the reasons the recorder's office wishes to pursue new technology.</p> <p>ACTION PLAN: The recorder's office has hired several nonperm employees to provide temporary relief for the current mailout backlogs statewide. Work with users to explore alternative options available to expedite this process under the existing system.</p>	None. The recorder's office has streamlined its processing measures as much as it can under the constraints of operating three separate systems (physical recording, receipting and index creation).	Program revisions to the existing index system would afford some relief, but would not result in the kind of comprehensive processing improvements needed to eliminate any of the three systems being used.	Yes. The opportunities a combined recording, indexing, cashiering and indexing system offers are significant. Workflow software would allow each piece of information to be dispersed through all parts of the system wherever it is needed rather than staff having to rekey them numerous times into separate systems. Such a savings would have immediate positive impact on the amount of time needed to process incoming work each day. If imaging is incorporated, it is possible to scan the document and rely on the scanned image for backup if there are any problems with the creation of the archival film. Documents could be returned immediately over the counter in locations that are equipped with a scanner or returned within days of recording from areas which must route their documents to a scanner.
e.	Date Stamp and other data is not readable.	<p>Twenty-two of the thirty-four recording districts still record documents manually by hand stamping a blank recording format and filling in all pertinent information (serial number, district, date, time, requesting party and price). Seven of the remaining twelve districts are using machine stamps that are more than 25 years of age. Replacement parts on these units are difficult to come by and their failure rate is increasing rapidly. Staff must watch each number as it is assigned to be sure the serial number, date and time wheels are advancing properly without skipping or sticking.</p> <p>ACTION PLAN: Pursue replacement of failing timestamps as funding is available. Work with users to determine if document formatting requirements should be considered</p>	A new stamping machine is being tested in five locations. The units must be customized to reflect all the information we need and the format is significantly larger than the older machines. Because of the increased stamp size, it is frequently necessary to attach blank pages to documents for recording purposes.	Replacing older failing timestamps would afford some temporary relief with legibility, but the volume of documents processed annually takes a rapid toll on impression units of this kind. Units would be phased in over time as funds allow.	Yes. Currently available computerized software utilizes adhesive labels and bar codes to record documents. Labels are generated on a laser printer for maximum speed and clarity. Machines stamps would be eliminated as would instances of sequencing errors which must currently be manually tracked for the majority of districts. Scanning the bar code would automatically create part of the index and link the image to the index file for rapid retrieval. Duplicative data entry would be eliminated and workflow software would ensure that all documents are accounted for and complete each day according to the management parameters requested.

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f.	Online access to document images, ability to request fax copies online	<p>Both of these capabilities represent expansions in customer service the recorder's office supports. The existing system could be modified to add an additional processing layer to the existing three processing systems so document images could be captured, but this would be a costly and cumbersome way of approaching new technology. Access would likely be limited to within each DNR office only or via paid vendor subscription.</p> <p>ACTION PLAN: Work with users to define the scope of request and possible future options to provide broader dissemination of public information.</p>	None. To work effectively, imaging technology requires a telecommunications network with high speed full duplex transmission capability and PC workstations to host and display the images.	Additional staff, program revisions and scanning equipment	Yes. Utilizing remote Internet access is a basic feature of currently available software. Customers can pay for the service via pre-defined account numbers or they can furnish credit card information when they are reviewing online.
g.	Some customers may prefer working with a private vendor rather than state government.	<p>Copies of this state owned database are available upon request according to established fees or the cost of duplication. Customers can continue to work with the vendor of their choice if that vendor expresses an interest in and continues to receive ongoing updates of the recording information.</p> <p>ACTION PLAN: Continue to make information available on request.</p>	Procedures are already in place to distribute copies of all public information on request.	None.	Yes. Any vendor can continue to receive complete copies of recording information. In addition to data tapes, customers could request electronic transmission or CD format.
h.	Update records which predate 1992 and ensure uniform conventions are applied to the existing database/new entries.	<p>How information is keyed into the system has changed over the years, usually to offer more information rather than less. The existing system offers the ability to make corrections to the database, but these methods of laborious and time-consuming. Corrections to the "current" file (approximately the past two years) are applied to the file each night. Corrections to the remainder of the 26 year file, or "base updates" are accumulated in a holding tank and do not reflect in the public database until a base file rollover is done approximately every 3-6 months. In order to make historical changes, staff must view film records or make paper copies to compare to the online index. There are insufficient staff resources to accommodate this type of long term update process.</p> <p>ACTION PLAN: Work with users to identify how this item should be prioritized within the framework of the existing cooperative agreement.</p>	<p>Review database entries against film one by one.</p> <p>Request database extractions for specific time frames against specific criteria (for example, list all names in 1991 with the & symbol to locate "married up" entries which need to be keyed as two separate names.</p>	<p>Additional staff and computer equipment.</p> <p>Additional staff, program revisions and computer equipment.</p>	Yes. As part of a backfile conversion, the entire recording database could be transferred and corrected according to the parameters we specify. Married up entries could be separated, number entries could be double keyed as numbers and words, etc. Our research has indicated that most conversions have been completed within one month to a year of the time the new system was installed depending upon the complexity of what was requested in the conversion process.
i.	Enter records which predate 1970 in the automated system.	<p>This is a highly desirable improvement the recorder's office favors. However, the existing system does not leave sufficient staff resources to accomplish a project of this type without compromising our ability to handle the incoming daily work. Linking this item to technological improvements would be the fastest and most economical means of addressing this request.</p> <p>ACTION PLAN: Work with users to identify how this item should be prioritized. This item cannot be accomplished with existing staff and resources.</p>	Poor quality 35mm microfilm and the original books with inadequate indices are the only two sources of this information at the present time available for public access to pre-1970 records.	Additional staff and computer equipment.	Scanning the original books would be the easiest and fastest way of accomplishing this backfile conversion. If staff had the ability to index the historical documents under an integrated comprehensive system from images, the speed of the project would be significantly faster and workflow software would ensure that the project was always available online by switching between windows or batches rather than having fragile original vault books out in circulation being handled on a regular basis.
j.	Provide access to the reception report at the time office opens.	<p>The recorder's office strives to accomplish this goal on a daily basis. Unfortunately, the production limitations associated with processing documents under three separate labor intensive systems is substantial. At a minimum, offices close half an hour before the end of their workday in an effort to ensure the reception report is ready. This buffer is clearly inadequate if there is any type of increase in daily recording activity.</p> <p>ACTION PLAN: Have at all times either reception reports (both verified and unverified) or document copies in each office available to the public at the opening of business.</p>	Divert staff from recording and over to indexing earlier in the day. Indexing will start earlier in the day, but recording will slow down and customer assistance will suffer.	Additional staff and computer equipment.	Yes. Eliminating duplicative and redundant steps will simplify the recording process overall. Currently available intuitive software allows supervisory personnel to identify the workflow settings which will most benefit their office workload and staffing volumes. Such a system can provide regular reporting feedback on the status of the day's work, alerting the supervisor to slow areas or bottlenecks which can be rerouted or avoided. Reception reports accumulate throughout the day automatically and can be electronically transmitted to users or printed out in paper form as they are created. Customers would no longer have to wait until the following business morning to receive their completed reception report.

Item No.	Item Requested	Recorder's/UCC Comments & Action Plans	Existin;; Options to Accommodate	Resources Needed to Succeed Under the CURRENT State/Private System*	Could Item be Accomplished With Currently Available Industry Package Software that Combines Recording, Indexing, Cashiering and Imaging Functions?
k.	Explore methods to avoid folding and damaging original documents.	<p>The entire current recording process is characterized by repetitive handling of documents which may or may not necessitate folding the document. Stamping equipment utilized by the recorder's office frequently requires that documents be folded in order to properly affix the recording information. Additionally, virtually all of the 200,000 original documents recorded annually are returned by regular first class mail making cost of postage and envelopes is a significant budget factor. Recording staff do fold documents, but we have a very low document damage rate while documents are in our custody.</p> <p>ACTION PLAN: Work with users to determine alternative means of processing documents to minimize document damage.</p>	<p>Mailback procedure could be modified to keep all unfolded documents flat in a manila envelope or a pick up option could be offered. This results in special handling of sorts and would slow down the mail back procedure.</p>	<p>Additional staff and postage funds.</p> <p>Possible regulatory change to require SASE inclusion at the time of document submittal.</p>	<p>Yes, partially. Offices equipped with scanners would be able to scan the original and return it immediately to the submitting party if presented in person. Items submitted unfolded through the mail would need a modified mail back procedure to ensure they were returned the same way. The extra expense of special handling could more easily be absorbed if a high percentage of documents were being returned over the counter at the time of recording.</p>
l.	Develop a fact sheet about the indexing or recording changes which have influenced the database.	<p>Each of the offices have unique circumstances related to their databases which staff should have available or posted in each office. However, identifying changes in the historic database is difficult because little or no documentation exists relative to changes prior to 1992. Indexing changes implemented since then have been consistently applied to all offices. The current system is limited in how it accepts, reads and reports against data entry putting the burden for completeness and accuracy entirely on recording staff.</p> <p>ACTION PLAN: Develop general search guidelines for use in recording library facilities by 1/1/98.</p>	<p>Prepare additional detailed handouts which must be taken into account so users can modify how and what they ask from the current system.</p>	<p>Time to compile into handout form all known changes to the indexing procedure.</p>	<p>Yes. The currently available software under this integrated comprehensive system is constantly working with and filtering all data keyed in. Workflow shortcuts make it possible to key in minimal information and have the system duplicate and distribute the data as necessary for repetitive names, married spouses, similar documents, etc. This is markedly different from the current system which requires each name to be rekeyed in full with no ability to compare data from one document to the next and no shortcuts to speed the process along.</p>
m.	Waive small fees to improve operational efficiencies.	<p>The recorder's offices supports waiving fees for amounts too small to justify staff time to receipt and collect them.</p> <p>ACTION PLAN: Identify the cutoff amount and implement in all offices by 12/1/97.</p>	<p>Identify the appropriate amount and implement a procedural change.</p>	<p>None. The State Recorder has the authority to make this change.</p>	<p>The currently available software under an integrated system has the ability to honor this type of procedural modification should it be established before a new system is installed.</p>
n.	Notification of office closures or backup coverage online for all offices.	<p>Closure information is always available through recorder managers and in non-emergency situations is also stated on each office's message machine. Additionally, the recorder's office is in the process of designing a web page where closure information could be posted. This information would be available to remote users with Internet access, but would not be available in each recording location until all offices are equipped with PC units and converted to the state's TCP/IP network. Currently, the majority of staff terminals as well as all public access terminals are dumb and have no Internet capability.</p> <p>ACTION PLAN: Develop an Internet web page for the recorder's office site. Explore possibility of implementing an 800 number statewide to provide current information to users about closures.</p>	<p>A web page can be created for display on the Internet with no internal use capability.</p>	<p>None. The department has the ability to create this website and the Recorder's/UCC section management can access the site to enter updates.</p>	<p>Yes. The currently available software under an integrated system is fully Internet capable and each office would have the ability to enter updates as needed for immediate customer review on and off site.</p>
o.	Record documents for other districts at any office or merge all districts into one.	<p>The recorder's office has considered this possibility and its internal operational benefits, but recognizes that this is a substantial change which requires extensive public input.</p> <p>ACTION PLAN: None at this time. Continue to work with users to identify ways to improve recording operations statewide.</p>	<p>Conduct public meetings if the concept is supported by the users. Identify the statutory and/or regulatory changes which need to be made.</p>	<p>Public participation and support.</p>	<p>Yes. The currently available software under an integrated system is capable of supporting one or hundreds of number series. Under the current 34 recording district structure, the comprehensive system could track serial numbers quickly and successfully enough to assign sequential serial numbers for a particular district from different locations without duplicating or skipping numbers. This would enable a customer in Nome, for example to record, a document in Anchorage without leaving the city of Nome and the image of the document could potentially be available immediately online.</p>

Item No.	Item Requested	Recorder's/UCC Comments & Action Plans	Existing Options to Accommodate	Resources Needed to Succeed Under the CURRENT State/Private System*	Could Item be Accomplished With Currently Available Industry Package Software that Combines Recording, Indexing, Cashiering and Imaging Functions?
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p.	Expand payment options to include credit, prepaid accounts, etc.	<p>The recorder's office supports these kinds of customer service expansions. The department is looking into implementing credit card payments now. Accounts are more challenging as they would require an additional layer of tracking and accounting that recording personnel don't have the time available to accommodate.</p> <p>ACTION PLAN: Work with users to clarify the request and coordinate implementation with the department's financial services section.</p>	<p>Statutory and/or regulatory change. Establish an accounting structure to support accounts and generate bills and statements.</p>	<p>Additional staff and computer equipment.</p>	<p>Yes. The accounting portion of this currently available software under an integrated system is already formatted to accommodate customer accounts and credit card payments. Reports are generated daily, weekly monthly, or as often as you choose to track and summarize accounting information cumulatively or as you specify.</p>
q.	<p>Conduct a benchmark study of recording techniques or systems already in use to reengineer Alaska's recording system.</p>	<p>The recorder's office has been gathering data from the Lower 48 for approximately the past 5 years on recording technology. We have learned a great deal about what works and doesn't work from the efforts of other recorders. We believe it is critical to pursue a system that combines all aspects of the recording process under one system. Open architecture is also vital to ensure the most suitable equipment for each phase of the operation and avoid proprietary technology which can become costly and difficult to maintain.</p> <p>ACTION PLAN: Continue to work with national organizations and other jurisdictions to gather information relative to recording and UCC systems used elsewhere and keep users informed. Work with users to identify scope of proposed benchmark study and implement only with their support and participation.</p>	<p>We have conducted extensive research in other jurisdictions and the systems they have used and would be happy to discuss the merits of an integrated comprehensive system and what it can accomplish for the recorder's office and our users.</p>	<p>Public participation and support.</p>	<p>Preservation of the historic public record is the driving force behind this effort to modernize. An Ombudsman's report in 1992 had numerous criticisms of the recorder's office for the manner in which historic records are handled and stored. We have made little progress in resolving these issues with minimal funding and look to this new system to free up existing resources to tackle these preservation concerns before it is too late.</p>

Data Elements Suggested for Addition to the Uniform Commercial Code Database

Item No.	Item Requested	Recorder's/UCC Comment & Action Plan	Existing Options to Accommodate	Resources Needed to Succeed Under the CURRENT State/Private System ^h	Could Item be Accomplished With Currently Available Industry Package Software that Combines Recording, Indexing, Cashiering and Imaging Functions?
1.	Index Serial No./VIN No. of Collateral Item	<p>This is the kind of index expansion the recorder's office does not favor. Document preparation is inconsistent making it difficult to locate and identify this information. Additionally, multiple serial or VIN numbers would be problematic to enter into a single field and indexing this level of detail takes the index beyond an access tool to a document substitute which is not our objective. The document is the public record and should be relied upon for reviewing information of this nature.</p> <p>ACTION PLAN: Work with users to clarify this request and identify the documents which would be affected. Additionally, gather information from other jurisdictions and national organizations/publications relative to current practices regarding indexing of collateral.</p>	None.	Program revision and additional staff.	Yes from the standpoint that documents would be accessible for review as soon as they were scanned. You could not search fields which have not been indexed.
2.	General Classification of Collateral Item.	<p>Having recording staff summarize and classify collateral type has been a controversial issue. Recorder's are trained not to read and make value judgments on the content of documents, nor is there any assurance that any two employees would arrive at the decision for what is the most important collateral heading. Staff focus their attention on scanning UCC documents for the minimum criteria needed to accept and index as they do all other documents.</p> <p>ACTION PLAN: Work with users to clarify this request and identify the documents which would be affected. Additionally, gather information from other jurisdictions and national organizations/publications relative to current practices regarding indexing of collateral.</p>	None. Statutory and/or regulatory revisions could be considered which would require indexing cover sheets that identify the collateral entry the user would like to see keyed into the system.	Public participation and support. Program revision and additional staff.	Yes. See comment 1 above.
3.	Location of Collateral and filing expiration date.	<p>Again, this level of indexing goes beyond creating an access index. To key this type of data is to risk relying on the index for information the document should furnish. We recognize that this type of information would be highly useful, but feel the public would be better served by using the document image rather a rekeyed translation which could be erroneous.</p> <p>ACTION PLAN: Work with users to clarify this request and identify the documents which would be affected.</p>	None. Statutory and/or regulatory revisions could be considered which would require these fields to be indexed and identified on an indexing cover sheet by the submitting party.	Program revision and statutory review/change, additional staff.	Yes. See comment 1 above.
4.	Verbal collateral descriptions or description categories furnished by submitting party.	<p>If something uniform could be established, the recorder's office could work with these type of parameters. Establishing a rule which will cover all documents prepared could be extremely difficult. A contingency would have to be established for those documents which don't fit the agreed upon codes. The use of codes would also mean conversion time when indexing and when researching which is not particularly user friendly.</p> <p>ACTION PLAN: Work with users to clarify this request. Contact the few jurisdictions using collateral code systems for more information.</p>	None. Statutory and/or regulatory revisions could be considered which would support the use of collateral codes for indexing purposes. The problem with lists is that new categories emerge regularly that are not covered by the list.	Program revision and statutory review/change, additional staff.	Yes. See comment 1 above.

does not include cadastral plats, cadastral control plats, open-to-entry plats, or remote parcel plats created by or on behalf of the state regardless of whether these plats include easements or other public dedications. (§ 7 (ch II) ch 116 SLA 1953; am § 3 ch 95 SLA 1956; am § 41 ch 113 SLA 1981)

Revisor's notes. — Formerly AS 40.15.190. Renumbered in 1988.

NOTES TO DECISIONS

Quoted in *Konai Peninsula Borough v. Konai Peninsula Bd. of Realtors, Inc.*, 652 P.2d 471 (Alaska 1982); *State v. Weidner*, 684 P.2d 103 (Alaska 1984).

Chapter 17. Recording in Public Records.

Section

- 10. Place of recording and access to records
- 20. Recording conveyances
- 30. Formal requisites for recording
- 35. Recording criteria
- 40. Indexing
- 50. Incorporation of master form
- 60. Documents executed under former law
- 70. Duties of recorder
- 80. Effect of recording on title and rights; constructive notice

Section

- 90. Conveyances and recorded documents as evidence
- 100. Recording a reconveyance
- 110. Documents eligible for recording
- 120. Recording memorandum of lease
- 130. Action against recorder and state
- 900. Definitions

Effective date of chapter. — Section 44, ch. 181, SLA 1988, provides: "This Act takes effect January 1, 1989."

Legislative history reports. — For a sectional

analysis and commentary on SB 304, from which ch. 181, SLA 1988, which enacted this chapter, derives, see Senate-House Joint Journal Supplement No. 7, May 16, 1987.

Sec. 40.17.010. Place of recording and access to records. (a) The Department of Natural Resources shall provide at each public office designated by the department

- (1) the documents and indices or alternative document retrieval system of the recording district or districts served by that public office;
- (2) a machine, device or system with which to retrieve stored documents;
- (3) a means for making copies of recorded documents and a person authorized by the recorder to certify the copies;
- (4) to the extent money is appropriated for the purpose, a machine, device, or system capable of rapidly transmitting a document eligible for recording to a recorder at one place of recording in the state, and a person to operate the machine, device, or system; if the department determines that it is not feasible to provide a machine, device, or system in an office serving a recording district, it shall provide for transmitting documents from the office by other expeditious means;

(5) instructions that explain to the public the formal requirements that a document must satisfy to be recorded.

(b) The department shall provide the staff and equipment to receive and record documents and to store them permanently.

(c) When rapid recording and retrieval and secure storage of documents can be provided for all recording districts with a single place of recording in the state, the recorder shall record the documents at a single place in the state designated by the department.

(d) The recorder shall provide reasonable public access during business hours to recorded documents, indices, and facilities provided for in this section. (§ 1 ch 161 SLA 1988)

Sec. 40.17.020. Recording conveyances. (a) A conveyance that is eligible for recording under AS 40.17.030 and 40.17.110 may be offered for recording only in the recording district in which land affected by the conveyance is located. If land affected by the conveyance is located in more than one recording district, an original conveyance may be offered for recording in the recording district in which part of the land is located and an original or a certified copy may be offered for recording in each other recording district in which part of the land is located. A certified copy recorded has the same effect from the time it is recorded as though it were the original conveyance.

(b) A certified copy of a conveyance that is eligible for recording under AS 40.17.030 and 40.17.110 and that has been recorded or filed in a public recorder's office in another state or in the United States Bureau of Land Management may be offered for recording only in the recording district where land affected by the conveyance is located. When recorded, it has the same effect from the time it is recorded as though it were the original conveyance. (§ 1 ch 161 SLA 1988; am § 2 ch 119 SLA 1996)

Effect of amendments. — The 1996 amendment, effective July 1, 1996, substituted "offered for recording" for "recorded" in three places in subsection (a) and in subsection (b) and made minor stylistic changes.

NOTES TO DECISIONS

Applied in *Denardo v. State*, 887 P.2d 947 (Alaska 1994).

Sec. 40.17.030. Formal requisites for recording. (a) Except as provided in (b) and (c) of this section, to be eligible for recording, a document must

- (1) contain original signatures;
 - (2) be legible or capable of being converted into legible form by a machine or device used in the recording office;
 - (3) be capable of being copied by the method used in the recording office;
 - (4) contain a title reflecting the overall intent of the document;
 - * (5) contain the information needed to index the document under regulations of the department;
 - (6) contain a book and page reference or serial number reference if the document amends, corrects, extends, modifies, assigns, or releases a document previously recorded in this state;
 - (7) contain the name and address of the person to whom the document is to be returned after recording;
 - (8) if it is a deed, contain the mailing addresses of all persons named in the document who grant or acquire an interest under the document;
 - (9) be accompanied by or contain the name of the recording district in which it is to be recorded; and
 - (10) be accompanied by the applicable recording fee set by regulation; if the document is to be recorded for multiple purposes, it must be accompanied by the applicable fee for each of the multiple purposes.
- (b) To be eligible for recording, a certified copy of an official document from a governmental office need only meet the requirements of (a) (2), (7), (8), and (10) of this section.

(c) To be eligible for recording, an exact or fully conformed copy of an original document must be accompanied by an affidavit of the person offering the document. The affidavit must meet the requirements of (a) of this section and must state that

the exact or fully conformed copy was received by the person in the course of the transaction;

(2) the original is not in the person's possession; and

(3) the instrument offered for recordation is an exact or fully conformed copy.

(d) The recorder shall prescribe the style, size, form, and quality that a document, plat, plan, or survey map must satisfy for filing and recording under this chapter. (§ 1 ch 161 SLA 1988; am § 3 ch 119 SLA 1996)

Effect of amendments. — The 1996 amendment, effective July 1, 1996, rewrote this section.

NOTES TO DECISIONS

Annotator's notes. — The cases cited in the notes below were decided under former law.

Deed must be properly acknowledged and witnessed for recordation. — A deed to a mining claim that was recorded without acknowledgment or other proof of its execution, and without the signature of subscribing witnesses was not entitled to be recorded anywhere. *Alaska Exploration Co. v. Northern Mining & Trading Co.*, 152 F. 145 (9th Cir. 1907).

An unacknowledged conveyance cannot be recorded. *Smalley v. Juneau Clinic Bldg. Corp.*, 493 P.2d 1296 (Alaska 1972).

But such conveyance is not void as between the parties. — Failure to comply with the mandatory

acknowledgment requirement of AS 34.15.160(a), while affecting recordation and admissibility, does not have the effect of making the conveyance void as between the parties. *Smalley v. Juneau Clinic Bldg. Corp.*, 493 P.2d 1296 (Alaska 1972).

Certificate of notary must recite knowledge of identity of witness. — Since AS 34.15.210 and AS 34.15.250 require the certificate of a notary to contain a recital of the acquaintance of the officer with the subscribing witness, under such circumstances, the certificate must contain such a recital, or it is insufficient and will not authorize the recordation of the instrument. *Nelson v. Lord*, 4 Alaska 174 (1910).

Sec. 40.17.035. Recording criteria. When determining whether a document may be recorded, the recorder may not

(1) consider whether the contents of the document are legally sufficient to achieve the purposes of the document;

(2) reject a document because the document

(A) does not satisfy the current requirements for recording if the document satisfied the requirements for recording that existed at the time the document was executed;

(B) serves more than one purpose;

(C) does not state the name of the recording district if the name is given to the recorder at the time the document is offered for recording or if the name is contained in a cover letter accompanying the document;

(D) references an attached exhibit that is not labeled;

(E) is a certified copy of an official document that creates an interest in real property, that meets the requirements of AS 40.17.030(b), and that is from a governmental office; or

(3) require that a document that serves more than one purpose be recorded separately for each of the purposes; this paragraph does not prevent the multiple recording of the document if the person offering the document requests that the document be recorded for more than one of its purposes and the request is accompanied by the applicable recording fee for each of the multiple purposes. (§ 2 ch 83 SLA 1988; am § 4 ch 119 SLA 1996)

Revisor's notes. — Formerly AS 34.15.343. Renumbered in 1989.

Cross references. — For legislative findings, see sec. 1, ch. 83, SLA 1988.

Effect of amendments. — The 1996 amendment, effective July 1, 1996, in subsection (a), inserted "

that meets the requirements of AS 40.17.030(b)," and deleted "in this or another state" following "governmental office" in subparagraph (2)(E), added "and the request is accompanied by the applicable recording fee for each of the multiple purposes" at the end of paragraph (3), and made minor stylistic changes.

Sec. 40.17.040. Indexing. (a) The recorder shall maintain an index system for recorded documents in the manner prescribed by regulations adopted by the department.

The system shall be designed so the public may find documents by names of grantors and grantees, and the system may include other means for locating the documents.

(b) [Repealed, § 5 ch 119 SLA 1996.] (§ 1 ch 161 SLA 1988; am §§ 5, 14 ch 119 SLA 1996)

Effect of amendments. — The 1996 amendment, effective July 1, 1996, inserted "location and by" in the second sentence of subsection (a) and repealed subsection (b).

Editor's notes. — Section 18, ch. 119, SLA 1996 provides that the amendment to subsection (a) made by § 5, ch. 119, SLA 1996 "applies to documents received by the state recorder on or after July 1, 1996."

NOTES TO DECISIONS

Under former provisions indexing was held necessary for constructive notice. — See *Mortensen v. Lingo*, 13 Alaska 419, 99 F. Supp. 686 (D. Alaska 1951).

Sec. 40.17.050. Incorporation of master form. A recorded master form, or a numbered paragraph of it, may be incorporated by reference in a recorded document by referring to the form by its recording information and the number of the paragraph to be incorporated. The reference has the same effect as if the master form or the numbered paragraph were reproduced in full in the record at the place where the reference to the form or paragraph is made. (§ 1 ch 161 SLA 1988)

Sec. 40.17.060. Documents executed under former law. If a document was executed in accordance with the law in effect at the time the document was executed, the document remains recordable regardless of later amendments to the law changing the manner in which that document is to be executed. (§ 1 ch 161 SLA 1988; am § 6 ch 119 SLA 1996)

Effect of amendments. — The 1996 amendment, effective July 1, 1996, deleted "included under AS 40.17.110 (b) or (c)" following "if a document" near the beginning.

Sec. 40.17.070. Duties of recorder. (a) The recorder shall promptly record all documents presented that are recordable under AS 40.17.030 and 40.17.110.

(b) The recorder shall maintain in the central recording office a daily log and index for recorded documents.

(c) As a document is recorded, the recorder shall indicate on or attach to each document the date, hour, and minute of recording, enter that information and a consecutive serial number in a daily log of documents without delay in the order in which the documents are received, and note the serial number on the document.

(d) If a document presented for recording is reviewed and rejected for recording, the recorder shall indicate on or attach to the document the date, hour, and minute of rejection and a citation of the statute requiring rejection. If the document is later determined to be recordable in the form in which it was earlier presented to the recorder, later recording does not relate back to the time and date of rejection. Recording is effective when the document is accepted for recording, regardless of the cause of the rejection.

(e) The recorder shall promptly copy recorded documents and place them in permanent records and shall note the recording information at the entry of each document in the daily log.

(f) Promptly after recording a document, the recorder shall make the index entries required in this chapter and in the regulations of the department.

(g) After recording, the recorder shall return the document to the person who presented it or a person designated by the person who presented it.

(h) The recorder shall certify copies and provide a certified copy of a recorded document to a person who tenders the proper fee.

The recorder is not required to record part of a document if the part is identified and preceded by the words "From Previously Recorded Master Form—Do Not Record" and the recorded part contains a reference to the master form's recording information. (§ 1 ch 161 SLA 1988; am § 7 ch 119 SLA 1996)

Effect of amendments. — The 1996 amendment, effective July 1, 1996, made a section reference substitution in subsection (a).

Sec. 40.17.080. Effect of recording on title and rights; constructive notice.

(a) Subject to (c) and (d) of this section, from the time a document is recorded in the records of the recording district in which land affected by it is located, the recorded document is constructive notice of the contents of the document to subsequent purchasers and holders of a security interest in the same property or a part of the property.

(b) A conveyance of real property in the state, other than a lease for a term of less than one year, is void as against a subsequent innocent purchaser in good faith for valuable consideration of the property or a part of the property whose conveyance is first recorded. An unrecorded conveyance is valid as between the parties to it and as against one who has actual notice of it. In this subsection, "purchaser" includes a holder of a consensual interest in real property that secures payment or performance of an obligation.

(c) The recording of an assignment of a security interest is not in itself notice to the debtor. The debtor may pay the assignor unless the debtor has actual notice of the assignment.

(d) A recorded option or agreement to enter into a contract in the future ceases to be constructive notice for any purpose

(1) when six months have elapsed after the date of recording of the option or agreement, if the recorded option or agreement contains no expiration date;

(2) when 30 days have elapsed after the expiration date of the option or agreement, if the recorded option or agreement contains an expiration date. (§ 1 ch 161 SLA 1988)

NOTES TO DECISIONS

- I. General Consideration.
- II. Constructive Notice.
- III. Unrecorded Conveyance.

I. GENERAL CONSIDERATION.

Annotator's notes. — Many of the cases cited in the notes below were decided under former law.

Equitable estoppel against assertion of title. — A properly recorded title normally precludes an equitable estoppel against assertion of that title due to the requirement that the party raising the estoppel be ignorant of the true state of title or reasonable means of discovering it. *Dressel v. Weeks*, 779 P.2d 324 (Alaska 1989).

Interest of real estate lender in fixtures. — Industrial lighting and circuit breakers wired into a warehouse's electrical system that could be removed without damaging the warehouse structure were fixtures, and the holder of a recorded deed of trust had a security interest in the fixtures which followed them upon their removal by the installer who took them subject to the lender's interest. *K & L Distrib., Inc v. Kelly Elec., Inc.*, 908 P.2d 429 (Alaska 1995).

Cited in *K & L Distrib., Inc v. Kelly Elec., Inc.*, 908 P.2d 429 (Alaska 1995).

II. CONSTRUCTIVE NOTICE.

Under former provisions indexing was held

necessary for constructive notice. — See *Mortensen v. Lingco*, 13 Alaska 419, 99 F. Supp. 685 (D. Alaska 1951).

Recording of repurchase contract gives constructive knowledge of an interest in land. *Metcalf v. Bartrand*, 491 P.2d 747 (Alaska 1971).

As does recordation of use restrictions. — Recordation of use restrictions provides persons with constructive notice. *Stauber v. Granger*, 495 P.2d 67 (Alaska 1972).

Recorded document not entitled to recordation does not give constructive notice. — Where a document setting forth the restrictions on a subdivision was recorded but, not having been witnessed or acknowledged, was not entitled to recordation, it was insufficient to constitute constructive notice. *Hallet v. Sumpler*, 14 Alaska 13, 106 F. Supp. 896 (D. Alaska 1952).

Where a deed had but one witness, two then being necessary to authorize the recording of a deed, and the only acknowledgment was before the deed was altered, it was filed without authority, was not entitled to registration and had no effect as against people with actual notice. *Waskey v. Chambers*, 224 U.S. 664, 32 S. Ct. 697, 68 L. Ed. 885 (1912).

III. UNRECORDED CONVEYANCE.

Applicability to mortgages. — Former provisions relating to the invalidity of unrecorded conveyances applied to the recording of mortgages, as well as to deeds and other conveyances. *Jester v. Holt*, 1 Alaska 567 (1902).

Lessee of mining claim paying percentage of minerals is purchaser for value. — Where a lessee of a mining claim agreed to enter at once and work the mine continuously and to pay a percentage of the minerals or metals extracted, his working the mine was a valuable consideration and nonetheless so if in the event he was reimbursed for his expenditures and made a profit for his trouble. *Waskey v. Chambers*, 224 U.S. 664, 32 S. Ct. 697, 68 L. Ed. 885 (1912).

Quitclaim grantee as subsequent innocent purchaser. — Where the expressed consideration is nominal, and not paid, a grantee accepting a quitclaim deed with full knowledge of a prior unrecorded deed, is not a bona fide purchaser for value, nor a "subsequent innocent purchaser... in good faith for a valuable consideration," such as is described in this section, and the outstanding deed would not be void as to such a purchaser. *Crosby v. Campion Mining Co.*, 1 Alaska 391 (1901), distinguishing *Sabo v. Horvath*, 559 P.2d 1038 (Alaska 1976); *Crosby v. Campion Mining Co.*, 1 Alaska 391 (1901), which referred to a grantee accepting a quitclaim deed with full knowledge of a prior unrecorded deed.

A quitclaim grantee can be protected by the recording system, assuming, of course, the grantee purchased for value consideration and did not otherwise have actual or constructive knowledge as defined by the recording laws. *Sabo v. Horvath*, 559 P.2d 1038 (Alaska 1976).

Quitclaim deed, recorded outside the chain of title, did not give constructive notice to subsequent grantees and was not "duly recorded" under former AS 34.15.290. *Sabo v. Horvath*, 559 P.2d 1038 (Alaska 1976).

As between the parties themselves, a conveyance is good without record. *Wooldridge v. Williams*, 5 Alaska 149 (1914), cert. denied, *James v. Nelson*, 90 F.2d 910 (9th Cir.); 9 Alaska 235, 302 U.S. 721, 68 S. Ct. 41, 82 L. Ed. 658 (1937).

An unrecorded conveyance is void only against a subsequent innocent purchaser in good faith and for a valuable consideration of the same property, and is otherwise valid as between the parties. *Phillip v. United States*, 186 F. Supp. 397 (D. Alaska 1960).

An unrecorded deed is not rendered invalid as between the parties. *Sturtevant v. Vogel*, 167 F. 448 (9th Cir. 1909).

Failure to comply with the acknowledged requirement of AS 34.15.150(a) does not make an instrument invalid as between the parties to it, but rather only precludes its recordation and thus its effectiveness as against third persons. *Smalley v. Juneau Clinic Bldg. Corp.*, 493 P.2d 1296 (Alaska 1972).

Sec. 40.17.090. Conveyances and recorded documents as evidence. (a) A conveyance that is acknowledged, proven, or certified under AS 34.15.150 — 34.15.250 is admissible as evidence of the conveyance without further proof.

(b) An acknowledged and recorded signed document relating to title to real property creates presumptions with respect to title that

(1) the document is genuine and was executed as the voluntary act of the person purporting to execute it;

And unrecorded deed is valid as to privies of parties. — Failure of recordation does not affect the validity of a deed as between parties and privies, for purposes of estoppel or otherwise. *James v. Nelson*, 90 F.2d 910 (9th Cir.), cert. denied, 9 Alaska 235, 302 U.S. 721, 68 S. Ct. 41, 82 L. Ed. 658 (1937).

This statute was intended to protect innocent purchasers against unrecorded deeds to third parties, and not to deprive such purchasers of their title, as against their own grantors' privies, merely because their grantors had failed to record their deed. As to innocent purchasers, this section is a shield, not a sword. *James v. Nelson*, 90 F.2d 910 (9th Cir.), cert. denied, 9 Alaska 235, 302 U.S. 721, 68 S. Ct. 41, 82 L. Ed. 658 (1937).

The question of recordation is not important where the facts show actual notice. *James v. Nelson*, 90 F.2d 910 (9th Cir.), cert. denied, 9 Alaska 235, 302 U.S. 721, 68 S. Ct. 41, 82 L. Ed. 658 (1937).

Purchaser may rely on public records. — It would be impossible for one who was not present on the ground to pay valuable consideration in good faith for real property in reliance upon the public records if his title could be overthrown by proof of vague squatter occupancy of land, general rumors, reports, surmises or general assertions as to ownership or title to lands where the deed is not timely of record. *Nordling v. Carlson*, 265 F.2d 507 (9th Cir. 1958).

But adverse possession gives notice of rights. — Where a person is in visible possession of real property adverse to the world and open and notorious, notice must be taken of his actual rights. A purchaser would be placed upon notice thereby. *Nordling v. Carlson*, 265 F.2d 507 (9th Cir. 1958).

A conditional sales contract recorded prior to a warranty deed would take precedence over the deed. *Hill v. Dale*, 13 Alaska 690 (1952), aff'd, 15 Alaska 14, 212 F.2d 480 (9th Cir. 1954).

Consideration for purchase not given until after prior conveyance recorded. — Where a purchase is made, but the purchaser does not give substantial consideration until after a prior conveyance is recorded, the purchaser takes subject to the prior conveyance. *Lawn v. Nichols Plumbing & Heating, Inc.*, 634 P.2d 554 (Alaska 1981).

Deed of trust recorded prior to filing of bankruptcy petition. — See *Alsop v. Alaska, Comm'r of Revenue*, 22 Bankr. 1017 (D. Alaska 1982).

Grantee not chargeable with discovery of transfer to another prior to federal patent to grantor. — See *Sabo v. Horvath*, 559 P.2d 1038 (Alaska 1976).

Effect of incorrect filing. — The purpose of this section, requiring the recording of all conveyances of real property, is to protect innocent purchasers against unrecorded deeds to third parties. Nevertheless, where the grantee has recorded the deed and the recording officer incorrectly files it, the document is deemed to be recorded. *Gregor v. City of Fairbanks*, 599 P.2d 743 (Alaska 1979).

(2) the person executing the document and the person on whose behalf it is executed are the persons they are purported to be and the person executing it was neither incompetent nor a minor at any relevant time;

(3) delivery of the document occurred notwithstanding a lapse of time between dates on the document and the date of recording;

(4) any necessary consideration was given;

(5) the grantee, transferee, or beneficiary of an interest created or claimed by the document acted in good faith at all relevant times up to and including the time of the recording;

(6) a person purporting to act as an agent, attorney in fact under a recorded power of attorney or authority, officer of an organization, or in a fiduciary or official capacity, held the position the person purported to hold, acted within the scope of the person's authority, and in the case of an organization, the authorization satisfied all requirements of law; and in the case of an agent, acted for a principal who was neither incompetent nor a minor at any relevant time and who had not revoked the agency;

(7) if the document purports to be executed in accordance with or to be a final determination in a judicial or administrative proceeding, or to be executed under a power of eminent domain, the court, official body, or condemnor acted within its jurisdiction and all steps required for the execution of the title document were taken;

(8) the recitals and other statements of fact in a conveyance are true if the matter stated is relevant to the purpose of the document;

(9) the persons named in, signing, or acknowledging the document and persons named in, signing, or acknowledging another related document in a chain of title are identical, if the persons appear in those documents under identical names, or under variants of the names, including inclusion, exclusion, or use of

(A) commonly recognized abbreviations, contractions, initials, or colloquial or other equivalents;

(B) first or middle names or initials;

(C) simple transpositions that produce substantially similar pronunciations;

(D) articles or prepositions in names or titles;

(E) descriptions of entities as corporations, companies, or abbreviations or contractions of either; or

(F) name suffixes, such as "Senior" or "Junior", unless other information appears of record indicating that they are different persons; and

(10) all other requirements for the execution, delivery and validity of the document have been satisfied.

(c) The presumptions stated in (b) of this section arise even if the document purports only to release a claim or convey an interest of the person executing it or of the person on whose behalf it is executed.

(d) Facts stated in a recorded certificate of a public official in affidavit form or under the seal of the official's office and derived from information or documents obtained or kept by the official as part of official duties are presumed to be true.

(e) If presumptions created by this section are inconsistent, the presumption applies that is founded upon weightier consideration of policy and logic. If these considerations are of equal weight, neither presumption applies. (§ 1 ch 161 SLA 1988)

Cross references. — For court rules on admissibility of public records, see Evid. R. 902(4) and 1005.

NOTES TO DECISIONS

Annotator's notes. — The cases cited in the notes below were decided under former law.

Unacknowledged conveyance cannot be recorded and may not be read in evidence without

further proof of the conveyance. *Smalley v Juneau Clinic Bldg. Corp.*, 493 P.2d 1296 (Alaska 1972).

Certificate must be signed to be evidence. — Where a rubber stamp form of certificate by the

recorder appeared on a mechanic's lien but was not signed by the recorder, the lien was proof of nothing but its own contents; the certificate not being signed

proved nothing, so that there was no sufficient proof of the filing of the lien. *Howard v. Branchawk Mining Co.*, 7 Alaska 117 (1923).

Sec. 40.17.100. Recording a reconveyance. When the parties to a recorded conveyance absolute in its terms intend it to serve only as security for repayment of a debt, the conveyance is absolute as to all persons who rely upon it in good faith and for value before a reconveyance is recorded. (§ 1 ch 161 SLA 1988)

NOTES TO DECISIONS

Recordation of a repurchase contract gives constructive knowledge of an interest in land. *Metcalf v. Bartrand*, 491 P.2d 747 (Alaska 1971) (decided under former AS 34.15.260 and 34.15.320).

Sec. 40.17.110. Documents eligible for recording. (a) Subject to (b) — (d) of this section, a document that meets the requisites for recording under AS 40.17.030 may be recorded.

(b) If the document to be recorded is a conveyance, power of attorney, contract for the sale or purchase of real property, or option for the purchase of real property, the document must be acknowledged.

(c) If the document to be recorded is a subdivision plat, the document must comply with the requirements of AS 40.15.

(d) If the document is a declaration under AS 34.08, it must comply with the requirements of AS 34.08.090(b). (§ 1 ch 161 SLA 1988; am § 1 ch 39 SLA 1989; am § 2 ch 128 SLA 1992; am § 8 ch 119 SLA 1996)

Revisor's notes. — Paragraph (b)(69) was enacted as (b)(60). Renumbered in 1989, at which time former (b)(69) was renumbered as (b)(60) and related minor word changes were made in (b)(68) and (b)(69).

Effect of amendments. — The 1989 amendment, effective May 13, 1989, added present paragraph (b)(69).

The 1992 amendment, effective July 1, 1993, repealed paragraph (b)(38).

The 1998 amendment, effective July 1, 1998, rewrote this section.

NOTES TO DECISIONS

Required recital in certificate of notary. — Since AS 34.15.210 and AS 34.15.250 require the certificate of a notary to contain a recital of the acquaintance of the officer with the subscribing wit-

ness, under such circumstances, the certificate must contain such a recital, or it is insufficient and will not authorize the recordation of a contract. *Nelson v. Lord*, 4 Alaska 174 (1910) (decided under former law).

Sec. 40.17.120. Recording memorandum of lease. (a) Recording a memorandum of lease substantially complying with (b) of this section has the same effect as recording the lease.

(b) A memorandum of lease is a document signed by the lessor and lessee and containing a reference to an unrecorded lease, sublease, or agreement to lease or sublease, and supplying at least the following information:

(1) the names of the parties;

(2) addresses of the parties set out in the lease;

(3) the date of the lease;

(4) a description of the real property leased or subleased;

(5) the commencement and termination dates of the lease if fixed and, if not fixed, the method by which the dates are to be fixed; and

(6) a statement of the conditions upon which a party may exercise a right to extend or renew the lease or to exercise a right to purchase or refuse to purchase the real property or part of it. (§ 1 ch 161 SLA 1988)

Sec. 40.17.130. Action against recorder and state. If the recorder fails to record and index a document properly, the recorder may be compelled to record and index the document properly by an action filed in the superior court. (§ 1 ch 161 SLA 1988)

Sec. 40.17.000. Definitions. In this chapter

- ✧ (1) "acceptance" means the determination by the recorder that a document is recordable under this chapter accompanied by marking an identifying code on the document and entering the document in a daily log;
- (2) "certified copy" means a copy of a document certified as correct by the custodian or other person authorized to make the certification;
- (3) "conveyance" means a transfer of an interest in real property other than by will or operation of law;
- (4) "department" means the Department of Natural Resources;
- (5) "document" means a writing, plat, plan, or map, and includes information in a form, such as electronic, mechanical, or magnetic storage; microfilm; or electronic data transmission signals, that can be converted into legible writing, plat, plan, or map form by a machine or device;
- (6) "place of recording" means a place designated by the department where documents recordable under this chapter are recorded;
- (7) "record" means the acceptance of a document by the recorder that the recorder has determined is recordable under this chapter and that is presented for recording in the place of recording designated for the recording district where affected property is located whether or not the place of recording is in that district, and whether or not under applicable law the recorder is directed to record the document;
- (8) "recorder" means the commissioner of the department or the commissioner's designee;
- (9) "recording district" means a part of the state designated a recording district under AS 44.37.025; and
- (10) "recording information" means information needed to find a document in the public records such as book and page, document number, electronic retrieval code, or other specific information. (§ 1 ch 161 SLA 1988)

NOTES TO DECISIONS

"Conveyance" includes lease. — The statutory definition of "conveyance" in this section is sufficiently broad to include a lease. *Smalley v. Juneau Clinic Bldg. Corp.*, 493 P.2d 1296 (Alaska 1972) (decided

under former AS 34.15.350).

A lease is a conveyance. *Smalley v. Juneau Clinic Bldg. Corp.*, 493 P.2d 1296 (Alaska 1972) (decided under former AS 34.15.350).

Chapter 18. Preservation of Public Records.

[Repealed, § 3 ch 191 SLA 1970.]

Chapter 19. Recording Federal Liens.

Section

10. Applicability
20. Place of recording
30. Execution of notices and certificates

Section

40. Duties of recorder
50. Uniformity of application and construction

Effective date of chapter. — Section 44, ch. 161, SLA 1988, provides: "This Act takes effect January 1, 1989."

Legislative history reports. — For a sectional

analysis and commentary on SB 304, from which ch. 161, SLA 1988, which enacted this chapter, derives, see Senate-House Joint Journal Supplement No. 7, May 16, 1987.

Sec. 40.19.010. Applicability. The provisions of this chapter apply to federal tax liens and to other federal liens notice of which under an Act of Congress or a regulation adopted under the authority of an Act of Congress is required or permitted to be filed or recorded in the same manner as a notice of federal tax lien. (§ 38 ch 161 SLA 1988)

Sec. 40.19.020. Place of recording. (a) Notices of liens, certificates, and other notices affecting a federal tax lien or other federal lien shall be recorded under this chapter.

(b) Notices of lien upon real property for obligations payable to the United States and certificates and notices affecting the lien shall be recorded in the records of the recording district in which the real property subject to the lien is situated.

(c) Notices of federal lien upon personal property, whether tangible or intangible, for obligations payable to the United States and certificates and notices affecting the lien shall be recorded in the records of the recording district where the person against whose interest the lien applies resides at the time of recording of the notice of lien.

(d) For purposes of (c) of this section the residence of a corporation or partnership is the place in which the principal executive office of the business is located. (§ 38 ch 161 SLA 1988)

Sec. 40.19.030. Execution of notices and certificates. Certification of notices of lien, certificates, or other notices affecting federal liens by the United States Secretary of the Treasury or by the designee of the United States Secretary of the Treasury, or by an official or entity of the United States responsible for filing, recording, or certifying, of notice of any other lien, entitles the notices or certificates to be recorded and further attestation, certification, or acknowledgement is not necessary. (§ 38 ch 161 SLA 1988)

Sec. 40.19.040. Duties of recorder. (a) If a notice of federal lien, a rerecording of notice of federal lien, or a notice of revocation of a certificate described in (b) of this section is presented to the recorder under AS 40.17, the recorder shall endorse on the notice an identification and the date and time of recording and enter it first in the daily log of documents and then in an alphabetical index showing the name of the person named in the notice, the date and time of recording, the title of the official or entity certifying the lien, and the total amount appearing on the notice of lien.

(b) If a rerecorded notice of federal lien referred to in (a) of this section or a certificate of release, nonattachment, discharge, or subordination of lien or a revocation of any of these certificates is presented to the recorder for recording, the recorder shall record it in the way a document listed in (a) of this section would be recorded and shall enter the rerecorded notice or the certificate or revocation with the date of recording in the alphabetical index together with a reference to the recording information for the original notice or certificate to which it relates.

(c) A lien on file with records of a recording district on January 1, 1989 is considered to have been recorded at the date and time it was filed.

(d) In this section "rerecording" includes recording of a lien previously filed. (§ 38 ch 161 SLA 1988)

Sec. 40.19.050. Uniformity of application and construction. To the extent the provisions of this chapter follow the Uniform Federal Lien Registration Act (1978) they shall be applied and construed to effectuate their general purpose to make uniform the law with respect to the subject of this chapter among the states enacting it. (§ 38 ch 161 SLA 1988)

Issues Facing the Alaska Comprehensive Health Insurance Association (CHIA)

**Prepared by the Alaska Division of Insurance
March 1997**

Background:

The Alaska Comprehensive Health Insurance Association (CHIA) was established in 1992 by the Alaska Legislature to provide access to health insurance for individuals who are considered uninsurable and are unable to get insurance in the private marketplace. By its very nature CHIA was never intended to be a self-supporting entity. If the participants in the plan were able to obtain coverage in the private market by paying a premium appropriate to the risk, there would be no need for the plan.

Participants pay a premium based on their age and choice of deductible. This premium is limited by law to 200% of the standard premiums in the marketplace. The shortfall between premiums collected and the cost of the plan is funded through pro rata assessments to health insurers transacting business in Alaska. Additional information about CHIA is in the 1995 annual report which will be provided upon request.

CHIA and state self insurance:

The State of Alaska's health insurance plan represents almost 35% of the assessable health insurance premiums written in Alaska. Utilization projections provided by the CHIA administrator to the legislature and administration last year raised concerns about large assessment increases which would be passed on to the state's health plan and adversely affect the state budget. CHIA chairperson Cecil Bykerk addressed these concerns at a joint HESS Senate and House hearing on March 7, 1996. He also described how administration of the plan was hampered and made more expensive by existing statutes.

The CHIA administrator's projections assumed that the 1993 and 1994 growth rates in participants and claims would continue. In the program's first years, rapid growth was to be expected as previously uninsurable citizens signed up for the new program. However, the growth did stabilize. At the end of 1996, there were 189 participants, an increase of only 5 people during the year. The total of claims paid in 1996 was \$1,672,490. The CHIA administrator's 1996 projection had been for 253 participants and paid claims of \$3,515,965. Attachment 1 compares the administrator's and the board's projections with actual results through 1996.

Recent concerns have been raised about the impact of the proposed "self insurance" of the state health plan on CHIA. As shown in Attachment 2, the projected net liability to be funded through CHIA assessments is approximately \$1 million in 1997, \$1.3 million in 1998 and \$1.7 million in

1999. Under the current state health plan, the state share of these CHIA assessments will be approximately \$327,000, \$419,000 and \$520,000. If the state were self insured, these expenses would no longer be required in the state budget. The result of spreading the current state assessment over other health insurers would still be less than half of one percent or approximately .35%, .42% and .49%, compared to .23%, .28%, and .34% if the state continued to have an insured plan.

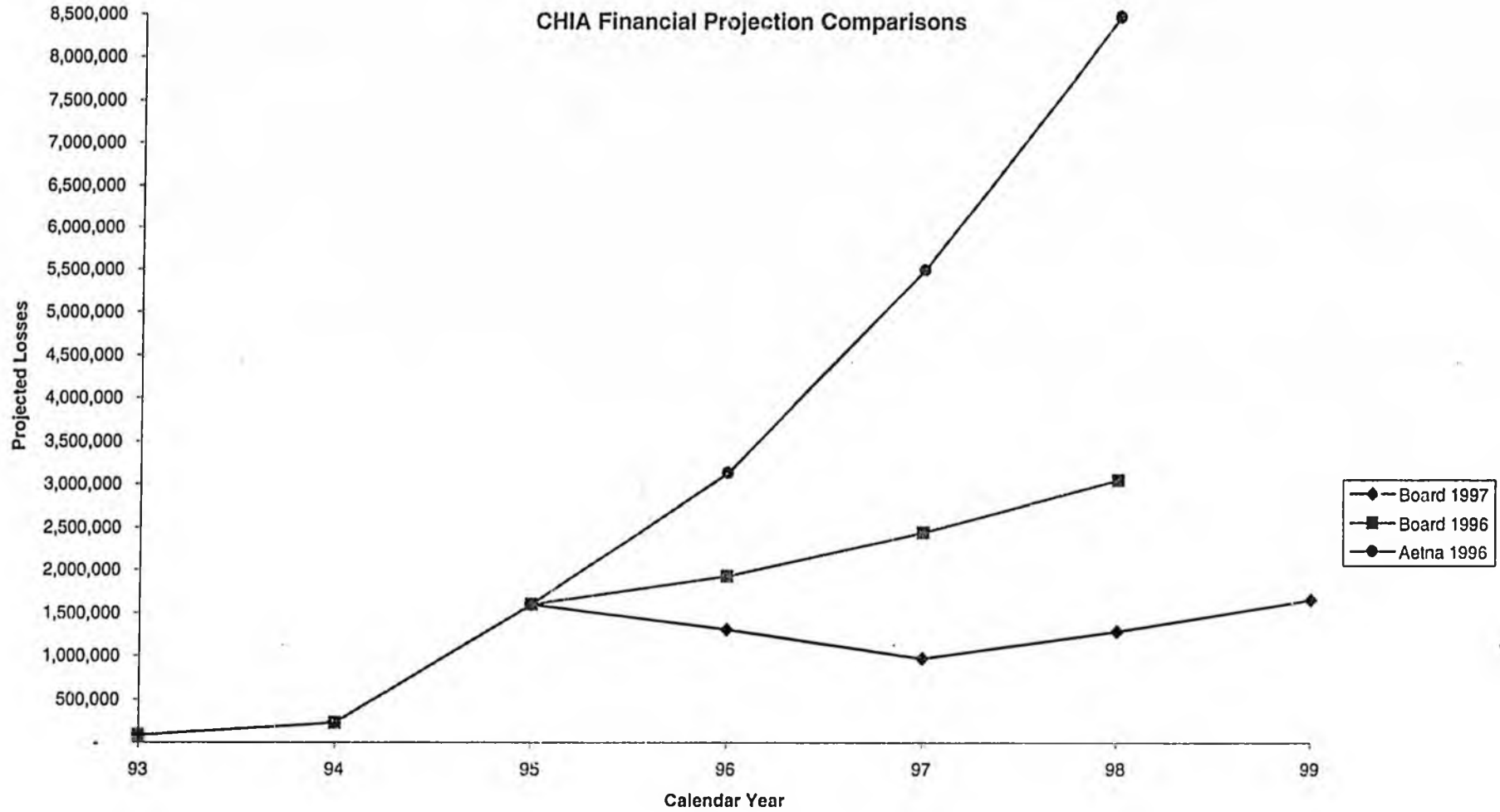
The impact on insurance premiums would not be significant. For example, an individual paying \$400/month for health insurance could expect their monthly premium to increase by only 48-60 cents as a result of the state's decision to self-insure.

Reducing the cost of CHIA:

The impact of state self-insurance on CHIA could be significantly offset by statutory changes permitting the CHIA board to administer the plan in a more effective and business-like manner. For instance, Alaska's high fees could be reduced by allowing more competitive bidding for the administrative contract. (Attachment 3 compares administrative fees for similar plans in Alaska and other states.) Under current statutes, only the members of CHIA can bid on the contract.

Several legislative changes were introduced in 1996 as part of a comprehensive streamlining bill which did not pass. This year, the CHIA board has requested separate legislation to help reduce CHIA's administrative costs, resulting in lower assessments necessary to maintain the CHIA program.

ATTACHMENT 1



"Board 1997" shows actual numbers through 1996 and CHIA board projected numbers through 1999

"Board 1996" shows the most likely projections made in 1996 by the CHIA board

"Aetna 1996" shows the projections made in 1996 by Aetna

ATTACHMENT 2

CHIA Financial Projections (1997-1999) 20% Claim Trend

Scenario 3:

1 participant per month growth, current premiums (175% of standard) through 1997 and increased at 10% after 1997

	Actual				Projected		
	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>1996</u>	<u>1997</u>	<u>1998</u>	<u>1999</u>
Average Members	23	110	167	189	194	206	218
Paid Premiums	88,375	348,744	479,001	610,173	698,400	815,760	949,608
Paid Claims	154,910	474,619	1,903,747	1,672,490	1,400,742	1,784,862	2,266,602
Administrator Expenses	35,600	101,587	155,183	243,832	262,645	315,872	334,272
Board Expenses	16,563	17,971	23,366	25,370	25,000	25,000	25,000
Net Liability to be Funded	(118,698)	(245,433)	(1,603,295)	(1,331,519)	(989,987)	(1,309,975)	(1,676,267)
Estimated Assessable Health Premium	317,000,000	347,000,000	362,000,000	392,000,000	424,000,000	460,000,000	499,000,000
Required Assessment as a % Premium	0.04%	0.07%	0.44%	0.34%	0.23%	0.28%	0.34%
Required Assessment as a % Premium without State Employee Premium	0.06%	0.11%	0.71%	0.51%	0.35%	0.42%	0.49%

ATTACHMENT 3

Administrative Costs by State 1995

<u>State</u>	<u>Average</u> <u># Participants</u>	<u>Admin Cost</u>	<u>Per Participant</u> <u>per Month</u>
WY	240	21,406	7.45
ND	1,378	201,809	12.20
WI	10,188	1,847,775	15.11
OR	4,329	806,328	15.52
NE	3,349	627,948	15.63
MN	31,974	6,563,213	17.11
IA	1,220	256,489	17.52
MO	1,019	219,190	17.93
CA	19,277	4,400,000	19.02
KS	786	196,328	20.83
MT	295	73,964	20.93
MS	723	200,640	23.14
FL	2,038	571,665	23.38
WA	1,085	311,910	23.97
NM	991	322,636	27.13
IN	4,561	1,595,978	29.16
CT	1,257	505,818	33.55
CO	1,747	717,432	34.23
UT	695	311,122	37.30
SC	1,171	546,618	38.90
IL	4,780	2,526,158	44.04
LA	459	443,901	80.59
AK 95	154	178,909	97.13
AK 96	184	269,202	121.92
 Maximum cost per participant per month:			97.13
Minimum cost per participant per month:			7.45
 Average cost per participant per month:			26.12

* Source: Comprehensive Health Insurance for High-risk
Individuals, Communicating for Agriculture, 1996 Report

NOTICE

SPONSOR:

HOUSE LABOR AND COMMERCE

TOPIC:

**Review from the
State Recorder's Office**

DATE: 10-16-97
TIME: 11:00 pm
PLACE: Room 220
TESTIMONY: By Invitation Only

Hoechst Marion Roussel

07-07-97P02:17 RCVD

Hoechst Marion Roussel, Inc.

10236 Marion Park Drive
Mail: P.O. Box 9627
Kansas City, MO 64134-0627
Telephone (816) 966-5000

Dear Elected Official:

The rapidly changing state of health care in America presents each of us in the health care industry with a series of tough challenges--challenges that demand innovative processes and solutions.

To help you address these challenges, Hoechst Marion Roussel is pleased to provide the 1997 edition of **The State of Health Care in America**, as reported by *Business & Health* magazine.

This unparalleled resource examines the complex and changing relationships among those who will tackle the most health care challenges--physicians, patients, employers, providers, suppliers, and academicians.

As new processes and solutions are created, **The State of Health Care in America** forecasts trends and looks to future developments concerning:

- The difficulties associated with assessing the quality and value of health care.
- The developing role of the patient not only as a self-manager of care but also as our ultimate health care customer.
- The impact of ongoing integration and consolidation in the health care marketplace.
- The creative "survival" plans that hospitals are implementing to meet health care marketplace pressures.

We hope that **The State of Health Care in America** will offer insight into your toughest health care challenges. As you face these challenges, we want you to continue to look to Hoechst Marion Roussel as a valued health care partner.

Sincerely,



Jerry Hedrick
Vice President of Government Affairs
97951405/0578C7

P.S. If you would like an additional copy of **The State of Health Care in America**, contact *Business & Health* at 1-800-223-0581.

Hoechst Marion Roussel
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A Message From Hoechst Marion Roussel



*Kirk Schueler
Vice President
Commercial Director U.S.*

The state of health care in America continues to offer each of us in the health care industry a series of tough challenges—challenges that require innovative solutions. Hoechst Marion Roussel can be your partner in finding these solutions. How will Hoechst Marion Roussel be of service to you?

- We will bring new pharmaceutical agents that treat significant unmet medical needs. Major therapeutic categories we're working in include cardiovascular diseases, respiratory diseases, infectious diseases, metabolic disorders, rheumatoid arthritis and other immune system disorders, the central nervous system; oncology and bone diseases.
- We will offer innovative services and resources that offer insight and information on today's significant health care issues. We made a long-term commitment to managed care before it became a widespread practice. Very early we realized that managed care organizations would play a vital role in shaping health care. As a result, we now focus on new areas of commitment including integrated health care systems, health management, health economics and outcomes, information management, and patient compliance and satisfaction.
- We offer sales associates who can be valued partners in quality health care delivery. A skilled team of account managers and sales representatives understand and anticipate your needs in a changing health care marketplace.
- We will be at your service.

Health care will continue to change and adapt to patients' needs. If you are a clinical decision-maker, we offer breakthrough therapies for optimal health management, medical education, patient education and professional programs for staff development.

If you are an economic decision-maker, we can help you control costs and assess value by providing the latest information on health economics and real-world applications for outcomes measurement and management.

If you are a strategic decision-maker, we can provide benchmark data and competitive trends, the latest developments in pharmacy benefit management, integration of health care systems and information management.

As a continuing service, Hoechst Marion Roussel is committed to offering a broad range of information on the crucial questions that arise when we consider the state of health care in America. This 1997 edition of "The State of Health Care in America" addresses these questions with the goal of helping each of us better understand how health care processes are changing and how we can ultimately impact these changes positively. Let's work together to improve the state of health care in America!

Hoechst Marion Roussel VISION

A personalized health care system where each individual is an active and accountable participant

Our Commitment to Healthcare

- *To be a preferred pharmaceutical partner for health care decision-makers*
- *To meet customers' diverse needs for products, services and resources*
- *To dedicate ourselves to innovation, not imitation, in all that we offer*
- *To bring quality and value to patients, health care professionals and the health care system itself*

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The wrenching debate pits individual rights against deeply held convictions about the role of physicians. The social, ethical and, yes, financial implications are profound.



Last December, the nation's largest managed care trade group held a Washington, D.C., press conference to launch "Patients First," an initiative that encourages health care plans to lay their cards on the table and reveal their inner workings—provider payment mechanisms, utilization review, formulary decision making—to all interested parties. The program, says American Association of Health Plans (AAHP) president Karen Ignagni, aims to "respond to patient and physician needs by putting more information in their hands about the policies and practices of health plans."

"We want people to see how we function," adds Michael Herbert, chair of AAHP's board of directors and president and co-CEO of Physicians Health Services, an HMO in the New York metropolitan area. "We believe there is very little objectionable about what we do."

It's unclear whether AAHP will compel member plans to abide by this newly articulated policy. Although the organization anticipates that members will take heed—"We expect full compliance with the policy by the end of 1997," says Herbert—an executive committee was considering possible sanctions for noncompliance.

The AAHP's new open-information policy, which is of a piece with the patient-centered "Philosophy of Care" it adopted earlier last year, is just one sign of what many observers see as a return to basic principles of managed care—principles that have, up to now, taken a backseat to purchasers' overriding concern about costs. Chief among these neglected fundamentals is the notion of quality, which comprises everything from the soundness of the doctor-patient relationship to more quantifiable matters, such as the percentage of breast cancer patients still living five years after diagnosis.

Another factor keeping the quality of HMO care high on the public agenda is an undiminished flood of sensational media reports of managed care

Health reform rediscovers the patient

Do the facts support the premise that our brave new health care system is finally managing care instead of cash? That's the overriding question for 1997.

By Susan Carleton

missteps that cast the quality/cost dichotomy in the stark terms of good vs. evil. Last year's cause célèbre—strict limits on hospital stays for new mothers—triggered a spate of state and federal legislation forcing insurers to pay for longer stays. Another version of the drama, this one featuring outpatient mastectomies, is likely to be staged in legislatures across the country this year.

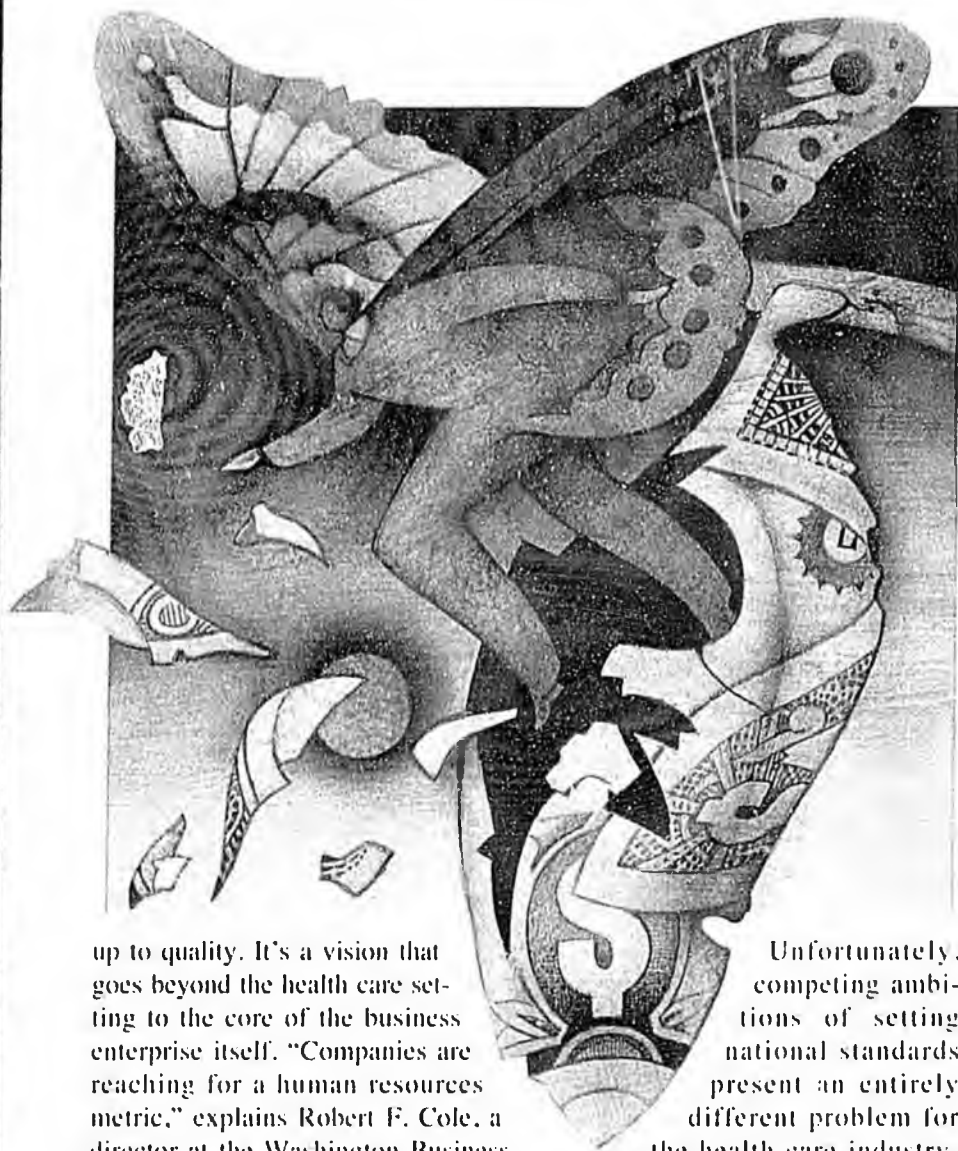
Public perceptions, purchaser realities

Experts say the implication that managed care inevitably compromises quality is seriously inaccurate. In an editorial last October in the *Journal of the American Medical Association (JAMA)*, Paul M. Ellwood, Jr., MD, president of the Jackson Hole Group, and *JAMA* editor George D. Lundberg, MD, wrote that "despite anecdotes (some lurid), we have no objective evidence of overall decline in the quality of care in the new system." But even Ellwood admits that the quality factor has gotten short shrift in the drive to control costs.

Presumably, the frightening anecdotes about substandard care are more compelling to tabloid editors and politicians than to the business community. After all, employers fueled the cost-cutting drive in the first decade of serious health care reform. Even now, they are at least as concerned about the cost of care as they are about its quality, according to *Business & Health's* seventh annual executive opinion poll.

Employers rated rising premium costs for employees and dependents as their top two concerns. Assuring quality of care came in fourth, after increasing government regulation. Still, the poll found a greater level of employer concern about quality than in past years; 60 percent of respondents said they were "very concerned" about assuring quality of care.

Business leaders concur that employers and other buyers are growing restive with the status quo, demanding that health plans deliver more value for every premium dollar—and insisting they demonstrate that value with hard numbers adding



up to quality. It's a vision that goes beyond the health care setting to the core of the business enterprise itself. "Companies are reaching for a human resources metric," explains Robert F. Cole, a director at the Washington Business Group on Health (WBGH). "They want to be able to demonstrate that quality health care has an effect on the company's bottom line—that products can be priced more competitively if employees have less disability and absenteeism and better morale and productivity as a result of their health care."

FAcct: A powerful alliance

Additional evidence that employers are ready to shift their focus to quality comes from the formation of the Foundation for Accountability (FAcct), a consumer-purchaser group that is developing objective quality measurement tools to guide individuals and employers in choosing health plans. "The hope," says WBGH's Cole, "is that FAcct measures will become the industry standard."

Unfortunately, competing ambitions of setting national standards present an entirely different problem for the health care industry. (See "Can consumers capture the essence of quality?" on page 12.)

Some of the nation's largest employers—American Express, AT&T, Ameritech, General Motors and EDS Health Care Industry Group—as well as the National Business Group on Health, a large-employer coalition, are on FAcct's board of trustees. Large government purchasers include the Health Care Financing Administration (HCFA), the U.S. Department of Defense and the Federal Employees Health Benefits Program.

Heavy hitters on the consumer side include the American Association of Retired Persons and the AFL-CIO. The combined clout of these entities, representing 30 million Americans, is bound to have an impact on national priorities and the

practices of health plans.

Although provider organizations are conspicuously absent from FAcct's board, the group has also established a health plans and providers advisory council. "Some organizations are way ahead in terms of quality outcomes measurement," says FAcct spokesperson Judith Graham. A number of well-established HMOs and integrated health systems—the Mayo Clinic, Kaiser Permanente, Group Health of Puget Sound, for instance—have been measuring and managing outcomes for years.

But they are the exceptions; most of the health care system is not yet equipped to measure and report on outcomes, says Ellwood, and it needs to get its act together soon. "The health care system is coming out of the closet," he writes. "Professional black boxes and undocumented claims of superior individual credentials and results are no longer enough! Organizational transparency and readily available objective evidence of health improvement are in!"

Help from the feds

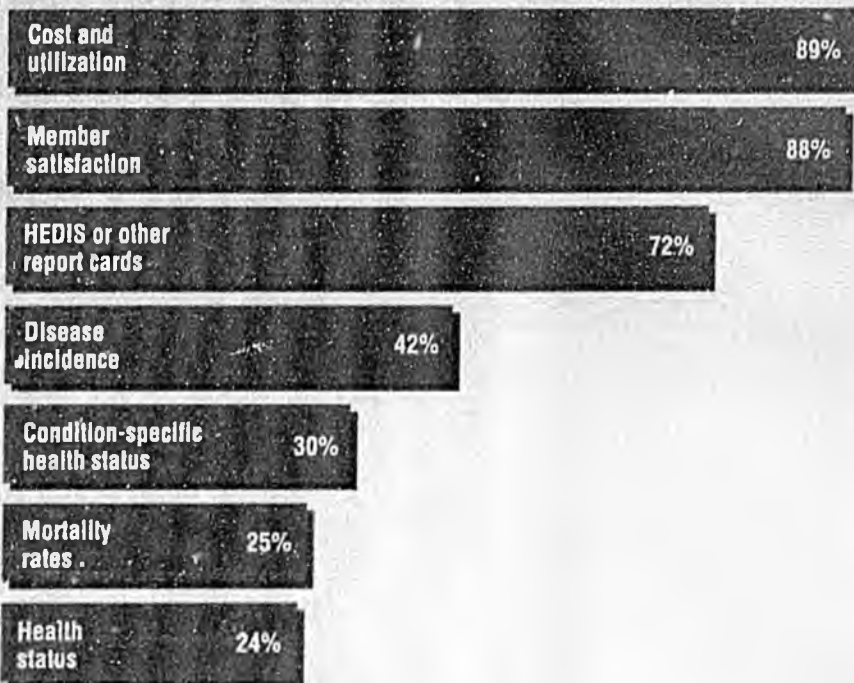
For its part, the federal government, through the Agency for Health Care Policy and Research (AHCPR), is furthering the quality cause by funding projects to help unify the thousand-odd measurement tools developed by private- and public-sector health care players in the last several years.

The Quality Management Network (QMNet), administered by the Ann Arbor, Mich.-based MEDSTAT Group and the Harvard University School of Public Health, is a major step in that direction. QMNet is essentially a resource set up to assist "every entity that is interested in measuring clinical performance—from physicians to physician groups, hospitals, quality improvement coordinators, integrated delivery systems, managed care organizations and purchasers," says Louis H. Diamond, vice president and medical director of MEDSTAT.

The accountability roll call

Stirred by media reports of HMOs denying coverage or otherwise interfering with patient care, consumer groups, employers and even legislators have joined the backlash against health plans that appear to focus more on profits than patients. But many plans are snapping to attention as they compete to demonstrate that they can manage care, not just costs. The chart below shows the types of quality reports HMOs are putting before purchasers.

Percentage of HMOs reporting specific quality measures to employers



Source: The InterStudy *Competitive Edge*, 5.1.

At the project's core is AHCPR's Computerized Needs-Oriented Quality Measurement Evaluation System (CONQUEST), a database released last April. It summarizes information on some 1,200 clinical performance measures originally developed by just about every group with a stake in the content of quality care—including AHCPR, HCFA, the U.S. Department of Veterans Affairs, a host of other federal agencies, plus the National Committee for Quality Assurance (NCQA), state hospital associations, health systems, business coalitions and research organizations such as Harvard University and RAND Corp.

QMNet will help CONQUEST users by providing technical support (via phone, Internet and mail) and holding annual conferences, starting this year, on searching the database

and using the measures it contains. It will also add to CONQUEST's capabilities, expanding information on a number of medical conditions and identifying gaps in the database. Information on disease-specific epidemiology, utilization and costs, potentially preventable adverse outcomes, comorbidities, risk factors and recommended clinical services will also be expanded. Finally, QMNet is charged with developing private support so it can be sustained beyond the three-year AHCPR grant period. "Our hope is that QMNet ultimately may aid in the creation of a freestanding quality network," says AHCPR administrator Clifton R. Gaus.

How does QMNet fit in with other quality measurement leaders such as FAect and the NCQA, which accredits health plans and assesses them

through its just-revised Health Plan Employer Data and Information Set (HEDIS)? Both these organizations, as well as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), have signed on as advisers to QMNet. As Diamond sees it, "QMNet provides the measurement infrastructure to assess clinical quality of health care, as opposed to the use of cost and expenditure measures. The CONQUEST database measures issues that are of clinical relevance: What does the clinical evidence justify from the point of view of service delivery? It's like the third leg of a stool, adding another dimension of understanding to the financial and use measures you already have."

Countervailing forces

Despite these developments, movement toward a more rational, quality-conscious health care system is slow and painful. "Quality assurance and accountability issues have acquired great urgency as a result of several things," says Ellwood. "One, the publicity about HMOs is, I believe, eroding the confidence and trust in managed care, and without that trust there can be no managed care. Two, health plan margins are way down, and they're having to be much more aggressive about cost control. In doing so, they're passing more risk onto providers, which means plans are increasingly losing control [of care]." The result: Providers are accountable mainly for keeping costs down, possibly at the expense of quality, which a remote HMO administration may not monitor closely.

Ellwood decries ham-handed legislative attempts to restrict and control managed care. In the California state legislature alone, more than 100 health care bills had been introduced by last October. If the system is micromanaged by the likes of Congress and state legislatures, he says, we might as well abandon all hope of applying rational standards to health care.

Equally troubling, already strapped

health plans may balk at the expense of careful quality monitoring and reporting. "When the health care plans start the measurement process, it will cost them something, and they'll say that there isn't enough money in the premium to cover it," says WBGH's Cole. "Then purchasers will have to tell them it's just the cost of doing business. My feeling, though, is that the plans are going to have to learn quickly that they need to do measurement to stay competitive." Regardless of who winds up bearing the cost, the inevitable standoff between profit-squeezed health plans and tight-fisted buyers will also slow the pace of change.

Investment in information technology will account for a large part of the

"cost of doing business," Cole cites. According to a recent report from the Council on Competitiveness, a forum made up of business, academic and labor executives, "The health industry's overall spending on information systems still trails that of other information-intensive sectors."

Existing systems tend to serve accounting rather than clinical functions, and they're rarely networked in any coherent pattern, even within large organizations. Thus, the data most essential for quality measurement are either nonexistent or scattered willy-nilly throughout the system among primary care physicians, specialists, hospitals, member services offices and pharmacies.

To fit these disparate data together,

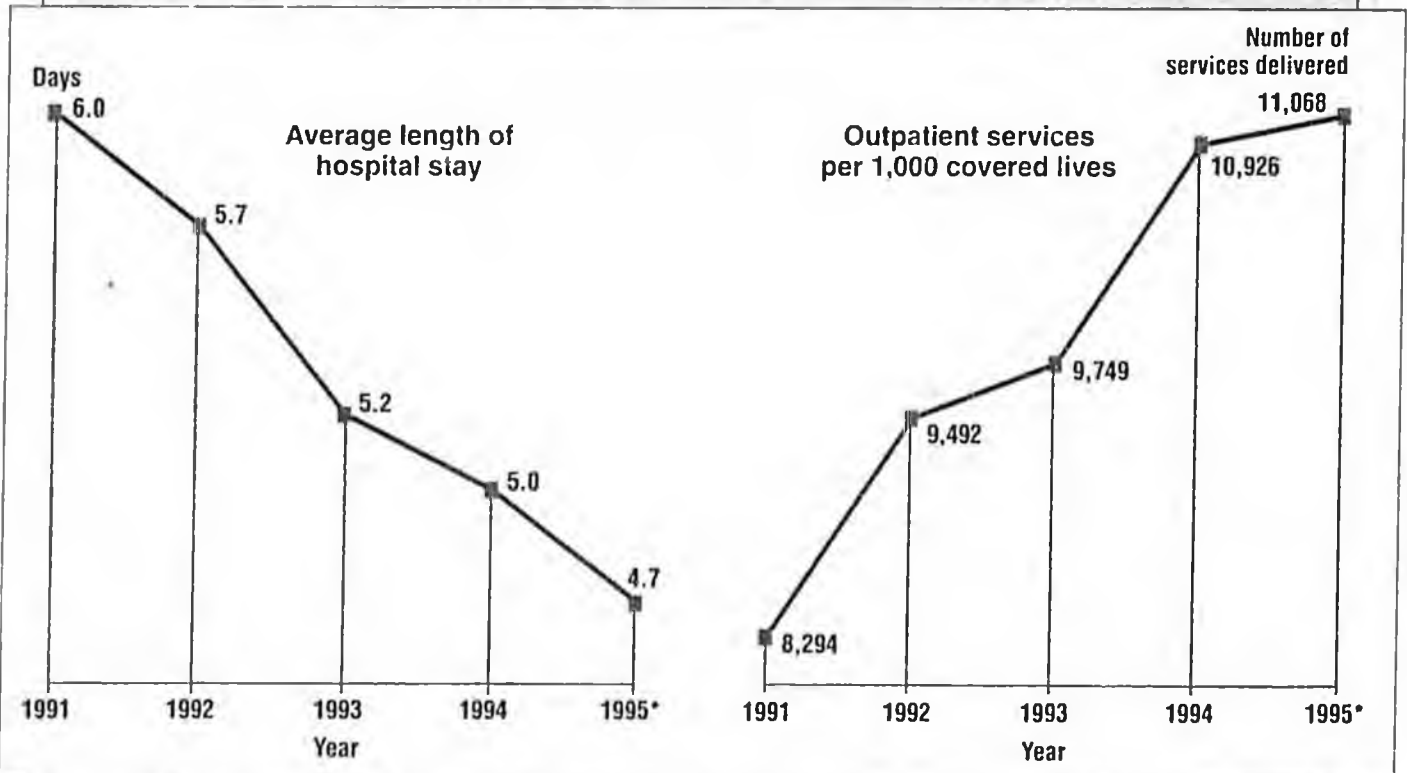
health plans need state-of-the-art information systems. Estimated costs range from \$5 million to \$50 million annually, the Council reports. Barring premium increases or even smaller margins, many plans may be unable to make this investment. (See "Private matters, public good" on page 18.)

Looking ahead

Consumers, of course, are the wild cards in the game of reshaping managed care. And, if the federal health reform debacle of 1994 taught us anything, it's that consumer attitudes about health care are deep-seated and contradictory. We want better access to care, universal coverage, the discretion to choose (and change) doctors at will—and virtually no limits on

Changing directions in patient care

The focus and site of health care delivery shifted radically during the first half of the decade. According to national insurance claims data analyzed by the MEDSTAT Group, the average length of hospital stay fell by 22 percent between 1991 and 1995, while the number of outpatient services grew by 33 percent. Note how the pace slackened in the final year reported.

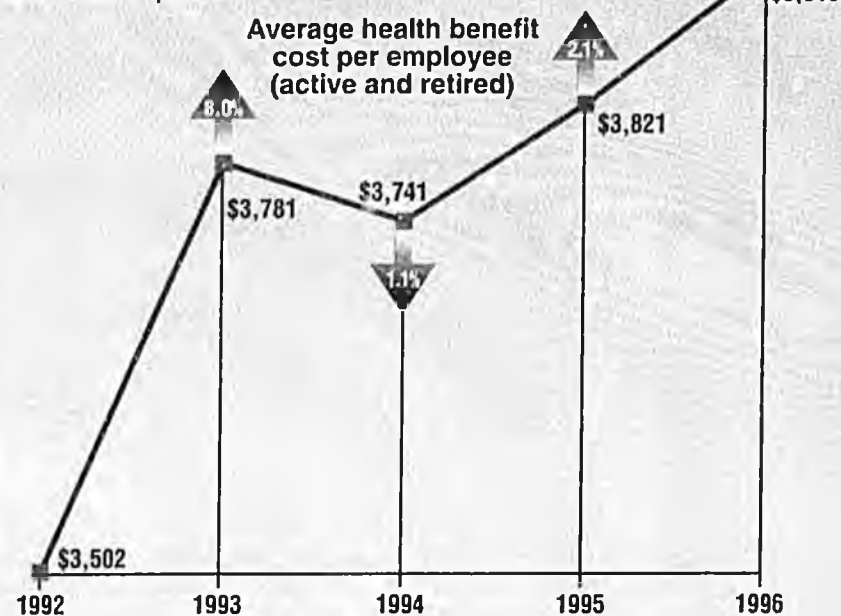


Source: The MEDSTAT Group MarketScan® Database.

*Estimated.

Health costs may be heading up again

Employers' costs for health benefits rose a moderate 2.5 percent last year, still below the overall rate of inflation, according to a Foster Higgins survey of about 3,300 employers. But health plan costs may go up 4 percent this year. Several factors are contributing to the upward trend: Most employers have already benefited from the one-time savings of switching to a managed care plan, HMO rates are rising, and the ongoing consolidation of providers has given them more bargaining power with health plans.



Source: Foster Higgins.

the services we receive. In fact, one of the latest twists in health care offerings, so-called "unrestricted plans," look a lot like plain old fee for service, albeit within an established provider network. Such unrestricted plans allow patients to self-refer to specialists, bypassing the primary care gatekeeper role entirely. That, some critics say, is a dangerous step backward.

"Health care programs that offer direct access to specialists and subspecialists imply that the primary care practitioner is a roadblock to specialty care," notes Melange Matthews, who heads the California Primary Care Consortium, an organization formed to improve access to quality primary care in underserved areas of California. "Actually, direct-access plans might do more harm than good by interrupting and thus interfering with the patient-primary care physician relationship and the patient's access to quality, comprehensive, coordinated health

care. Perhaps plans should pay more attention to providing greater ease and flexibility to primary care practitioners when they want to refer patients to other specialists and subspecialists."

Most visions of the health care system for the new millennium stress the central role of the consumer/patient, assigning individual employees or beneficiaries more responsibility for discerning and choosing quality and value in their care. As soon as consumers have meaningful performance and outcomes data on all their options, they will flock to the plans that offer the highest quality care, in a demonstration of market forces working just the way they should—or so the thinking goes.

Right now, though, surveys suggest that a somewhat less rational process steers consumer choices in health plans and doctors. (See "Bridging the consumer information gap" on page 44.)

Does this mean that the quality ini-

tiatives of health care purchasers and policy makers have all been for naught? Few observers would subscribe to such a pessimistic view. Instead, the prevailing attitude is that consumers need to learn how to shop for health care and use the system more wisely. (See "The consumer as health care manager" on page 51.)

A program Blue Cross and Blue Shield of Minnesota has adopted—what company senior vice president Mary Ann Stump calls a "transformative paradigm" labeled "Customer*ism"—exemplifies the new approach. "This paradigm encourages members to migrate from the passive medical recipient role to a more active medical customer role. That shift entails members taking personal responsibility for interacting with caregivers in effective ways," Stump explains. In the next evolutionary step, medical customers become health customers. "Health customers not only participate actively in care decisions and access the system appropriately, but they also learn how to better maintain their own health, using the health plan as a resource," she adds.

With business leading the way, government doing its part but not overstepping its bounds, health care systems rising to the challenge and consumers learning to make rational choices, the health care system has begun the transition to full accountability and true competition, a model more in keeping with Ellwood's original vision.

How long the transformation will take is a matter of debate. While optimists predict real reform by century's end, realists expect no major change for at least another decade. In the long run, though, both groups are betting that the investment in demonstrable quality care will pay off in improved lifelong health—and improved productivity—for the entire workforce.

Susan Carleton is a freelance writer based in Mt. Kisco, N.Y., who frequently covers health and medicine.

Reality check: A snapshot of hospital care

Be cautious in your assumptions about the efficiencies that can be gained from managed care. That's the conclusion to be drawn from two analyses by The MEDSTAT Group, Ann Arbor, Mich., based on hundreds of thousands of insurance claims from employees in large companies.

In the first set of charts, average lengths of stay for each of four procedures declined between 1992 and 1994. Did shorter hospital stays cause

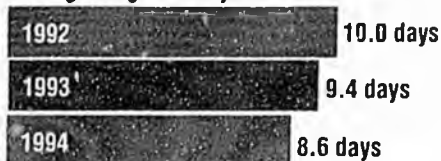
problems? For coronary artery bypass grafting and Cesarean section, the percentage of patients who needed to be readmitted within 30 days and 90 days progressively rose. The percentage of readmissions after transurethral prostatectomy generally declined, while readmissions after acute myocardial infarction fluctuated.

Data from the second analysis are shown on the next two pages.

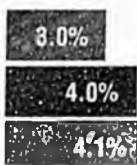
Readmission rates according to average length of stay

Coronary artery bypass

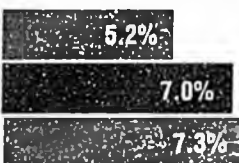
Average length of stay



% readmitted within 30 days



% readmitted within 90 days

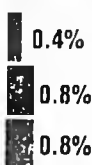


Cesarean section

Average length of stay



% readmitted within 30 days

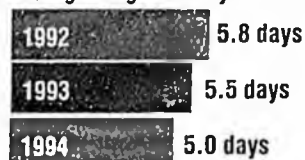


% readmitted within 90 days



Acute myocardial infarction

Average length of stay



% readmitted within 30 days

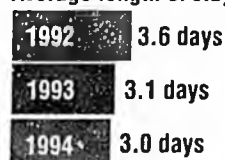


% readmitted within 90 days

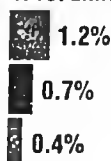


Prostatectomy

Average length of stay



% readmitted within 30 days



% readmitted within 90 days



Note: Readmissions are for diagnoses within the same major diagnostic category.

Source: The MEDSTAT Group MarketScan® Database.

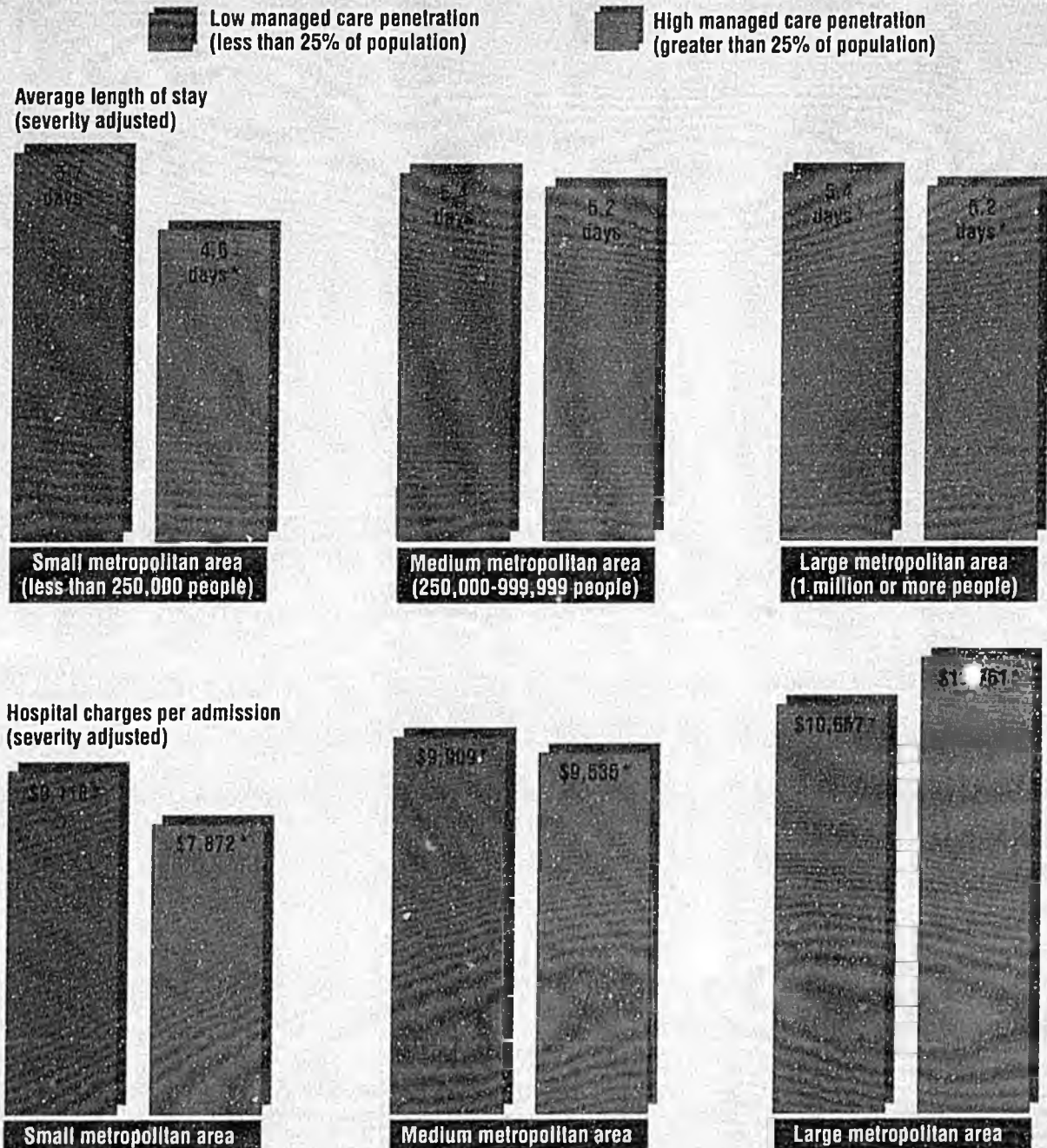
Reality check: A snapshot of hospital care

The second set of data analyzed by The MEDSTAT Group suggests that local practice patterns may overpower strong managed care influences. This analysis of 1994 data looks at different-sized populations with low penetration of HMOs (less than 25 percent of the total metropolitan-area population) versus those with high penetration (greater than 25 percent). For hospital care overall, high managed care penetration was associated with a statistically significant

decrease in average length of stay in large and small metropolitan areas, but not in medium-size metropolitan areas.

Despite shorter stays, however, large metropolitan areas with high managed care penetration showed significantly higher hospital charges per admission than their counterparts with less managed care. On the page opposite are cost and length-of-stay data for specific procedures.

Impact of managed care penetration—total inpatient admissions (n=247,874)



* Statistically significant difference, $P < 0.01$.

All data are from the 1994 MarketScan® Database of The MEDSTAT Group.

Impact of managed care penetration—specific procedures

Low managed care penetration

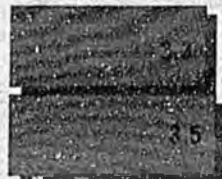
High managed care penetration

Coronary artery bypass grafting
(n=3,392)

Cesarean section
(n=7,915)

Coronary angioplasty
(n=4,904)

Average length of stay (severity adjusted)



Hospital charges per admission (severity adjusted)



* Statistically significant difference, $P < 0.01$.

** Statistically significant difference, $P < 0.05$.

All data are from the 1994 MarketScan® Database of The MEDSTAT Group.

Can consumers capture the essence of quality?

Makers of quality measures are suddenly inclined to ask J.Q. Public what matters most in comparing health plans.

By Lani Luciano

ot so long ago, quality-of-care researchers fretted mainly over technical barriers to comparing health plan performance. Incompatible data, inadequate risk adjusters and unreliable reporting by providers loomed dismayingly large. Now, the experts face a more daunting obstacle—consumer reaction.

Acceptance by these ultimate customers for comparative information is crucial to the future of external quality measurement. So far, however, consumers don't much like, understand or trust the fledgling measures they've seen. And, though demand for health plan ratings is so high that outsiders—such as the American Association of Retired Persons (AARP) and even some popular magazines—have jumped in with their own freelance judgments, progress on improved measures from the experts has been slowed by competitive jockeying over who can best meet consumer needs.

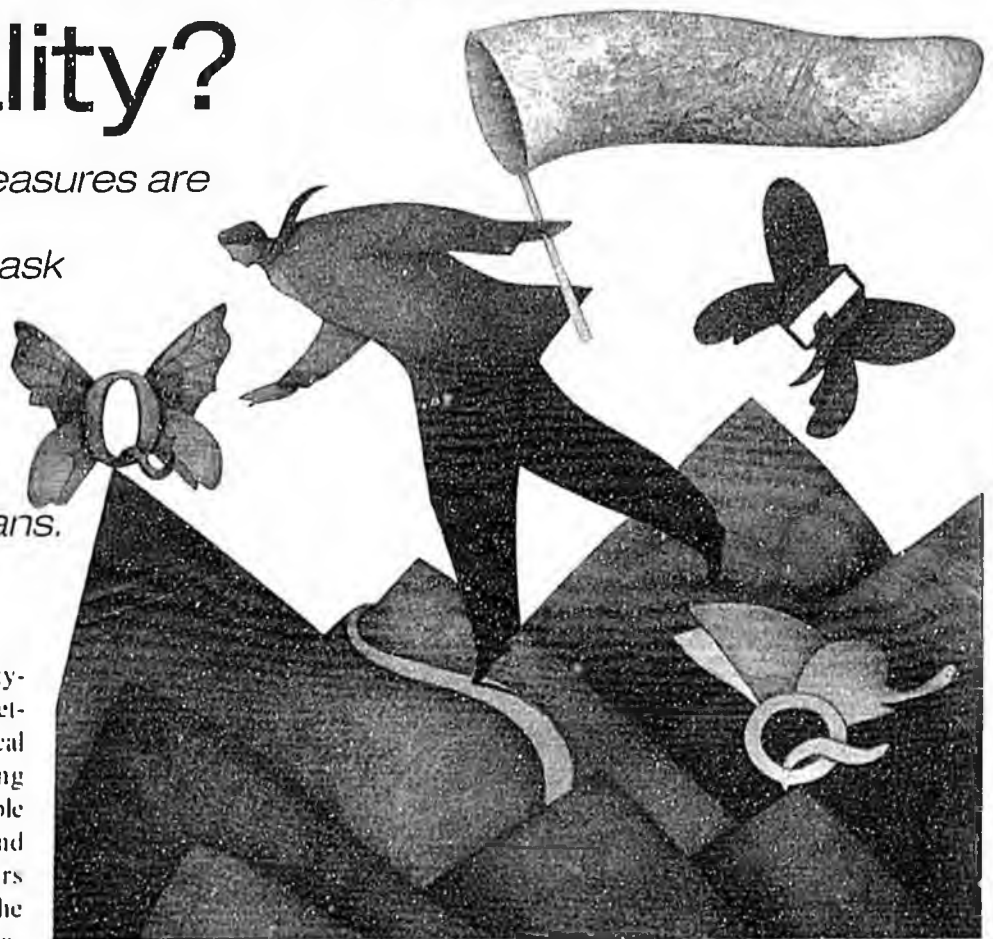
"I'm not surprised that consumers aren't impressed," says Susan Edg-

man-Levitan, director of the Picker Institute, a nonprofit organization promoting patient-centered care. "We haven't gotten to the level of information that really concerns them—doctors' performance. And we're spending too much time arguing about what patients want."

At the moment, the patients aren't too sure themselves. Focus groups and surveys suggest that their ideas on quality are intuitive and highly personal. When the Agency for Health Care Policy and Research (AHCPR) and the Kaiser Family Foundation polled 2,000 people last fall, a majority said they valued informal advice on health plans, hospitals and individual doctors from family, friends and other doctors

much more than reports issued by employers or outside evaluators. Consumers are impressed by easy access to care, particularly specialty care, and largely uninterested in indicators that don't relate directly to them. Pregnant women, for instance, are understandably interested in what percentage of babies are born underweight but fail to appreciate that the percentage of diabetics regularly screened for retinopathy also gives them a useful window on a plan's quality of care.

This demand for individualized—and simplified—measures may add up to big problems for quality advocates. "Policy makers are betting that giving consumers more and better information will lead them to seek value for



their money, but it's far from clear that that's the case," says Judith Hibbard, an expert in decision analysis at the University of Oregon. "Quality data are complex, confusing and imprecise." To make meaningful choices based on quality, says Hibbard, consumers will need standardized benefits, comparative information in small, digestible bites and possibly decision support from personal advisers.

Making patient needs a norm

Leading the drive to make quality measures more user-friendly are the Foundation for Accountability (FAcet), a consortium of purchasers, and the Consumer Assessment of Health Plans Study (CAHPS), a research project launched by AHCPR. Last year, FAcet released its first five measurement protocols—for breast cancer, diabetes, depression, health risks and health plan satisfaction. Under development are measures for asthma and health status. Alcohol abuse, AIDS/HIV, hypertension, pediatric/adolescent, reproductive health and end-of-life care are planned for the future.

FAcet's approach is to ask patients what they want to know, then look for existing measures that can answer those questions with data. For example, focus groups said that their most urgent question about breast cancer was the percentage of cases diagnosed at an early stage. To find out, FAcet's measure set mines data from tumor registries, claims/administrative records and self-reported questionnaires. It remains to be seen, however, whether the multifaceted data will satisfy consumers' desire for unambiguous answers.

"What matters to patients and the way they perceive care is often much different from the medical community's views," says FAcet spokesperson Judith Graham. "We think that's very important." The ideal has lagged behind reality, however. Because of the expense and political infighting by special interest groups slow to offer

their support, FAcet convened focus sessions only for the breast cancer measure set. The other four current sets rely on extrapolated information to surmise what patients want to know.

CAHPS, a joint effort by Harvard Medical School, RAND Corp. and the Research Triangle Institute, also uses consumers as a starting point. The project aims to create finely tuned surveys of how consumers view crucial aspects of their care, such as access to services, communication/interaction with providers and coordination/continuity of treatment.

Although CAHPS does not use purely clinical data, researchers expect survey results to provide a window on both clinical quality and satisfaction. Additional questionnaires will probe the views of specific populations, such

*So far, consumers
don't much like,
understand or trust
the measures
they've seen.*

as parents, the chronically ill, Medicaid recipients and non-English speakers. The Health Care Financing Administration, which is also testing FAcet measures, plans to start using CAHPS surveys in March.

Easier access to HEDIS data

Meanwhile, the National Committee for Quality Assurance (NCQA), despite challenges from groups who consider it too focused on the interests of health plans and purchasers, remains firmly in the lead of measure-makers. Because it is the main accrediting body for managed care plans, nearly 90 percent of HMOs collect data tailored to NCQA's Health Plan Employer Data and Infor-

mation Set. In a survey of its 100 members last year, the Managed Health Care Association found that at least 45 large purchasers either require their health plans to collect HEDIS data or are planning to do so soon. "We expect that number to grow dramatically when we survey this year," says Pam Kalen, the association's director.

To some observers, however, HEDIS measures reflect too much concern over health plan complaints about data burdens and too little for patient views. In fairness, the latest version of HEDIS—3.0, released in January—is considerably more ambitious than its predecessor.

The new set contains 71 recommended measures—compared with roughly 60 in HEDIS 2.5—plus 32 to be field tested. Heeding criticism that earlier versions were too focused on structure and process, the new HEDIS puts more emphasis on outcomes of care, such as follow-up after hospitalization for affective disorder. Many of the test measures evaluate efforts to screen and manage major health problems, such as cancer, heart disease and diabetes and, for the first time, a standardized survey probes patient satisfaction.

Even as it was refining HEDIS 3.0, NCQA expanded its reach to businesses and consumers with two new products. In July, it targeted consumers with two-page overviews of its accreditation reviews. The summaries, which cost \$3 by mail or are free on NCQA's Internet web site (<http://www.ncqa.org>), detail how an individual plan scored in each of the six areas of review: quality, members' rights, physician evaluation, preventive services, utilization management and medical records. By comparing performance with the national averages that are also provided, consumers can make their own quality judgments. Currently, summaries for roughly 100 plans are available, with nine or 10 added each month.

Last August, NCQA launched Quality Compass, a database of HEDIS

and accreditation information on more than 200 health plans. National and regional performance averages, plus best practices benchmarks, give shoppers—primarily small-business purchasers—comparative information previously available only to large corporations or through corporate consultants. Although not all of the data have been audited for accuracy, NCQA's reporting method cross-checks data submitted by plans, and the group hopes to have a formal auditing standard in place within a year.

Compared with the accreditation summaries, Quality Compass information is expensive. Printed profiles on reporting plans are divided into four regions and cost \$500 per region. The CD-ROM version costs \$800 for up to 25 plans, \$1,600 for up to 75, \$2,400 for up to 150 plans and \$3,200 for the entire database.

Early demand has been brisk, says NCQA spokesman Barry Scholl. "We've sent out roughly 2,000 CDs on approval." The growth of small-business coalitions with a declared interest in accessing quality data—there are now roughly a dozen across the country—should put Quality Compass within reach of small purchasers.

The challenge: Avoid confusing consumers

While experts ponder what people want and need, nonexperts may be confusing consumers with judgments that, though user-friendly, are short on rigor. Later this year, the AARP will give its seal of approval to selected managed care plans, screened through a consultant as much for the willingness to pay the organization's marketing fee as for medical quality.

Devising their own methodologies, four general-interest magazines—*Consumer Reports*, *Newsweek*, *U.S. News and World Report* and *Bloomberg Personal*—published health plan evaluations last year. Except for NCQA accreditation across the board, no two used the same indicators. Not surprisingly, the

results didn't line up. Admittedly, the publications didn't survey an identical selection of plans. Still, only a handful—including Harvard Community Health Plan, Fallon Community Health Plan, Kaiser Foundation Mid-Atlantic and Health Partners—rated high on more than one or two lists. Only Harvard scored high on all four.

Curiously, the results most likely to leave consumers scratching their heads came from the venerable *Consumer Reports*, which published a painstaking review in August. Its top-rated plan, Blue Choice of Rochester, N.Y., received only provisional accreditation from NCQA. Its fourth highest rated plan, Independent Health of Western N.Y., flunked altogether. Heritage National Healthplan, number 13 on the *Consumer Reports* list, even flunked twice. Although NCQA accreditation is widely recognized as a minimum threshold for acceptable quality—one that journalists regularly exhort consumers to look for—writer Trudy Lieberman, who supervised the study, says she relied more heavily on satisfaction surveys of the magazine's readers. "I don't have that much faith in the data coming out of the plans," explains Lieberman, herself a member of NCQA's board of directors.

The *Consumer Reports* story is not the first collision of quality measurement by data and measurement by consumer satisfaction. In a study conducted last March by the Massachusetts Healthcare Purchaser Group, researchers found that plans with the highest consumer satisfaction scores rated lower on five HEDIS measures than plans that got poor marks from consumers. Employee benefits consulting firms have noted this same disconcerting relationship between plan quality and consumer delight.

The challenge for measure-makers—and purchasers—is to engage consumers, educate them and learn from them, all at the same time. "Good plans all look about the same on HEDIS," says Southern California

Edison benefits manager Suzanne Mercure. "We need anecdotal information from our employees and from other employers to get at meaningful quality differences." To gather the anecdotes, Mercure and her staff are in a constant feedback loop between employees, doctor groups and health plans. "It's soft data," she admits, "but right now it's telling us more than the hard stuff is."

Based on focus group research, Southern California Edison has formulated simple questions that encapsulate employee concerns about quality. The questions are posed in an employee brochure, then answered with specific data on the six plan options. For instance, "How do you compare plan options?" is answered with a list of characteristics that focus groups have cited as important, such as profit-making status and percentage of board-certified physicians. The brochure then supplies the data for each plan.

The company also takes advantage of "teachable moments" by running an office intranet site with details on plans and physicians, and by reviewing plan choices when an employee contacts the benefits department to report a life-change event, such as marriage, divorce or a new child. "It's hand-holding but it seems to help," says Mercure.

What's next?

It's become clear that researchers, purchasers and consumers alike must feel their way into the proposition—radical until recently—that medical quality can be quantified. It's impossible to know where their explorations will take them, but here are the issues and influences looming on the horizon:

- Although measuring outcomes is indescribably difficult, efforts to find a reasonable way to do so will continue. Meanwhile, managed care's intrinsic focus on populations rather than individuals must be reconciled with the needs of patients on the extremes, such as the elderly, disabled and chronically ill. Thus, measures aimed at special needs will proliferate.

How consumers choose health plans

- Whether or not patient satisfaction is a reliable indicator of quality, it will dominate not only measurement but also physician hiring and compensation. Nearly a third of all health plans and more than half of network model plans use satisfaction surveys, such as the Pacific Business Group on Health's new Physician Value Check, as a factor in payments to doctors.

- At the same time, renewed recognition of the centrality of doctors in health care delivery will restore some of the authority and leverage they lost in the move to managed care. However, accountability will really begin to bite down. Nearly half of all plans and two-thirds of network models already base physician payment, in part, on adherence to quality guidelines.

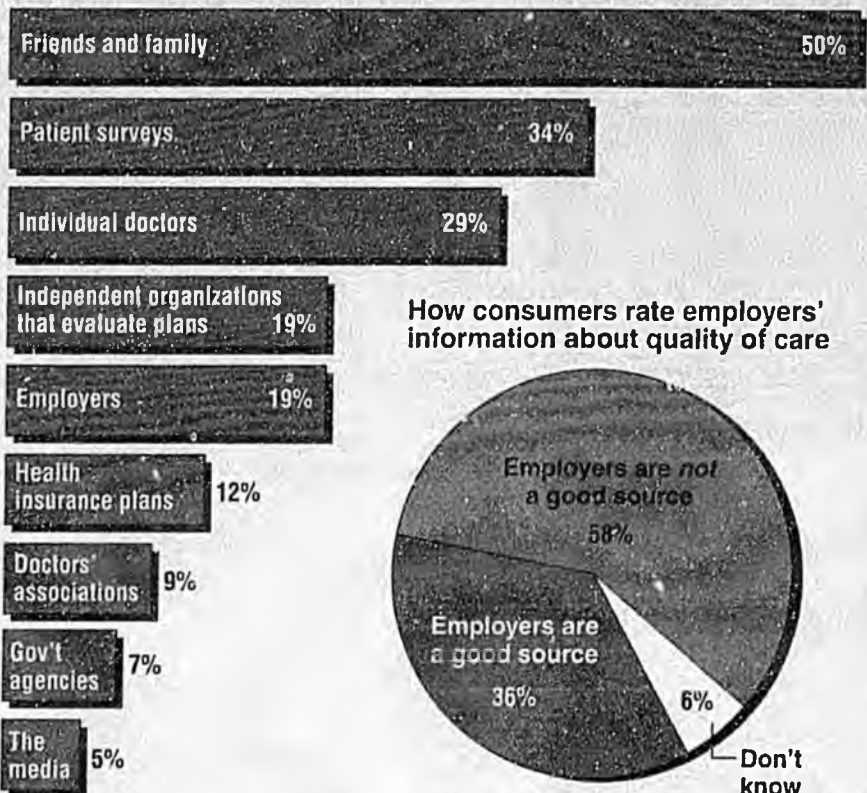
- As payment based on physician performance takes hold, small or solo practices—which are statistically impossible to measure—will fade away. Employees in Minneapolis and St. Paul are currently choosing their "care systems" for the coming year, based on profiles of how patients rate their experience with individual medical groups. "More than 90 percent of Twin City primary care doctors belong to one or another of the groups," says Patricia Drury, who oversees the program run by the Buyers Health Care Action Group.

- States have already begun to weigh in, and the federal government will almost certainly become involved in setting quality minimums for health plans. President Clinton has signed an executive order authorizing a 20-person panel to advise him on necessary consumer protections by the end of the year. Unfortunately, according to many policy makers, such remote micromanagement may hurt more than help quality efforts.

- Sooner or later, health plans will be forced out of the external measure-making process. In an editorial in the Oct. 1 issue of the *Journal of the American Medical Association*, editor George D. Lundberg, MD, and managed care pioneer Paul M.

Last fall, the Kaiser Family Foundation and the Agency for Health Care Policy and Research released a survey that asked more than 2,000 people what influenced their choice of health plan. Consumers favored their family and friends as sources of information about quality health care. Six out of 10 people said employers were not a good source of information because their main concern was "saving money on health benefits."

Percent of consumers who rate each source as "very believable"



How consumers rate employers' information about quality of care



Source: *Americans as Health Care Consumers: The Role of Quality Information* from Kaiser Family Foundation and the Agency for Health Care Policy and Research.

Ellwood, Jr., MD, laid out a framework for the development of quality measures, remarking, "With billions of competitive dollars at stake, no plan can be objective about how it should be judged."

- The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is gearing up its formidable infrastructure to challenge NCQA's long lead on accrediting health plans. JCAHO's edge: one-stop shopping—it already accredits hospitals, home health agencies and other satellite providers—and customized reviews for hybrid managed care systems. So far, only 10 health plans have undergone JCAHO review—compared with NCQA's 261—but more than 200 have expressed interest. Undeter-

mined as yet is whether JCAHO's reputation for cozying up to reviewers will hurt with purchasers more than it helps with health plans.

- For consumers to appreciate the value of quality measures, even small businesses must offer a choice of plans, as many now are able to with the help of new purchasing coalitions for firms that are not self-insured. Once they do, consumers may surprise everyone and quickly rise to the considerable task of managing their own health care needs. Judging by the explosive growth of web sites, chat groups and other health informatics on the Internet, it's more a matter of when than if.

Lani Luciano is a staff writer for *Money* magazine.

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An argument for human consideration

*M*edical disability is a complex psychosocial phenomenon that, in part, describes the relationship between individuals and their work lives. The concept is so deeply rooted in this human relationship that it is virtually impossible to imagine someone alone on an island as being "disabled." Disability without society is the sound of one hand clapping or of the unwitnessed tree falling in the forest.

In addressing disability, medicine is simply as much art as it is science. We lack the critical tools to objectively measure an individual's pain, much less emotional discomfort. Likewise, medicine and the psychological sciences lack tools to fully understand the complexities of human motivation and the myriad psychological factors that impact disability. Certainly, we know that functional limitation is not necessarily the most important determinant. We've all seen and admired individuals who remain productive despite significant functional limitation and others who consider themselves disabled with minimal objective findings.

There is an old maxim in medicine: The patient knows the answer. It is the caregiver's responsibility to patiently ask appropriate questions with genuine concern and to educate individual patients about their capacity for transformation from their current role to what they can become. Those of us in the disability management industry should always remember that although we cannot objectively explain the cause of pain or disability, that doesn't make either of them cease to exist.

As with health care reform in general, exploding costs have riveted employer attention on strategies designed to deal with disability. Some methodologies measure and manage

By Presley Reed, MD

lost time. Many include precise tracking and aggressive—even intrusive—interventions. All promise "significant cost savings." Tracking, measurement, comparison to standards and intervention are important ingredients in successful disability management, but only tell part of the story.

Keep in mind that disability management—just like health care—is about people. People who are often alienated, frightened and angry. People who perceive themselves as having few options. Yes, some of these people are dishonest, deceptive and manipulative. They are the minority, but I've been humbled more than once by surveillance findings that support the need for measured skepticism and scrutiny to identify those who would lie, cheat and steal.

The challenge, however, is not catching wrongdoers but rather creating an environment that allows individuals to redefine themselves as "able" people, capable of functioning in the work environment. Not just any work environment will do. Employers need to build workplace cultures that value workers' contributions and build their self-esteem.

Ultimately, this will be an employer's most effective strategy for managing disability costs. Coincidentally, it is the most effective strategy for encouraging productivity among all workers.

The threshold events in life are about people. Likewise, the threshold events in recovery from a disabling condition are about people. As practitioners, we must not abdicate the important role of human interaction and communication of genuine concern to technology, nor allow ourselves to become a medical police force. To do so would be to abandon people—disabled or not—to a web of technology that will confirm the most jaundiced views of the world and the workplace.

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Presley Reed, MD, chairman of the Reed Group Limited in Denver, is the author of *Medical Disability Advisor: Workplace Guidelines for Disability Duration*.

Private matters, public good

Sarasota, with its sugar-sanded Gulf Coast beaches and affluent Florida ambience, is sometimes called a "little piece of paradise." Certainly its residents worry about their health, but a major concern on any given day is also whether the skies will be sunny.

Thus it may come as a surprise to learn that 70-year-old Sarasota Memorial Hospital—an airy, all-white complex in a lush green campus—is so concerned about the security of medical records that it's installing sophisticated fingerprint identification technology similar to the type being adopted by the criminal justice system.

When installation is completed over the next several years, those who seek information about a patient will not only need to have the usual authorization and password; they will also have to touch the correct finger to the screen. The new system represents, at the very least, the perception of greater security. As vice president and chief information officer Jim Turnbull puts it: "It's not unusual to share passwords, but it's very unusual to share fingers."

That a community hospital would go to such lengths shows how significant the question of privacy and confidentiality of medical records has become. For, as medical institutions computerize and connect with each other to provide greater efficiencies and research opportunities, the number of people viewing patient records has increased. So too have the threats of privacy invasion and inappropriate use. The issue involves all segments of society, from the patient concerned about individual rights to employers, associations, all branches of the gov-

ernment and the entire health care industry.

New technology inevitably raises new fears and concerns. Many people believe that computer databases are more vulnerable than paper files to outside intruders. Their impression may be mistaken, but it is certainly true that computer records allow more frequent and sophisticated manipulation of data to assess costs and results. Thus, there are more reasons for people to look at records. Many believe that increased usage carries a proportional risk of misuse.

So far, only a few disturbing stories have been reported, but they are being taken as warning signs that potentially worse and more widespread harm could result. The breach of privacy to end all breaches of privacy, says Denise Nagel, MD, executive director of the National Coalition for Patient Rights, "is just an accident waiting to happen."

Health plans, employers and providers are, in fact, just coming to grips with the questions that greater computerization raises. How well they respond will influence whether subscribers trust and stay loyal to plans, whether workers are honest about their health and whether management of care is based on accurate information.

In this controversy, "privacy" and "confidentiality" are generally considered to be separate but overlapping concepts. Heidi Hayduk, a lawyer and consultant to the Health Care Leadership Council, which represents about 50 hospitals, health plans, vendors and device manufacturers, explains the distinctions: Privacy applies to the consumer and implies ownership of infor-

Millions of individual outcomes must be analyzed to define the disease management strategies that will make America healthier. How much of our privacy must we surrender in the process?

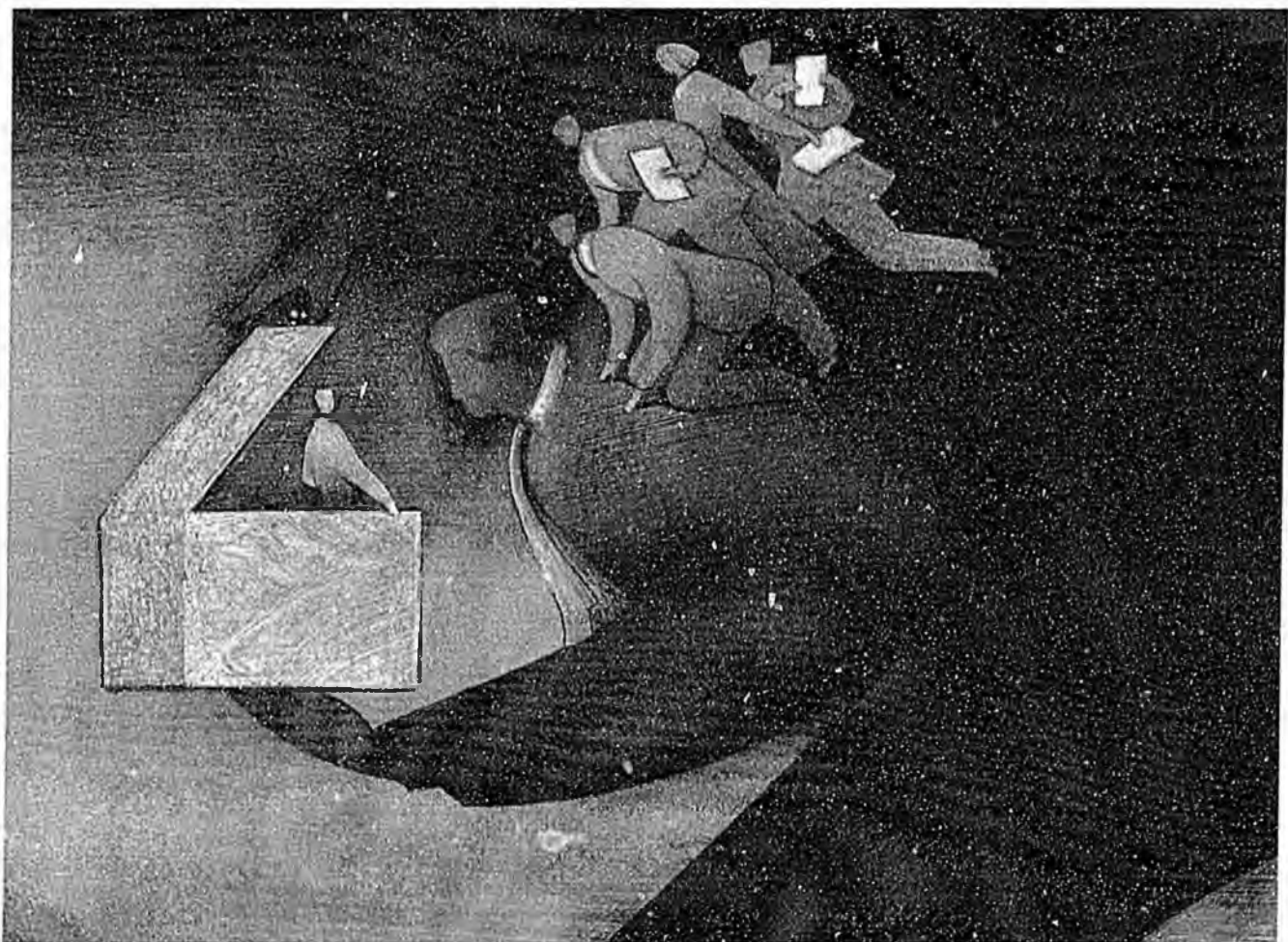
By Jan Ziegler

mation, she says. "It's described almost as a constitutional thing: 'This is my information, and I have the right to control its flow.'" The question here is who will have access to the information. Confidentiality, according to Hayduk, is more an institutional term: That is, once a plan or a doctor's office has patient information, how will it be protected? In this case, the issue is how the information will be used.

Promises and threats

A key promise of managed care is to improve treatment strategies and the health of entire populations through outcomes research using data from medical records.

Northern California's giant Kaiser Permanente system conducts 20 to 30 outcome studies a year drawing on patient records both computerized and printed, says Richard Rabens, MD, director of the department of quality review and utilization. Many studies require impersonal data, but others



demand individual chart review.

Dreamers also envision a day when every person's medical record will be accessible at any health care facility in the country. Whether that record resides in some huge database on the Great Plains or is carried on a "smart card," the benefits are undeniable: No matter how urgent the circumstances, practitioners would have all necessary information at their fingertips when a new patient walks in the door.

Some of this is happening now. Many organizations are creating their own versions of the computerized or virtual patient record and linking up in local communication networks. A coalition led by Infinity Health Care in Mequon, Wis., is building a nationwide network that one day, project leaders hope, will allow emergency room clinicians to punch up a patient's records anywhere in the country. This would eliminate what project director Edward Barthell, MD, calls the "black hole" that forces ER care-

givers to take their best guess when treating a stranger.

To some, this sounds like a juggernaut—Hayduk admits that "there are a lot of people who need access to medical records to ensure the quality of care"—but E.g. Brother is not yet in complete control of the system. "The current state of affairs," explains Margaret Amatyakul, executive director of the Computer-based Patient Record Institute, "is really limited to exchanging information within an organization (the lab system 'talks' to the pharmacy system) and to a very limited extent among organizations of a given enterprise (the hospital passes the discharge summary to the home health agency of the same enterprise).

"Any exchange of information across enterprises is presently done in much the same manner as in the past," she says. In other words, someone within a health care organization must make a phone call, put a file in the mail and transfer information from one

database to another.

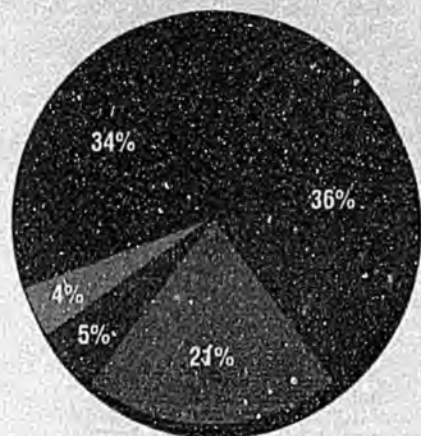
Frankly, says J.D. Kleinke, senior director of HCIA, Inc., a health information systems firm outside Baltimore, the threat to privacy through improper use of records has existed "ever since records were kept on clay tablets." Robert Hughes, president of the Massachusetts Association of HMOs, agrees. "Years ago, my wife worked at a big downtown hospital," he recalls. "She used to have to chase records down. The doctors would be carrying them around in their briefcases; they'd be taking them to lunch."

Still, warns Laura Brown, manager of information security at Ernst & Young LLP in San Francisco, "If a clinical system is connected in some way to the Internet, and it's not using safeguards, a hacker could hack it." And as patient rights advocate Nagel points out: "The fact that information can be transferred in a way that is neither onerous nor impossible is leading an increasing number of people to

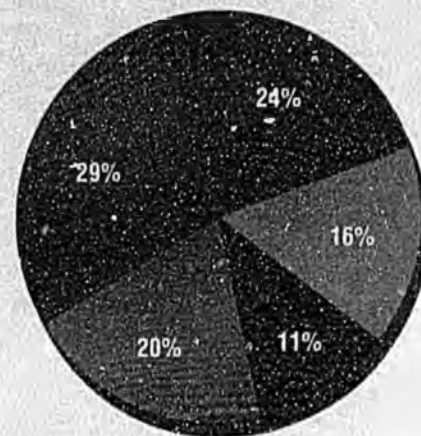
Who's driving the info explosion?

Employers and health plans see information systems as a key to making disease management efforts pay off. In a national survey on pharmacy benefit management, William M. Mercer company found that about 70 percent of employers plan to require their pharmacy benefit manager to integrate prescription and medical data and communicate clinical information to their medical carriers. Such systems multiply the number of people with quick and ready access to patient records, and some observers fear this will increase the risk of security lapses.

Employers that plan to require integration of Rx and medical data



Employers that plan to explore development of an integrated Rx plan for Indemnity, POS, and HMO



Very likely

Somewhat likely

Somewhat unlikely

Very unlikely

Undecided

n=150 companies.

Source: William M. Mercer.

desire it, to feel entitled to it and, in large part, to be getting it."

Nagel has consulted on some lawsuits filed against state organizations, such as the state of California, which demanded that PacifiCare turn over "hundreds of thousands of computer files, including personal medical records and peer review records, without patient knowledge or consent."

Hypothetically, the state could have sent clerks to look at armloads of paper records. But, says Nagel, "The ease of being able to collect the information makes it much more likely to be desired." The suit was settled so that only records pertaining to the state's specific questions were provided.

Selectivity is needed, even in the age of computers, says Fran Bastien, health and welfare benefits manager at self-insured Digital Equipment Corp. in Maynard, Mass. "I should

not, nor do I need to have, access to individual health records. I couldn't care less about individual data," says Bastien. "Sharing information drives better-quality outcomes and better cost-effectiveness, but I care about the aggregate. If the data show I have an employee population at high risk of heart disease, I want to sit down with my provider and structure a plan that will help my workforce."

In fact, it's not necessary to reveal patient identity in mass data searches such as those used in outcomes research; in that kind of work names can easily be stripped from records. "That is what computers do best," Amatayakul says. "Computers can do just about anything you can program them to do."

Of course, insurers have for many years been requiring doctors to provide complete copies of paper records

as part of quality assurance review. While many physicians have regarded this as unwarranted intrusions on their turf, Hughes argues that review of a specific case can provide benefits. "What happens if you're doing talk therapy for a case of depression, when drugs could have helped? And instead you've got the patient coming in for two years?" he asks. "Someone checking the chart could find out. It may not have anything to do with cost. That's a quality issue."

But whether it's individual records or masses of data, "the perception out there that the health care industry is willy-nilly providing this stuff is just not true," maintains Hayduk.

What the public fears most

"Do you masturbate? How are your relationships with your parents, friends? Have you ever been preg-

nant? Have you had an abortion?" These are questions about patients that Ricardo Lewitus, MD, chief of pediatrics at Marlboro Hospital in Massachusetts, says insurers routinely require physicians to answer. "As a pediatrician," he says, "I am very concerned about how information available to third parties will affect these children's futures."

Lewitus' comments are among many that appear in a report by the Massachusetts Medical Society's task force on patient privacy and confidentiality, one of the most complete to be issued by such an organization.

Beyond embarrassment, employees worry that if certain health conditions become known, they may lose out on a promotion or job security. "I hate to tell you how much this goes on every day," says Kathleen Frawley, vice president for legal and public policy services for the American Health Information Management Association. In a 1996 study reported in *Science and Engineering Ethics*, a team led by Lisa N. Geller of Harvard Medical School's division of medical ethics, found 206 cases in which individuals had been denied jobs, insurance, the right to adopt children, educational opportunities or participation in the armed services because they had or were suspected of having a predisposition to a genetic disease.

This type of action is, of course, illegal, but Hayduk points out that it is "a discrimination issue, not a confidentiality issue." If an employer or insurer acts in a discriminatory way, employees may take action under federal law, such as the Americans with Disabilities Act and the Health Insurance Portability and Accountability Act of 1996.

Among the most sensitive issues are mental health, as was learned by a Massachusetts grandmother who sought treatment through her HMO during a family dispute. "She thought her sessions with the psychiatrist were confidential," Nagel says, and would remain in the doctor's private file.

And then, "she found out that detailed notes on her every meeting with him had been entered into her computerized medical record."

A more calamitous case occurred at the Southeastern Pennsylvania Transit Authority, where an official underlined names of all patients on an AIDS drug and started making inquiries about a manager who was taking it. Before she was stopped, employees found out and made the man's life miserable. A federal jury awarded him \$125,000.

In most states, records on mental health, HIV/AIDS and substance abuse fall under statutes requiring specific authorization for release. A more effective solution may be keeping them physically separate.

That's the strategy at St. John Health System, which encompasses seven hospitals in four counties of Michigan. Its computerized patient record system will use encryption, passwords and audit trails, but psychiatric data, HIV/AIDS status and other

*"It's not the
hospitals or the
health care providers
that are the problem.
It's the people who
are unregulated."*

sensitive information will be kept only in local systems within the appropriate departments. Providers interested in these data "will have to follow up with the attending physician," says Rod Dykehouse, vice president of information systems.

The technology fortress

Ernst & Young's Brown says there are three aspects to computer security, and the technology exists to deal with each one. The basic question of privacy involves the likes of the 16-year-old hacker who retrieved Bob Dole's medical records from the Internet. Integrity is a matter of whether a message arrives in exactly the format it started out in. Was it caught along the way, altered and set back on its course?

Both of these issues are easily handled by encryption, the computer-generated garbling and ungarbling of a message. Yes, encryption can be broken, but the job can take one or two supercomputers, says Brown, and the vast majority of hackers and snoops do not have access to such resources.

The third consideration, authenticity, is a matter of determining the legitimacy of the user. How do you know, for instance, that a prescription is coming from an authorized issuer? Certificate authorities, third parties who verify identity, says Brown, can help determine if the prescription is coming from the health plan or the brilliant 15-year-old niece whose aunt wants an unauthorized refill.

Unfortunately, there are no absolute guarantees that protective technology will be put in place, staffs properly trained or policies honored. In a survey of 1,320 chief information officers and other senior executives at companies, 71 percent expressed a lack of confidence in the security of their computer networks "both from internal and external attack," according to Ernst & Young and *Information Week*, which conducted the study and released the results last October.

Among the 100 survey respondents

from the health care industry, including HMOs and hospitals, 77 percent indicated their senior management thought information security was important or extremely important, says Brown, but their commitment was spotty. For instance, only 21 percent had a system in place to classify data by its sensitivity and determine who will have access to it. Only 26 percent had policies governing the conduct of electronic business transactions, such as sending a batch of prescription orders to a pharmacy supplier.

Eighty-two percent did not offer stand-alone security orientation programs to new employees, and 72 percent did not provide regular updates on information security as systems changed, Brown says. Both of these are important in the event of lawsuits, she points out. If you're not taking care of your employees this way, "you're going to fall down in court."

Some organizations are taking no chances. The emergency physicians at Infinity Health Care are leading a consortium of companies in setting up the civilian portion of the emergency network project, which will mesh with a loop under development by the U.S. Department of Defense.

Data safety is an integral part of the project, Barthell says, "and we have a whole group working on it." The head of that group, Steven Kulick, MD, also of Infinity, says that not only will transmission take place on a network separate from the Internet, but both software and hardware will be encrypted. Audit trails, which keep a record of who has tapped into on-line information, will be installed as well.

On the whole, says Hughes, HMOs "go to all sorts of lengths—passwords, double-blind stuff—to provide protection in this area." Many fear the idea of the brilliant wacko who, from the outside, is able to crack what seem like secure data, but a far greater threat is the worker with authorized access to records.

A few examples of serious misuse

already exist: The state public health employee in Florida who allegedly passed a list of AIDS patients around a gay bar; the employee who sent a country singer Tammy Wynette's computerized medical records to a national tabloid.

The role of ethics and law

"All the professions have codes of ethics, all of them addressing confidentiality. Every hospital in the nation has a code of ethics," says Frawley of the American Health Information Management Association. At some, such as Kaiser, breach of confidentiality is reason for immediate dismissal. But, she adds, "It's not the hospitals or the health care providers that are the problem. It's the people who are unregulated." Insurance companies and large HMOs, she believes, simply do not have to answer to a provider's code of ethics.

"The average hospital admission record is seen by 60 to 80 people," adds Deirdre Mulligan, staff counsel for the Center for Democracy and Technology, "most of whom are not governed by any federal policy and who are regulated by very little state policy." Aware that many existing confidentiality statutes predate the technology that now serves as the spine of health care, states are beginning to take on the complex task of crafting new legislation.

The potential difficulties that lawmakers face were illustrated at the federal level last year in actions surrounding two key pieces of confidentiality legislation: a bill concerning individual patient rights sponsored by Rep. James McDermott (D-Wash.) and a measure governing access submitted by Sens. Robert Bennett (R-Utah) and Patrick Leahy (D-Vt.).

Neither passed, in part because of disagreement over technical issues, but behind-the-scenes skirmishing also slowed the process. Some HMOs and traditional payers publicly favored protections; but Frawley heard lobbyists for some of these

organizations make pitches against regulation in meetings with House and Senate staff.

Frawley expects that lobbyists "will be out in full force again" when the legislation is re-introduced this year, but she points out that if Congress doesn't act by August 1998, the Health Insurance Portability Act requires Secretary of U.S. Health and Human Services Donna Shalala to step in. "I still think the legislation will pass Congress," she predicts. "I don't think anyone wants to give the Secretary of Health and Human Services the final authority to draft legislation, because they're afraid the result would be overly broad."

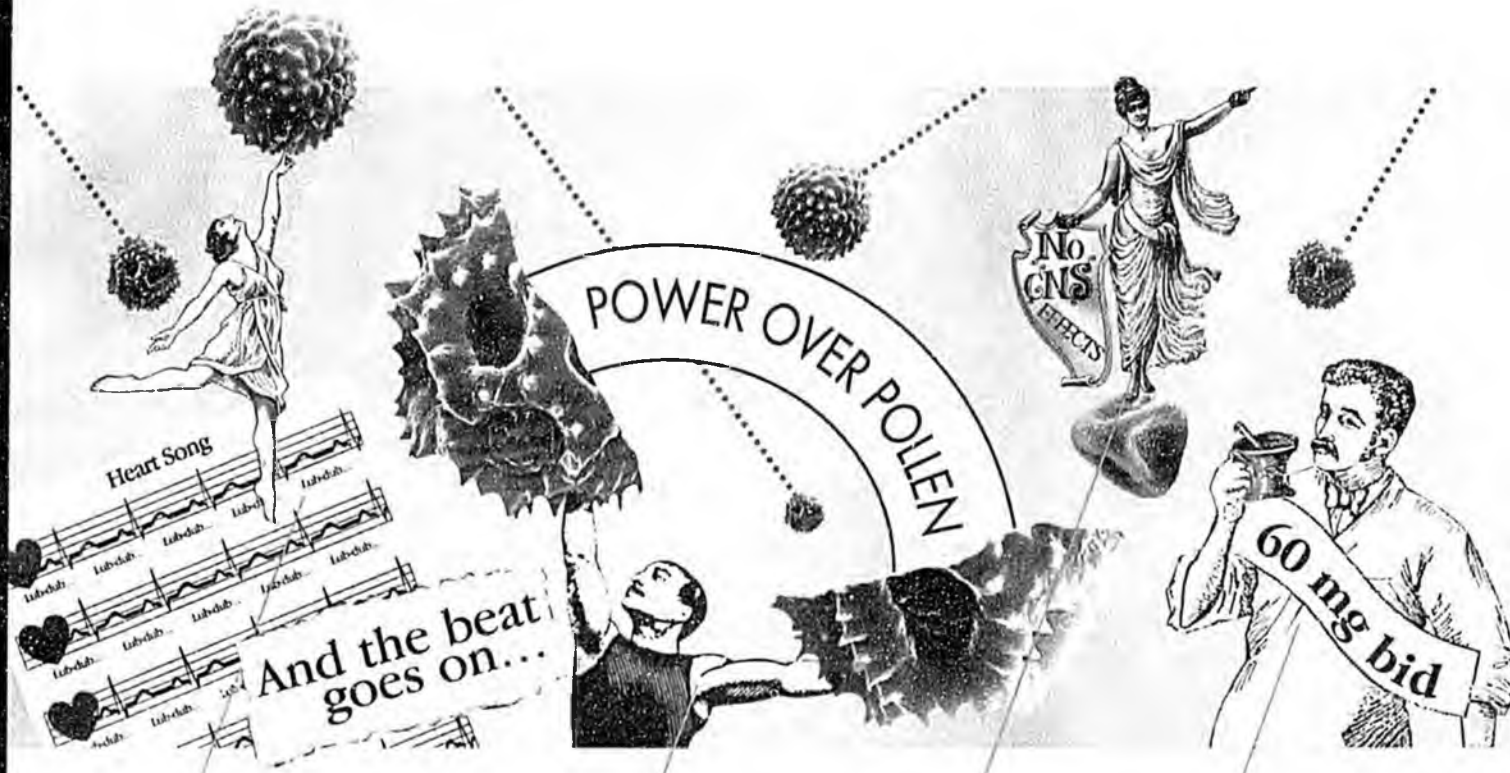
The importance of ethical and legal considerations, however, is equaled by the financial bottom line of the privacy and confidentiality issue—and it's not just that untrustworthy health plans will lose customers. "If the system you offer improves health and prevents illness at the lowest cost, everyone wins," Nagel says.

"If, on the other hand, employees and patients see the health care system as too leaky with personal information, patients will withhold it from their doctors and delay treatment until the last possible moment. They will lie about their lifestyle, conceal their genetic background, and all the outcomes studies that we are designing to answer questions about health care will be based on erroneous information."

Hayduk looks on the bright side, arguing that the controversy "provides an opportunity to better safeguard this information much more effectively than in the old days of a file folder sitting in someone's drawer." Adds Hayduk, "While it's new and scary, it's a chance to improve the health care system."

Jan Ziegler is based in Washington, D.C., and writes frequently on managed care and social issues. She is a contributing editor with Business & Health.

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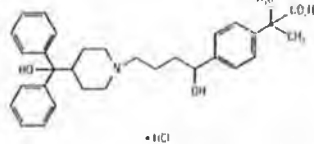
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CLINICAL PHARMACOLOGY

Mechanism of Action

Fexofenadine is a metabolite of terfenadine, an antihistamine with selective peripheral H₁-receptor antagonist activity. Fexofenadine inhibited antigen-induced bronchospasm in sensitized guinea pigs and histamine release from peritoneal mast cells in rats. In laboratory animals, no anticholinergic or alpha₁-adrenergic receptor blocking effects were observed. Moreover, no sedative or other central nervous system effects were observed. Radio-labeled tissue distribution studies in rats indicated that fexofenadine does not cross the blood-brain barrier.

Pharmacokinetics

Fexofenadine hydrochloride was rapidly absorbed following oral administration of a single dose of two 60 mg capsules to healthy male volunteers with a mean time to maximum plasma concentration occurring at 2.6 hours postdose. After administration of a single 60 mg dose as an oral solution to healthy subjects, the mean plasma concentration was 209 ng/mL. Mean steady-state peak plasma concentrations of 246 ng/mL were observed when healthy volunteers were administered multiple doses of fexofenadine hydrochloride (60 mg oral solution every 12 hours for 10 doses). Fexofenadine pharmacokinetics were linear for oral doses up to 120 mg twice daily. Although the absolute bioavailability of fexofenadine hydrochloride capsules is unknown, the capsules are bioequivalent to an oral solution. The mean elimination half-life of fexofenadine was 14.4 hours, following administration of 60 mg, twice daily, to steady-state in normal volunteers.

Human mass balance studies documented a recovery of approximately 80% and 11% of the [¹⁴C] fexofenadine hydrochloride dose in the feces and urine, respectively. Approximately 5% of the total dose was metabolized. Because the absolute bioavailability of fexofenadine hydrochloride has not been established, it is unknown if the fecal component represents unabsorbed drug or the result of biliary excretion. The pharmacokinetics of fexofenadine hydrochloride in seasonal allergic rhinitis patients were similar to those in healthy subjects. Peak fexofenadine plasma concentrations were similar between adolescents (12-16 years of age) and adult patients. Fexofenadine is 60% to 70% bound to plasma proteins, primarily albumin and α₁-acid glycoprotein.

Special Populations

Special population pharmacokinetics (for age and renal and hepatic impairment), obtained after a single dose of 60 mg fexofenadine hydrochloride, were compared to those from normal subjects in a separate study of similar design. While subject weights were relatively uniform between studies, these special population patients were substantially older than the healthy young volunteers. Thus, an age effect may be confounding the pharmacokinetic differences observed in some of the special populations.

Effect of Age. In older subjects (> 65 years old), peak plasma levels of fexofenadine were 59% greater than those observed in normal volunteers (< 65 years old). Mean elimination half-lives were similar to those observed in normal volunteers.

Renally Impaired. In patients with mild (creatinine clearance 41-80 mL/min) to severe (creatinine clearance 11-40 mL/min) renal impairment, peak plasma levels of fexofenadine were 87% and 111% greater, respectively, and mean elimination half-lives were 59% and 72% longer, respectively, than observed in normal volunteers. Peak plasma levels in patients on dialysis (creatinine clearance < 10 mL/min) were 82% greater and half-life was 31% longer than observed in normal volunteers. Based on increases in bioavailability and half-life, a dose of 60 mg once daily is recommended as the starting dose in patients with decreased renal function. (See DOSE AND ADMINISTRATION.)

Hepatically Impaired. The pharmacokinetics of fexofenadine hydrochloride in patients with hepatic disease did not differ substantially from that observed in healthy subjects.

Effect of Gender. Across several trials, no clinically significant gender-related differences were observed in the pharmacokinetics of fexofenadine.

Pharmacodynamics

Wheat and Flare. Human histamine skin wheel and flare studies following single and twice daily doses of 20 mg and 40 mg fexofenadine hydrochloride demonstrated that the drug exhibits an antihistamine effect by 1 hour, achieves maximum effect at 2-3 hours, and an effect is still seen at 12 hours. There was no evidence of tolerance to these effects after 20 days of dosing.

Effects on QTc. In dogs (10 mg/kg/day, orally for 5 days) and rabbits (10 mg/kg, intravenously over one hour) fexofenadine did not prolong QTc at plasma concentrations that were at least 20 and 63 times, respectively, the therapeutic plasma concentrations in man (based on a 60 mg twice daily fexofenadine hydrochloride dose). No effect was observed on calcium channel current, delayed K⁺ channel current, or action potential duration in guinea pig myocytes. No current in rat neonatal myocytes, or on the delayed rectifier K⁺ channel cloned from human heart at concentrations up to 1 × 10⁻⁶ M of fexofenadine. This concentration was at least 32 times the therapeutic plasma concentration in man (based on a 60 mg twice daily fexofenadine hydrochloride dose).

No statistically significant increase in mean QTc interval compared to placebo was observed in 714 seasonal allergic rhinitis patients given fexofenadine hydrochloride capsules in doses of 60 mg to 240 mg twice daily for two weeks or in 40 healthy volunteers given fexofenadine hydrochloride as an oral solution at doses up to 400 mg twice daily for 6 days.

Clinical Studies

In three, 2-week, multi-center, randomized, double-blind, placebo-controlled trials in patients 12-60 years of age with seasonal allergic rhinitis (N=1634), fexofenadine hydrochloride 60 mg twice daily significantly reduced total symptom scores (the sum of the individual scores for sneezing, rhinorrhea, itchy nose/palate/throat, itchy watery/red eyes) compared to placebo. Statistically significant reductions in symptom scores were observed following the first 60 mg dose, with the effect maintained throughout the 12-hour interval. In general, there was no additional reduction in total symptom scores with higher doses of fexofenadine up to 240 mg twice daily. Although the number of subjects in some of the subgroups was small, there were no significant differences in the effect of fexofenadine hydrochloride across subgroups of patients defined by gender, age, and race. Onset of action for reduction in total symptom scores, excluding nasal congestion, was observed at 60 minutes compared to placebo following a single 60 mg fexofenadine hydrochloride dose administered to patients with seasonal allergic rhinitis who were exposed to ragweed pollen in an environmental exposure unit.

INDICATIONS AND USAGE

ALLEGRA™ is indicated for the relief of symptoms associated with seasonal allergic rhinitis in adults and children 12 years of age and older. Symptoms treated effectively include sneezing, rhinorrhea, itchy nose/palate/throat, itchy watery/red eyes.

CONTRAINDICATIONS

ALLEGRA™ is contraindicated in patients with known hypersensitivity to any of its ingredients.

PRECAUTIONS

Drug Interactions

In two separate studies, fexofenadine hydrochloride 120 mg twice daily (twice the recommended dose) was administered with erythromycin 500 mg every 8 hours or ketoconazole 400 mg once daily under steady-state conditions to normal, healthy volunteers (n=24, age 6 study). No differences in adverse events or QTc interval were observed when subjects were administered fexofenadine hydrochloride alone or in combination with erythromycin or ketoconazole. The findings of these studies are summarized in the following table:

Effects on Steady-State Fexofenadine Pharmacokinetics After 7 Days of Co-Administration with Fexofenadine Hydrochloride 120 mg Every 12 Hours (twice recommended dose) in Normal Volunteers (n=24)

Concomitant Drug	C _{max,SS} (Peak plasma concentration)	AUC _{0-12h} (Extent of systemic exposure)
Erythromycin (500 mg every 8 hrs)	+82%	+103%
Ketoconazole (400 mg once daily)	+135%	+161%

The mechanisms of these interactions are unknown, and the potential for interaction with other azole antifungal or macrolide agents has not been studied. These changes in plasma levels were within the range of plasma levels achieved in adequate and well-controlled clinical trials. Fexofenadine had no effect on the pharmacokinetics of erythromycin or ketoconazole.

Carcinogenesis, Mutagenesis, Impairment of Fertility

The carcinogenic potential and reproductive toxicity of fexofenadine hydrochloride were assessed using terfenadine studies with adequate fexofenadine exposure (based on plasma area under-the-curve [AUC] values). No evidence of carcinogenicity was observed when mice and rats were given daily oral doses of 50 and 150 mg/kg of terfenadine for 18 and 24 months, respectively; these doses resulted in plasma AUC values of fexofenadine that were up to four times the human therapeutic value (based on a 60 mg twice-daily fexofenadine hydrochloride dose).

In *in-vitro* (Bacterial Reverse Mutation, CHO/HGPRT Forward Mutation, and Rat Lymphocyte Chromosomal Aberration assays) and *in vivo* (Mouse Bone Marrow Micronucleus assay) tests, fexofenadine hydrochloride revealed no evidence of mutagenicity.

In rat fertility studies, dose-related reductions in implants and increases in postimplantation losses were observed at oral doses equal to or greater than 150 mg/kg of terfenadine; these doses produced plasma AUC values of fexofenadine that were equal to or greater than three times the human therapeutic value (based on a 60-mg twice-daily fexofenadine hydrochloride dose).

Pregnancy
Teratogenic Effects: Category C. There was no evidence of teratogenicity in rats or rabbits at oral terfenadine doses up to 300 mg/kg; these doses produced fexofenadine plasma AUC values that were up to 4 and 37 times the human therapeutic value (based on a 60-mg twice-daily fexofenadine hydrochloride dose), respectively.

There are no adequate and well-controlled studies in pregnant women. Fexofenadine hydrochloride should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic Effects. Dose-related decreases in pup weight gain and survival were observed in rats exposed to oral doses equal to and greater than 150 mg/kg of terfenadine; at these doses the plasma AUC values of fexofenadine were equal to or greater than 3 times the human therapeutic values (based on a 60-mg twice-daily fexofenadine hydrochloride dose).

Nursing Mothers

There are no adequate and well-controlled studies in women during lactation. Because many drugs are excreted in human milk, caution should be exercised when fexofenadine hydrochloride is administered to a nursing woman.

Pediatric Use

Safety and effectiveness of ALLEGRA™ in pediatric patients under the age of 12 years have not been established. Across well-controlled clinical trials in patients with seasonal allergic rhinitis, a total of 205 patients between the ages of 12 to 16 years received doses ranging from 20 mg to 240 mg twice daily for up to two weeks. Adverse events were similar in this group compared to patients above the age of 16 years.

Geriatric Use

In placebo-controlled trials, 42 patients, age 60 to 68 years, received doses of 20 mg to 240 mg of fexofenadine twice daily for up to two weeks. Adverse events were similar in this group to patients under age 60 years.

ADVERSE REACTIONS

In placebo-controlled clinical trials, which included 2461 patients receiving fexofenadine hydrochloride at doses of 20 mg to 240 mg twice daily, adverse events were similar in fexofenadine hydrochloride and placebo-treated patients. The incidence of adverse events, including drowsiness, was not dose related and was similar across subgroups defined by age, gender, and race. The percent of patients who withdrew prematurely because of adverse events was 2.2% with fexofenadine hydrochloride vs 3.3% with placebo. All adverse events that were reported by greater than 1% of patients who received the recommended daily dose of fexofenadine hydrochloride (60 mg twice daily) and that were more common with fexofenadine than placebo, are listed in the following table:

Adverse Experiences Reported in Placebo-Controlled Seasonal Allergic Rhinitis Clinical Trials at Rates of Greater Than 1%

Adverse Experience	Fexofenadine 60 mg Twice Daily (n=679)	Placebo Twice Daily (n=671)
Viral Infection (cold, flu)	2.5%	1.5%
Nausea	1.6%	1.5%
Dysmenorrhea	1.5%	0.3%
Drowsiness	1.3%	0.9%
Epigastric	1.3%	0.6%
Fatigue	1.3%	0.0%

Adverse events occurring in greater than 1% of fexofenadine hydrochloride treated patients (60 mg twice daily), but that were more common in the placebo-treated group, include headache and throat irritation. The frequency and magnitude of laboratory abnormalities were similar in fexofenadine hydrochloride and placebo-treated patients.

OVERDOSAGE

Information regarding acute overdosage is limited to experience from clinical trials conducted during the development of ALLEGRA™. Single doses of fexofenadine hydrochloride up to 600 mg (6 normal volunteers, at this dose level), and doses up to 690 mg twice daily for one month (13 normal volunteers, at this dose level), were administered without the development of clinically significant adverse events. In the event of overdose, consider standard measures to remove any unabsorbed drug. Symptomatic and supportive treatment is recommended.

Hemodialysis did not effectively remove fexofenadine from blood (up to 1.7% removed) following terfenadine administration.

No deaths occurred at oral doses of fexofenadine hydrochloride up to 5000 mg/kg in mice (170 times the maximum recommended human daily oral dose based on mg/m²) and up to 5000 mg/kg in rats (330 times the maximum recommended human daily oral dose based on mg/m²). Additionally, no clinical signs of toxicity or gross pathological findings were observed. In dogs, no evidence of toxicity was observed at oral doses up to 2000 mg/kg (450 times the maximum recommended human daily oral dose based on mg/m²).

DOSE AND ADMINISTRATION

The recommended dose of ALLEGRA™ is 60 mg twice daily for adults and children 12 years of age and older. A dose of 60 mg once daily is recommended as the starting dose in patients with decreased renal function. (See CLINICAL PHARMACOLOGY.)

HOW SUPPLIED

ALLEGRA™ 60 mg capsules are available in high-density polyethylene (HDPE) bottles of 60 (NDC 0008-1102-41), HDPE bottles of 100 (NDC 0008-1102-42), HDPE bottles of 500 (NDC 0008-1102-53), and aluminum foil blister packs of 100 (NDC 0008-1102-50).

ALLEGRA™ capsules have a white opaque cap and a pink opaque body. The capsules are imprinted with "M" on the cap, and "1102" on the body. Six ALLEGRA™ capsules, at controlled room temperature 20-25°C (68-77°F). Foil backed blister packs should be protected from excessive moisture.

Prescribing Information as of July 1996

Hoechst Marion Roussel, Inc.
Kansas City, MO 64107 USA

4/96/96g

Hoechst Marion Roussel

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Are we squeezing the life out of hospitals?

A decade of cost cutting has left

many hospitals in

financial disarray,

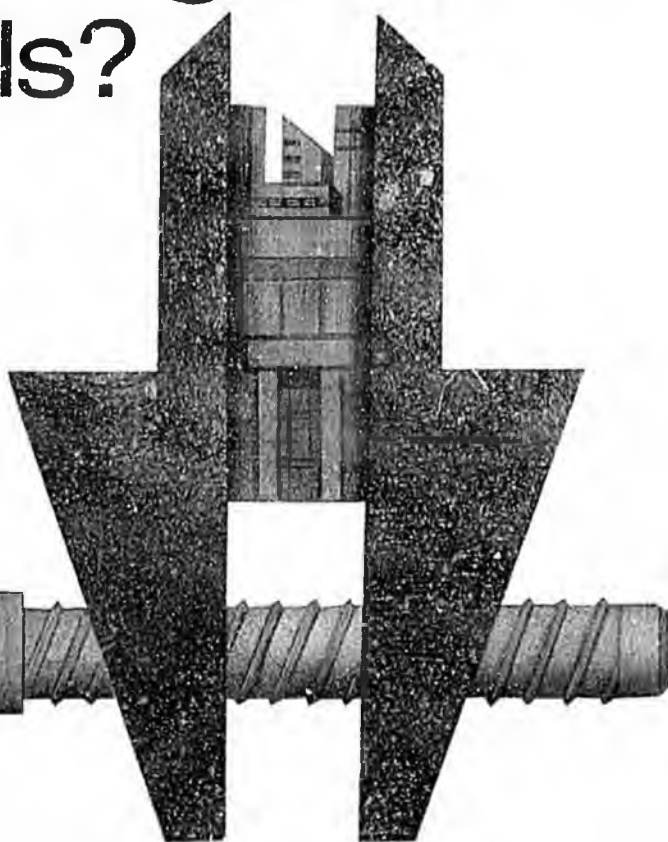
yet others are thriving

amid the forces

of change. Their

creative responses

are blueprints for survival.



**By Vicki Gerson
and Emil Vernarec**

Hospitals have been a favorite target of cost-cutters throughout a decade of restructuring health care delivery—and for good reason. Given a fee-for-service system that encouraged overutilization and cushioned consumers from the full financial consequences of demanding “the best,” there’s no doubt that hospitals provided care with only a brief nod to cost.

But the days of such largesse—which some would call gross inefficiency—are over. While many hospitals have met the challenge of fiscal accountability by adopting an entrepreneurial spirit, others have succumbed to the pressure: Well over 700 acute care hospitals closed their doors between 1987 and 1995, according to

data from the U.S. Department of Health and Human Services.

The flurry of hospital closings and consolidations, the trend toward for-profit status and the spread of huge hospital systems have raised public alarm and forced the question: Have we squeezed hospitals too hard?

Dennis S. O’Leary, MD, president of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) doesn’t think so. “Many hospitals have succeeded in building complex organizations that provide an array of services, of which acute care is only one part and may even be a diminishing part,” he says. “Many own and operate ambulatory and sub-acute units, home health companies, as well as nursing homes. But these are not hospitals as America knew

them in 1950. They’re networks of services, only some of which fly, operating under the banner of integrated delivery systems.”

Yet, according to James Bentley, senior vice president for policy at the American Hospital Association, the upheaval is far from over. Indeed, AHA forecasts more hospital closings, a continued increase in outpatient care and further reduction in an already scaled-back RN staff. “It’s partly from economics, partly from new technology and partly from changing public expectations,” he says. “Twenty to 25 percent of all hospitals are losing money on the bottom line. They need creative ways to keep out of the red.”

Cost crises spawn innovation

Reminders of how creative hospitals can actually be come at year’s end.

when health care management consultants HCIA, Inc., of Baltimore, and the Boston-based William M. Mercer Health Care Provider Consulting Practice released its list of the "top 100" U.S. hospitals and industry-wide benchmarks for 1996.

The annual analysis, now in its fourth year, rates the performance of more than 3,500 short-term, acute care facilities, based on Medicare cost reports and discharge data. Data for each hospital are compared to others within its peer group, defined by size, location and teaching status. Performance measures include risk-adjusted mortality and complications, average length of stay, expense per adjusted charge, profitability, outpatient activity, long-term growth in equity and productivity. Hospitals with the highest scores on all eight measures determine the benchmark performance within each peer group.

The study found that the performance of the 100 top hospitals advanced over 1995's benchmarks in the majority of measures and improved significantly in long-term growth in equity, outpatient revenue and productivity. The two indicators of clinical quality—median mortality and complications—improved modestly. The researchers forecast that if all U.S. hospitals could match the performance of the benchmark-setters, some \$27 billion in hospital expenses would be cut.

The financial health of this year's benchmark hospitals was dramatically higher than their peers'—achieving a 114 percent higher median growth in equity between 1993 and 1995. The largest concentrations of benchmark hospitals were in the West and South, areas that have experienced fierce competition and high managed care penetration.

"Our study shows you can be very profitable and build your business by operating as the benchmark hospitals do," says Jean Chenoweth, senior vice president with HCIA. "It's real. What you have in those hospitals are superb management teams."

What impressed Chenoweth most was the steady upward trend of the benchmarks overall. "The performance keeps improving every single year," she says, "and not only on the West Coast, but in Florida, Tennessee and Texas—all highly competitive areas. The beneficiary of the competition appears to be the consumer, because hospitals work hard at improving in a number of categories."

Mike Blaszyk, a partner with Mercer's Health Care Provider Consulting Practice, says the analysis shows that "the best hospitals have gotten better.

“The percentage of benchmark hospitals that are for-profit decreased, which means not-for-profits have gotten very competitive.”

Efficiency and effectiveness did not reduce quality.

"We also expected to see more penetration by for-profits," says Blaszyk, "but that percentage actually decreased, which means the not-for-profits have gotten very competitive." The group of benchmark hospitals included 27 investor-owned and 73 not-for-profit hospitals, with 42 hospitals from last year's list repeating. In 1995, 33 investor-owned and 67 not-for-profit hospitals made the list.

One not-for-profit that has appeared on the "top 100" list two years in a row is St. Luke's Hospital, New Bedford, Mass. (Last year, St. Luke's merged with two neighboring community hospitals, Charlton Memorial of Fall River and Tobey Memorial in Wareham, to form the Southeast Hospitals Group.) Robert P. Millen, now the Southeast COO, credits the hospital's success to its strong community involvement and continuous quality improvement.

"We learned the lesson from business and industry that if you improve quality, your costs go down," says Millen, "and at the same time you improve the individual's health and the organization's health." The hospital targeted two key areas with a big impact on costs, explains Millen: the rate of hospital infections—each incidence of which adds about \$2,000 in costs—and the rate of complications from procedures and surgery.

Like many other hospitals, Southeast also has dedicated substantial resources to outpatient treatment, which accounts for about 40 percent of revenue and has eclipsed inpatient procedures by a ratio of seven to three, says Millen. Southeast operates about 35 outpatient units throughout the community. As part of the shift, it upgraded those facilities and established a visiting nurse service, which makes about 6,000 visits a year.

The HCIA-Mercer study recognized an ongoing and significant trend toward outpatient activity. Among the benchmark hospitals, the median proportion of outpatient revenue was 35 percent. For all hospitals studied, growth in outpatient revenue ranged from 5.6 to 10 percent. But benchmark hospitals increased their outpatient business at a rate 50 percent higher than their peers. HCIA's Chenoweth notes that over the four years of doing this study, "the site of care appears to be becoming more appropriate."

Southeast's Millen also credits his organization's success to its responsiveness to community need, a factor

that steered St. Luke's away from an offer to join a for-profit chain. "Our trustees wanted to focus on the needs of the local community we serve and did not want to be controlled by an entity several states away," he says.

Another benchmark hospital with a strong community focus, but which is part of a for-profit chain, is Columbia Castlevue Hospital in rural Price, Utah. An 84-bed facility, Castlevue has set "top 100" benchmarks three years in a row. Although the nearest hospital is 75 miles away and separated from Price by the Wasatch Mountains, Castlevue faces competitive pressure nonetheless, according to CEO Allen Penry. "People think 'bigger is better.' Yet Castlevue was accredited by JCAHO with commendation."

Penry says that being part of the Columbia system has given Castlevue access not only to lower supply costs from national contracts, but also to shared information among the nearly 350 hospitals in the system. "Every quarter, Columbia sponsors Gallup surveys of patients, physicians and employees to assess what we can be doing better and then suggests action plans and marshals resources behind them," says Penry. Columbia also regularly disseminates "best demonstrated practices" within the system.

Most recently, Castlevue has focused on making the emergency room, which often forms people's first impression of a hospital, more attractive and comfortable and cutting the wait time to treatment by having emergency medical technicians do triage and clerical processing simultaneously.

The hospital has also established "clinical pathways" for specific conditions, to streamline care and reduce length of stay. Penry says such protocols are now in place for pneumonia and joint replacement and have helped lower the hospital's overall average length of stay from about four days to a little under three-and-a-half days.

Another factor Penry credits for the hospital's success is close collaboration with its community advisory board. In

three years, the board has grown from 10 people to more than 200 as it has involved local government and schools in addressing community health problems such as high teen pregnancy rates and—Price being a coal-mining town—pulmonary disease.

In an environment on the opposite extreme of Castlevue's is Hermann Hospital in Houston, which also has appeared in the "top 100" two years straight. Hermann sits among 13 hospitals concentrated in a two-to-three-square-mile area in Houston called the "Texas medical center."

Few areas could be as competitive: Together, the cluster of hospitals has more than 6,800 beds. "All the hospitals were booming years earlier when

the money was freer," says Lynn Walts, COO of Hermann. "As revenue has tightened, competition has gotten fiercer for managed care contracts."

According to Walts, Hermann's high performance is the result of several initiatives, such as forming a network of 300-plus primary care physicians, targeting areas for quality improvement, monitoring patient satisfaction and offering a more comprehensive range of services than neighboring hospitals.

Price competition has been a particular challenge for Hermann because of its added expenses as the teaching hospital for the University of Texas Medical School at Houston. About three years ago, says Walts, Hermann

Thinning the ranks of U.S. hospitals

In 1995 the number of hospital closures increased for the first time since 1988, according to the latest annual report from the U.S. Department of Health and Human Services, even though four new hospitals opened and one hospital that had been closed was reopened. Over the years, HHS has found that most of the hospitals that closed were small, and their closings did not severely affect access to care.



Source: Office of Inspector General, U.S. Dept. of Health and Human Services.

readdressed its relatively higher costs of care compared with its neighbors.

"We attacked inefficient care," she says. "It's not that the care was bad, just inefficient." For each category of chronic illness, the entire reporting line of staff met to examine what was needed to prevent complications and repeat hospitalizations.

For instance, to trim expenses from repeated pediatric asthma emergencies, that department devised a strategy to use outpatient clinics for early intervention by a full team of providers. By educating parents and establishing protocols for care, they were able to cut hospital stays of three to four days down to less than one day.

Walts says the hospital also invests a "huge effort" in improving patient satisfaction. Hermann surveys patients twice yearly and gives direct, immediate feedback to each department. These patient-focused initiatives also include intensive training of staff and providers about patients' perceptions of quality care.

According to Walts, teaching hospitals face roughly 15 percent higher costs because of their training expenses. In the past this was funded through Medicare/Medicaid programs, which adjusted reimbursement upwards depending on the number of residents being trained. Funding is drying up, she says, as HMOs assume more coverage and cut expenditures. Hermann is working to keep the issue in front of legislators. "Awareness is high that such funding must be there," says Walts, "and that we can't bear the brunt of it by ourselves."

The HCIA-Mercer analysis found an even greater cost burden among major teaching hospitals. According to Blaszyk, major teaching hospitals had a median expense per case of \$5,027 compared with a minor urban teaching hospital's expense of \$3,647. "It's a huge cost difference that makes you wonder how they'll be able to continue in the future and how graduate medical education is going to be paid for," he says.

The sound of hospital doors closing

Few aspects of the restructuring of health care achieve the high drama of two palpable acts—hospital closures and RN layoffs. It's unlikely that either trend will end soon. According to an analysis by the Sachs Group of Evanston, Ill., demand for inpatient

According to one analysis, while about 1.14 million hospital beds were available in 1995, only about half that number were needed.

beds is likely to drop precipitously as managed care strategies continue to spread.

In 1995, the firm notes, while there were an estimated 1.14 million hospital beds nationwide, demand required only about half that number. The Sachs Group projects that if nationwide hospital utilization follows a pattern like that of Seattle under managed care (which served as their model of analysis), demand for inpatient beds in the year 2000 would drop to 315,000; the average length of stay would fall from about six to four days; and the total number of discharges would shrink from 33 million to 23 million.

Part of the reason for the increase in empty hospital beds, says Joanne M. Krumberger, president of the

American Association of Critical Care Nurses, is that for many years hospitals were built without regard for community need. In addition, she says, "as we've gotten better at caring for patients, they don't need as much time in the hospital."

But some experts question whether shrinking hospital stays can pay off much longer. In spite of fewer hospitalizations and shorter stays, health care costs have continued to rise. In an analysis in *Health Affairs*, Princeton University economics professor Uwe Reinhardt reported that while inpatient days per 1,000 population fell by 36 percent between 1980 and 1993, real per capita spending on inpatient care rose by 53 percent. What's more, real per capita spending on all health services rose by 87 percent and total national spending increased from almost 9 percent of GNP to nearly 14 percent.

For Reinhardt, the focus on drastically reducing inpatient days is misdirected. Since the vast majority of the money poured into hospitals covers basic overhead, he concluded, some expenses can't be cut no matter how many beds go unoccupied.

Others consider factors like acuity and interpret the findings differently. Bob Mayo, a senior vice president at the Sachs Group, says, "The discrepancy in inpatient days and costs exists because you're often getting older, sicker patients and your resources and demands are much greater." He adds that it wasn't until 1993 that the system began moving from a fee-for-service structure to one that instilled some accountability. "Data reflecting this change won't be available for a few years," he says.

With fewer RNs, is quality harmed?

Equally unclear is the impact of cutting back on the number of RNs on hospital floors. A survey of 7,355 RNs conducted last spring by the *American Journal of Nursing* found that nearly two-thirds of them have

seen a reduction in RNs providing in-hospital care and four out of 10 reported the hiring of unlicensed assistants, technicians or aides to provide direct patient care previously given by RNs. More than two-thirds of the nurses also said they had seen an increase in patient loads and nearly 90 percent indicated serious concerns about the safety and quality of care as a result of cost-cutting practices.

About five months later, conflicting research appeared in the *Journal of the American Medical Association*. The study, based on census data on employment and earnings of nursing personnel between 1983 and 1994, reported that the ratio of RNs per hospital bed had actually risen more than 50 percent, due to a 16 percent decline in beds used. During the same period, the study reported, the ratio of LPNs and aides fell by 36 percent and 21 percent, respectively.

The American Nurses Association (ANA) criticized the *JAMA* article for not having looked further into the impact of higher patient acuity and for using data that did not differentiate clinical and nonclinical nursing.

"Some of the changes could be positive," says ANA president Beverly Malone, "but when unlicensed assistive personnel are underprepared, when the education is not in place, we have great concerns. Unlicensed assistive personnel can be people who just four weeks ago were flipping burgers at McDonald's. Now, they're asking you, 'How are you feeling?'"

Critics of the cutbacks have no shortage of anecdotes to fuel the fear about the potential for harm. In one case last year, a Cincinnati, Ohio, hospital paid out a \$3 million settlement for the wrongful death of a 46-year-old mother of two. The post-surgical patient had complained of pain in her upper abdomen. An assistive personnel worker charted this as "incisional pain," even though the incision was in the lower abdomen. In fact, the patient's bowel had been nicked during surgery, causing a mas-

sive infection as the wound leaked feces. After three days the patient's vital signs dropped drastically. She died two days later.

Malone decries what she considers misguided policy and a lack of understanding among health care executives about the importance of qualified nursing care. She says that hospital CEOs surveyed by the ANA ranked nursing care as the primary contributor to hospital costs. But, says Malone, "Nursing comprises on average only 23 percent of hospital labor costs."

Action by JCAHO may provide the kind of data required for a more complete answer on the impact of reduced RN staffing. JCAHO plans this year to require all accredited hospitals and nursing homes to enroll in a performance measurement system—which will include data on patient outcomes—by the end of 1998.

Competing on quality

The focus on quality performance, a trend bordering on impatience on the health plan front, is sure to determine who leads and who survives among hospitals. Indeed, the HCIA-Mercer report predicts that "the future financial strength of investor-owned hospitals will become less of a factor than the overall patient-focused service provided by a hospital, investor-owned or not, in determining success."

Until that day, COOs like Walts worry that purchasers might believe hospital advertising rather than expect reliable information about quality performance. "There's no perfect quality measure," she says, "but a hospital should be able to define its outcomes, show its progress and say, 'This is how we've done it.'"

Certainly "centers of excellence" have an edge. That enviable designation enables a hospital to draw a large enough volume of patients to amortize the costs of talent and technology and to maintain proficiency for the intensive services the center provides.

"Outcome measures demonstrate

the effectiveness of specialty centers," says Michael Lanzilotta, president and CEO of the Georgia-based National Cardiovascular Network, a partnership of 40 centers of excellence hospitals.

Lanzilotta points out that while 80 percent of patients treated at the network have high-risk multivessel disease, their observed mortality is only 2.8 percent, less than half the expected mortality. "This is testimony of why centers of excellence make sense from an economic and outcomes perspective," says Lanzilotta. "When focusing care in high-volume centers, they tend to be more efficient and blend the use of their resources more efficiently."

Quality and efficiency may well win the day, but the long-term forecast for hospitals, particularly the not-for-profit institutions that are traditionally identified with charitable care, also depends on how the country answers more fundamental questions about funding health care. (See "The uninsured: An American time bomb" on page 55.)

AHA's Bentley, for one, maintains that the "Robin Hood system" of the past is faltering. "If we won't allow hospitals to overcharge some patients to support others, then who will subsidize the indigent? Maybe the United Way will have to start a free bed fund, because we have to do something. Purchasers and managed care companies are saying, 'I only want to pay for the cost of my patient.'"

John E. Curley, Jr., president and CEO of the Catholic Health Association, voices the other horn of the dilemma: "Even if we're being squeezed, are we supposed to tell people who come through the doors of our acute care hospitals that we won't serve them?" he asks. "I don't think so."

Vicki Gersc is a freelance writer in Northbrook, Ill. Emil Vernarec is a senior editor with Business & Health.

In the shadow of the managed care monolith

Merger after merger, the trend moves inexorably forward.

But is bigger really better for your employees or your bottom line?

By all accounts, managed care is a major success story. Its methods broke the back of double-digit inflation in health care, and nearly three out of four American workers are in some sort of managed care.

For employee benefits, the increased dependence on managed care means that what happens within this booming industry is of vital importance to the business community as a whole. And mergers and consolidations are what's happening in managed care. The spectrum of potential consequences ranges from major new efficiencies in delivering care to the crushing of competitive forces that have so radically changed the delivery system.

The financial stakes are huge: In 1995, United Healthcare Corp. spent upwards of \$1.6 billion to buy Metrahealth, which had been formed not too long before as a joint venture by Metropolitan Life Insurance Co. and Travelers Life Insurance Co. In April 1996, Aetna spent \$9 billion acquiring U.S. Healthcare, creating an entity that covers 14 million people. Last November, Las Vegas-based Sierra Health Systems announced a \$421 million merger agreement with Physician Corp. of America.

Not-for-profits are merging as well. Two of the oldest and best-known, Group Health Cooperative of Puget Sound and Kaiser Permanente, are in talks, with a decision expected this spring. "There isn't a week we don't get some kind of announcement of a merger or an acquisition that affects us in some way," says Susan Moriconi,

By Joanne Silberner

health benefits and worklife manager of Hewlett-Packard, which has 62,000 employees in the United States.

How far will it go? "I think it's going to keep on going," says John Erb, a principal with Foster Higgins, benefits consultants in New York. "I don't know a single HMO that I'm dealing with right now that isn't in discussion with other HMOs for acquisition or merger. Like manufacturers, they need capital to expand and grow."

After the Aetna/U.S. Healthcare deal, one health care investment analyst told *The New York Times* that he expected there would only be three to five national players in five years. Not so, says Tom LaLoggia of the MEDSTAT Group, a health care consulting firm, based in Ann Arbor, Mich. "It will take a long time to get down to just a few HMOs."

At the same time, more HMOs are forming—60 in the last year, according to health care analyst Doug Sherlock of the investment banking firm Sherlock Co.: "Some were started by big insurers, but I'm guessing that many are provider-sponsored." Some analysts say what's likely to happen is that big insurers will gobble up medium-size ones, while new ones form in the hope of becoming medium-size and being bought out.

Will consolidation help or hurt?

The heady pace of mergers and acquisitions may be good for stationers working up the new letterheads, but what about businesses that buy health

care services? The answer, says Helen Darling, manager of health care strategies for Xerox Corp., depends on whether the profit motive gets more entrenched in the process. "By itself a merger or acquisition is not bad; but when it leads to inferior products or services, then it's a problem."

Size, she says, can be an advantage—allowing HMOs to do things like technology assessment, quality monitoring, sending members off for high-cost care and letting doctors know about new findings. But, she adds, "We're very concerned that firms with a predominant interest in shareholder returns might look at things differently from us. Those that are not returning shareholder value may not be as interested in customer satisfaction." Darling is also worried about what mergers, consolidations and alliances will do to the quality of care. "Are they aimed at improving genuine efficiency, quality and technology at a better price, or are they a new way to squeeze out more money for shareholders or a handful of moguls?"

Even with all this, health care analysts expect there will always be a choice among plans. Xerox, for example, still offers an indemnity plan; its workers still have alternatives if HMOs merge. Darling has observed that other managed care organizations (MCOs) form when it looks like one company is becoming a monopoly. MEDSTAT's LaLoggia says, "The top 25 MCOs only control about a third of the HMO enrollment, and HMO enrollment itself is about 40 percent of the commercially covered people in the nation. As long as the marketplace is fragmented

among plans, multiple-option plans and carveout plans, I think the effect on businesses and on the purchasers of health care will be mitigated. I don't see any real lessening of choice."

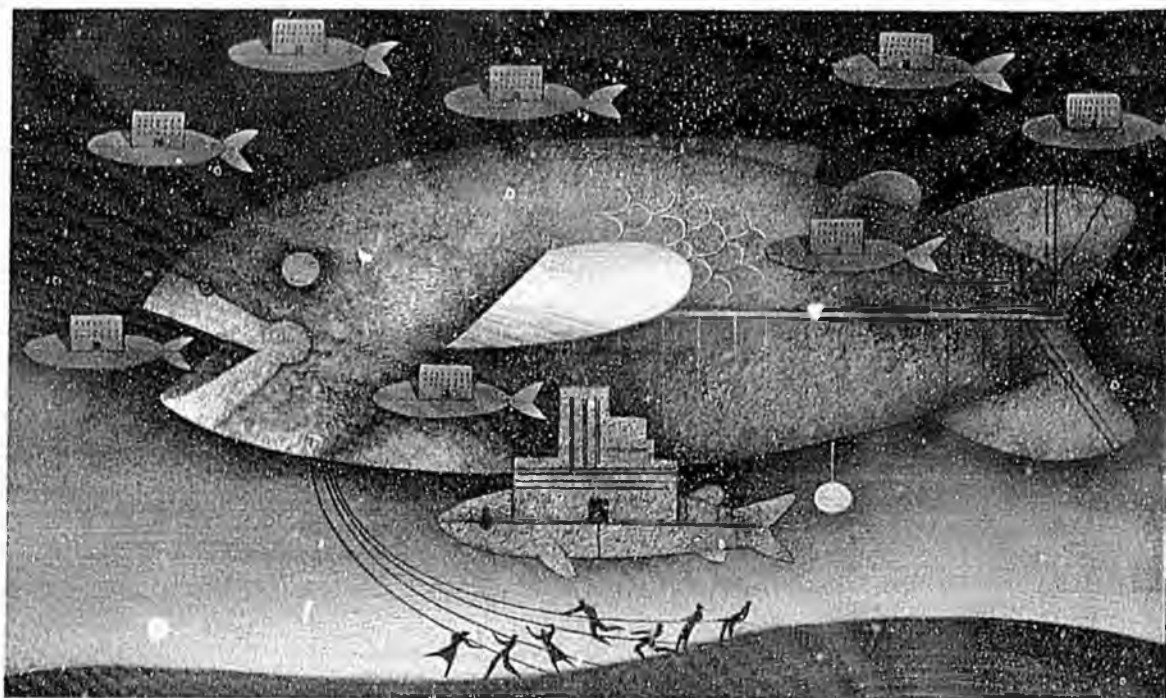
The price question, when there is only a handful of MCOs, is a little tougher to answer. "In that sort of situation, do they really go at each other?" asks Henry

Aaron, an economist at the Brookings Institution. "It's not in their best interests. There's a broad theory of behavior by oligopoly." Like most health care experts, Aaron says it's too early to tell if mergers mean prices will go up or down. But he's willing to predict that as the market consolidates, the government is more likely to step in, since it's easier to regulate a less fragmented market.

What makes cost predictions especially hard is that even if MCOs are national, they sell their product—and they compete—locally, says investment banker Sherlock. It's only when two companies servicing the same area combine and increase market share that a merged entity is likely to raise its rates.

Just to illustrate how many factors weigh in to health care pricing, he points out, you also have to consider the doctors and hospitals in that situation. Imagine, he says, a doctor with 10 percent of his patients from PacifiCare and 10 percent from FHP, two companies that are in the process of merging. Suddenly, 20 percent of the doctor's patients are from the same HMO. So that particular HMO can bargain harder with the doctor. Sherlock's bottom-line prediction: Mergers and acquisitions will lead to lower prices.

But already there are signs that the dam is breaking. The *Hartford Courant* reported last December that



Connecticut's HMO prices are on the rise. Rising the fastest is Aetna/U.S. Healthcare, which announced an increase of 6 to 7 percent. Kaiser held firm on rates for large groups, but raised its small-group rates 5 percent. Blue Cross and Blue Shield's Connecticut HMO prices went up 1.6 percent. And the *Capital District Business Review* of Albany, N.Y., reported that most HMOs in the area had filed requests for group price increases of 1 to 9 percent for this year. Foster Higgins predicted widespread rate increases for 1997 in its latest annual survey of health care costs, albeit in response to slimmer margins rather than increased market share.

Xerox's Darling says raising rates after a merger or acquisition will eventually hurt an MCO. "If Xerox buys a company, we don't turn around and tell our customers that we're raising our copier prices. If I have a message to the people doing mergers and acquisitions, it's, 'Don't ever take advantage of purchasers.' They can always go back to direct contracting or a fee-for-service world."

What's to stop MCOs from taking advantage?

In fact, there's a "no-man's land" between what MCOs can charge and what businesses are willing to pay. "If you're a large company, you do have the option of trying to deal indepen-

dently with physicians," says Brookings economist Aaron. "The effect of that option will be to constrain the behavior of HMOs in any given community, as they'll want to keep the largest market share possible."

"Bank of America knows it knows banking. It doesn't know health care. But if prices got too high, it would learn health care," Aaron adds. "The fact that providers of health care know that would prevent them from setting prices too high, even if there weren't the kind of intense competition there is right now in California. As long as there are enough large players in each community, Bank of America may need to worry about quality of care and availability of services, but it probably can continue to do banking rather than provide health care."

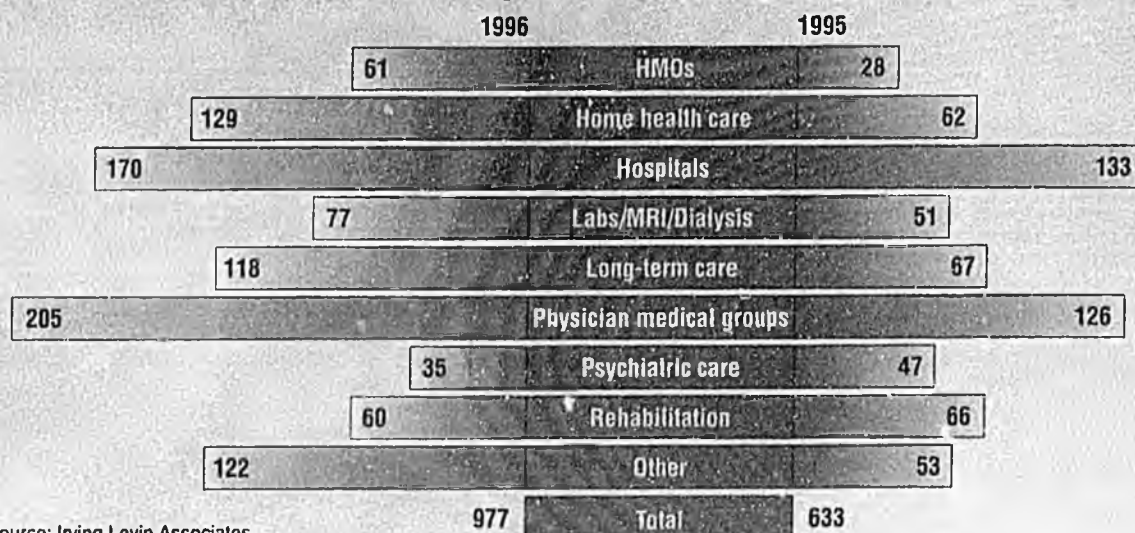
Even in a world where there are giant MCOs, businesses remain the customer. "When whoever is left standing stops providing adequate access, cost or quality, American business is going to step up again and say, 'Enough! Let's try something else,'" says LaLoggia.

In some places, it already has. Corporations like Xerox and Hewlett-Packard are focusing on measuring the quality of care. "If mergers result in only one HMO serving an area, the quality of care could be threatened," says Darling. "It means there are not two competing organizations that are making an effort to offer the lowest

Building bigger players

In 1996, the feeding frenzy of mergers and acquisitions among health care service organizations was 54 percent greater than the record number of transactions seen in 1995, according to Irving Levin Associates. Consolidations among HMOs rose 118 percent. Stephen Monroe, a partner with Levin, predicts activity this year will match last year's volume of M&A transactions.

Health care mergers and acquisitions by type of organization



Source: Irving Levin Associates.

cost and highest quality at the same time. That's where outside reviewers such as the National Committee on Quality Assurance are going to become more important."

Some businesses are so concerned about quality that they're forming their own measurement teams. Five of Cincinnati's biggest businesses, for example, hired the consulting firm Towers Perrin to evaluate managed care plans based on quality of care, access, customer satisfaction, cost, utilization review and plan management.

The federal government is also getting in on the act. During his reelection campaign, President Clinton announced the formation of a panel to monitor the quality of managed care.

The public, meanwhile, is essentially disengaged from the issue of managed care mergers and acquisitions. When asked in a recent survey how they picked a health plan, most said they ignored issues like quality measurements and even their doctors' advice. What they depended on was not the size of the MCO, but the suggestions of friends and family.

Doing it themselves

Businesses themselves are making

sure that competitive markets do not give way to managed care monoliths, most notably in the Minneapolis/St. Paul market, one of the furthest along in terms of HMO consolidation. Four major health plans have most of the market and basically control pricing. The 26 large companies that make up the Buyers Health Care Action Group (BHCAG) had fostered the growth of the big plans but were unhappy with the lack of competition that resulted.

BHCAG convinced doctors and hospitals to form themselves into 15 "care systems" that provide complete and standardized benefits at varying prices. The employees of BHCAG companies make their own choices—comparison shopping by price, by reputation of physicians or by whatever factor makes the most sense to them as consumers. Rates already are 5 percent below those of the local HMOs, says BHCAG executive director Steve Wetzell. (See "Who needs the middleman?" on page 34 for more on the trend toward direct contracting.)

There's something else that may put the brakes on the profit motive of giant HMOs, says Sherlock: More and more doctor- and hospital-run MCOs are forming across the nation, and

these "provider-sponsored health plans will give many of these larger, unintegrated HMOs a run for their money." He reasons that it's easier for doctors to ride herd on each other—to set standards that minimize costly excessive care—than it is for HMOs, which many doctors and hospitals see as the enemy.

Where they work, provider-sponsored plans could also do a lot toward making doctors feel more autonomous, which could lead to better relationships with patients.

Sherlock sees a second brake on the power of large HMOs in an idea that was in the failed Clinton health plan: health insurance purchasing cooperatives, or HPCs. Small, medium and even large businesses group together and set up an insurance supermarket, where employees can choose on the basis of cost and quality, with the idea that competition will hold costs down. "With HPCs you can have all the efficiency you'd ever want, at the same time as you have brutal competition," says Sherlock.

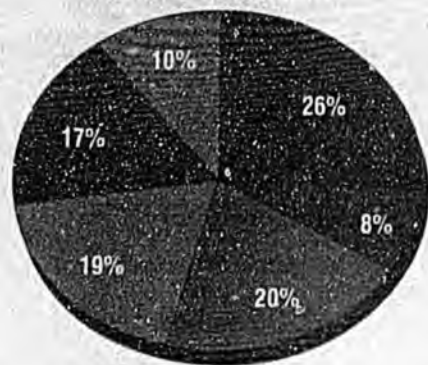
According to the *Baltimore Sun*, 7,000 businesses were members of 140 purchasing coalitions nationwide in 1996, nearly twice the number of coalitions

Consolidating HMO market share

Consolidation has placed more than half of total HMO enrollees in the hands of only 10 percent of HMOs. While the number of HMOs grew by 20 percent in 1995, SMG Marketing Group predicts an increase of only 7 percent in 1996 and less than half that in 1997. The number of enrollees, however, is projected to rise an average 9 percent in 1996 and 1997, to a total of nearly 80 million people. Between 1998 and 2000, growth in the number of HMOs will slow to less than 1 percent per year, but membership will grow by about 6 percent per year. And by the year 2000, predicts SMG, about 750 HMOs will be covering nearly 100 million people.

Size of HMO	Number of HMOs	Total number of enrollees (in millions)
0-14,999	171	0.9
15,000-24,999	53	1.1
25,000-49,999	136	5.95
50,000-99,999	128	8.96
100,000-249,999	116	17.7
250,000 +	65	33.9
Total	669	>68

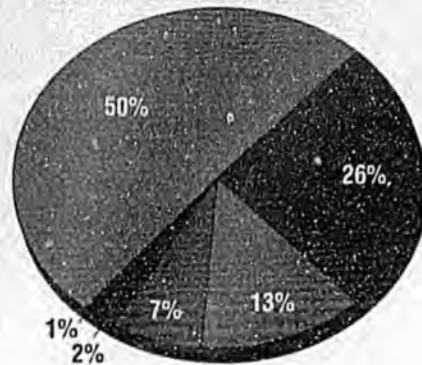
Percentage of total HMOs according to size of HMO



Size of HMO



Percentage of total HMO enrollment according to size of HMO



Source: SMG Marketing Group.

tions in the previous year. How powerful the coalitions are remains to be seen. Foster Higgins analyst Erb says they haven't saved much. Then again, the Twin Cities' BHCAG has become a major player, and the *Star* reports that a local coalition with 20 employers and 20,000 workers claims a 10 percent savings in health care costs.

Realistic prospects

It may seem that managed care mergers could do one unquestionably good thing by smoothing out differences in patient care from region to region. But John Wennberg, MD, of Dartmouth Medical School, who studies regional differences in care, says that's not necessarily so. "It will nationalize the economic structure, but dealing with the variations in practice patterns and quantities of services is much more complicated," he says. "HMOs can't write rules that doctors can follow. It's not going to be that quick and easy." The regional variations are based much more on the availability of hos-

pital beds and specialists than on who owns an MCO.

Consolidation could have at least one positive effect, predicts Foster Higgins' Erb: waking up some businesses. "A lot of our large national clients, and even some local clients, have not gone out to bid for health care recently. It's been so easy to go from renewal to renewal, especially in the last couple of years with premiums flat or down," he says. But just the attention the changes in the marketplace are getting could make businesses look at what's out there.

To Hewlett-Packard's Moriconi, the disappearance or reorganization of some of the companies she's been dealing with is a lesson. "What all this does is remind employer purchasers of the need to stay tuned in to the market and to be adaptable and flexible. You can't make long-term plans about your HMO providers because they may not exist tomorrow . . . and you also have to make that clear to your employees."

What it gets down to is this: In the

complex health care marketplace, with businesses, insurers, doctors, hospitals, governments and patients often at cross-purposes, it's hard to tell whether the mergers and acquisitions will be good or bad.

If MCOs get greedy and government fails to stop them, the profit motive in health care could become even more entrenched, businesses will find themselves in an adversarial relationship with health plans, and people might wind up turning to the government for relief.

On the other hand, if businesses continue to ride herd on MCOs on quality and cost, if providers continue to set up alternative MCOs, if people learn to distinguish between good and bad health plans, and if the government keeps a watchful but not overbearing eye, then the market may very well make the health care delivery system work.

Joanne Silberner, a writer based in Washington, D.C., has been covering health care policy and medicine for 15 years.

Who needs the middleman?

Provider-sponsored organizations say they keep third party players from meddling in the doctor-patient relationship. While their viability is uncertain, their focus on quality is raising the competitive stakes.

The more things change, the more they stay the same," seems to be the apt platitude to describe the health care marketplace of 1997. The latest addition to the array of options for employers that offer health benefits is the provider-sponsored organization (PSO). Set up and managed by hospitals and/or doctors, PSOs hold out the delectable promise that they will cut out the middleman—the insurance carrier.

In theory, contracting directly with PSOs could translate into lower administrative and premium costs and higher quality care. In practice, it might attach employers to underregulated and possibly underfunded entities with little risk-bearing experience.

Most PSOs lack track records and have little quality data or proof of ability to manage utilization. They stand on somewhat shaky regulatory ground as well, because enforcers are having trouble defining them. Should PSOs be licensed as insurers or left to their own devices?

As a result, not many employers have ventured into this uncharted territory, and the daring few that have signed contracts have been reluctant to eliminate all the functions of the middleman. Many still pay a third party administrator (TPA) or a health plan to process claims, provide customer service and collect quality data.

That doesn't surprise Peter Kongstvedt, MD, a partner with Ernst

By Alicia Ault Barnett

& Young's Washington, D.C., office. Providers and payers may dream about cutting out the middleman, he says, "but all you can do is replace him," because there are "absolutely necessary administrative functions," such as managing billing, enrollment, benefits tracking and financial management. "I don't know that providers and purchasers can do any better than the so-called middleman," agrees Dennis Bush, senior vice president with the MEDSTAT Group.

For at least the next five years, "there are advantages that middlemen bring to the table," adds Ken Berkowitz of the Towers Perrin office in Miami. TPAs, and managed care organizations (MCOs) in particular, he says, are skilled in account and customer servicing and can offer sophisticated information systems. Most of them can make the daunting prospect of administering to the needs of several hundred or several thousand employees a lot less complex, and Berkowitz concludes, "Administrative simplicity still sells in the employer segment."

So even though the name of the provider and the form of the delivery system may have changed, the basic shape of the financial structure remains constant. Employers are not transferring financial risk to these PSOs, and many are struggling with the implications of making the physi-

cian more directly accountable for meeting quality and budget targets.

Still, employers say that PSOs are injecting competition into their markets. In Minneapolis, for example, which was on the verge of domination by a few MCOs, the Buyers Health Care Action Group (BHCAG) thinks its encouragement of PSOs—through an experimental program just getting under way in 1997—may keep the market from stagnating. BHCAG, which last year purchased health care for 100,000 workers, put out a request for proposal, asking providers to align in "Care Systems" to bid on coverage. Of the 19 systems that responded, 15 qualified for the 1997-98 plan year, says BHCAG executive director Steve Wetzell. "We've given them a customer and brought them to the front of the marketplace."

Providers: Driven by fear

But employers rarely have that much clout. In most areas, physicians and hospitals are organizing not to serve a new customer, but to fend off encroaching MCOs. "Without question, it's purely reactionary in some places," says Kongstvedt, "and if it's not providing value to the marketplace, the market won't respond positively."

Physicians want to hold on to their incomes and have more say over their destinies. In starting their own organizations, they hope to eliminate the insurance broker standing between them and patients.



Hospitals are losing on all fronts. Inpatient costs still eat up a large portion of the health care dollar, but admissions are declining and MCOs increasingly determine hospitals' futures. Thus, they, too, are looking for a way to get back in the driver's seat.

The scenario varies and often depends on what institution is dominating the local market—hospital, HMO or physician. Not surprisingly, most PSOs are hospital-based. In Ernst & Young's most recent annual report on these entities, hospitals were the principal owners of 76 percent of the 200 systems surveyed. Most are located in hospital-centered states, such as Florida, Indiana, New York, Pennsylvania and Texas. Second-tier states include Arizona, California, Massachusetts, Michigan and New Jersey.

Such hospital-driven organizations have existed for decades, but their

growing direct acceptance of risk and premiums—without being licensed as insurers—and the explosion in physician-driven enterprises have pricked up the ears of the managed care industry.

According to Tom Hodapp, an analyst with the investment banking firm Robertson Stephens & Co., just seven years ago, physicians didn't feel enough pain to change their structures. Now, there's no escaping the need to consolidate their practices to win managed care or, eventually, employer contracts.

That reality has brought a flood of money from investors, who see physician integration as one of the last unpenetrated frontiers. Publicly traded physician practice management companies have existed on a small scale for almost a decade. Hodapp sees these firms becoming ever-larger national players, better-positioning their doctors

for contracting. They also give physicians capital to build information systems infrastructure and to handle billing and administration more efficiently. This all paves the way for cutting out the insurance broker.

At Robertson Stephens' annual medical conference last November, there were more than a dozen practice management companies competing for investors' attention. Many are built around specific specialties, including neonatology, oncology and obstetrics and gynecology. While some are securing MCO contracts for their physicians, Hodapp says Wall Street is watching to see how these companies take on and handle risk. In the eastern United States in particular, he says, where there is not as much experience with capitation, physicians will have to take "baby steps."

Physicians are coming together in

other ways, too. Some have begun their own HMOs. In a novel approach, the 300-physician Scripps Clinic Medical Group, spun off from the Scripps Health System as a for-profit company in February 1996, is consolidating doctor groups across the nation under its "brand" name. Scripps has capitulated contracts in its San Diego market and hopes to extend its reach both geographically and into employer contracting.

Scripps is a respected name, but most PSOs don't have as much to trade on. Ernst & Young found that the majority of those it surveyed are under five years old, have few covered lives and are attempting risk-sharing without a good handle on utilization. Most have little capability to share meaningful data with clients, and only a third are profitable. That's a risky profile for employers who want to cut out the middleman.

Most irritating to the HMO industry: 72 percent of the 105 PSOs that receive premium payments do not have HMO licenses. Ernst & Young found significant differences between the licensed and nonlicensed entities. Licensed plans had average revenues of \$118 million, while the nonlicensed plans took in an average \$30 million. The unlicensed organizations also had substantially fewer enrollees.

Regulators: Frankly puzzled

Under pressure from the American Medical Association, the American Hospital Association and other interested parties, the federal government last summer issued revised guidelines on antitrust regulations that made it easier for physicians and hospitals to organize.

In the past, physicians who came together in networks risked accusations of price fixing. The government now seems willing to allow the arrangements if they bring "efficiencies" to a market. That might mean providing a new service or creating savings, but the feds set no hard-and-fast rules. This has given rise to an army of consul-

tants advising providers on how to safely join together.

The HMO and insurance industries are neither happy about these safe harbors nor pleased that the new federal guidelines allow physician-owned organizations to contract directly with employers and share risk without being regulated as insurers. They want these entities to be subject to strict licensure and solvency requirements.

The individual states, however, have final say on licensure requirements. Some PSOs that would share risk want the imprimatur of being licensed, while others see no benefit in the expense and hassle of the process, says Dan Krane, an attorney with the Philadelphia firm Drinker, Biddle & Reath.

Alarmed at the rise of unlicensed entities, the National Association of Insurance Commissioners (NAIC) has been working on standardizing requirements. Krane says NAIC is still smarting from the 1980s debacle of multiple employer welfare arrangements, which argued that they were exempt from state licensure laws. Many did not understand the insurance business, and some ended up insolvent.

Last August, NAIC advised state commissioners that its working group on PSOs—a definition that includes integrated provider organizations, integrated practice arrangements, physician-hospital organizations (PHOs) and provider-sponsored networks—had decided that any organization accepting prepaid risk "is in the business of insurance."

But Krane says it generally takes years for NAIC to solidify a position and that states don't always fall into line. Thus far, a handful of states have enacted and others are considering laws that regulate PSOs. Some seem weak at best. In Colorado, for instance, physicians and hospitals need only \$100,000 in reserves to take on capitation.

NAIC reports that other states have said they have no intention of regulating risk-sharing by PSOs. Krane thinks their stance could easily

change. "If there's one highly publicized insolvency of a provider organization in a given state," he says, "that state will be forced to start regulating all the provider organizations."

The uncertain regulatory environment, however, has not scared off some self-insured employers.

Minnesota: Out in front again

As has often been the case, employers and providers in Minnesota are pushing the envelope of health care delivery and financing. The Minneapolis-based BHCAG, representing 26 companies, overhauled its already innovative benefits plan in early 1996. It issued a request for proposal that defined a standard benefit package, specified requirements for quality data disclosure and gave historical claims information on the 100,000 workers in the BHCAG plan.

Area providers were asked to align themselves and bid as "Care Systems." The systems operate as primary care gatekeepers, overseeing referrals to specialty and hospital care. They are allowed to decide on their own structure, set their own premiums and manage their own utilization. A key point: Physicians can't be in two Care Systems simultaneously and thus can't approach employers and consumers through two different middlemen.

Fifteen of the 19 respondents—including PHOs and physician-driven systems—were selected. Employees choose systems based on price and on results of a consumer satisfaction survey completed in the summer of 1996. It rates the 430 primary care clinics available in 1997, based on patients' overall satisfaction, access to medical care and information, patient care and communication and health promotion for children and adults.

BHCAG will risk-adjust claims targets so providers aren't penalized if they have an adverse selection. Member companies will remain self-insured and do not plan to share risk, says Wetzell, and thus are not worried

about any of the Care Systems becoming insolvent. Should that ever happen, he says, employees would be inconvenienced only to the extent of having to find other providers.

Although BHCAG is working directly with providers, it hasn't eliminated the administrative functions of the middleman. The group pays a flat per-member-per-month administrative fee to Health Partners—a local health delivery system that also owns an HMO—to process claims and to provide number crunching for risk adjustment and member service. But even with that fee, there are savings, says Wetzell. He notes that premiums dropped by 11 percent when BHCAG moved from an insured HMO product to a self-insured PPO in 1993, and Care System bids for 1997 are 9.5 percent less than what would have been expected with the PPO.

Plus, the arrangements have finally given BHCAG the clout it wanted. "We become a market maker, not a market taker," says Wetzell. "The customer is defining the product." Wetzell thinks employers in any market can follow BHCAG's example: "If you give physicians incentives to manage their own business and the care, they will respond."

Iowa: Raising the ante

The 30 companies that make up the Des Moines-based Community Health Purchasing Corp. (CHPC) believe that they can not only follow the BHCAG example but also wield even more clout, thanks to the nature of their local market.

CHPC vice president Linda Jones says that the employers-only group has been able to work more closely with providers than even BHCAG, because managed care has made small inroads in the area. "We weren't reinventing something; we were shaping something that was in its infancy," she says. CHPC also represents fewer covered lives, says Jones, and thus may be more nimble than BHCAG. Finally, she notes, Des Moines is a

Is direct contracting a direct route to the courtroom?

Does eliminating the middleman cut down an employer's line of defense against liability suits? Philadelphia-based attorney Dan Krane thinks that's the case.

In what Krane calls "garden variety" malpractice, physicians and hospitals have long been sued for bad results of medical care. Numerous legal decisions have established a chain of liability that extends beyond the direct providers of care to those who hired them, supervised them or checked their professional credentials. Over the past decade, suits against managed care organizations (MCOs)—as representatives of physicians and hospitals—have proliferated. Litigation often stems from instances where there is alleged malpractice due to a patient's not receiving prompt or correct care, or being referred to the wrong specialist. Krane says provider-sponsored organizations (PSOs) will face similar risks as they behave more like managed care plans and begin offering more nonmedical services, such as benefit design, credentialing, utilization review, enrollment and claims processing and advertising. Krane and other consultants recommend that PSOs purchase insurance against that risk and that employers would do well to verify that the organizations they deal with are adequately covered.

To the extent that employers become more closely involved in benefit design, development of clinical guidelines, and other aspects of both medical care and nonmedical services, they too may be exposed to the liability arising from those activities, says Krane. An employer that is sharing risk with a PSO and getting involved in care by imposing referral restrictions or insisting on second opinions could end up being assigned some liability for malpractice.

Judi Morgan, a consultant with Towers Perrin's Atlanta office who works with PSOs and employers, says that many employers have had experience with direct malpractice liability exposure stemming from on-site medical clinics. Now, as they contract with and rely on PSOs to select physician panels and to perform utilization reviews and other functions necessary to operate an MCO, employers will find themselves in the liability stream for bad outcomes related to those functions, she says.

So far, there does not appear to be any precedent-setting case law in the area of PSOs or employers being sued for managed care-related activities, but both Krane and Morgan say it is only a matter of time before plaintiffs' attorneys look for the next deep pocket. Meanwhile PSOs, which are usually formed in a reactive mode, often push risk management down the priority list. For employers, managing liability risk related to direct contracting might not even be on the radar screen.

close-knit community, which makes negotiations simpler.

CHPC had been sending its workers to HMOs with point-of-service options and to a PPO. For 1996, CHPC designed a benefit plan—a point-of-service option with a primary care gatekeeper—with the advice of area providers and then issued a request for proposal. CHPC stipulated that it would own all the patient data and would share results with providers and consumers. The group hopes to devel-

op report cards for consumers, who will choose systems based on price, outcomes and patient satisfaction.

Three-year contracts were awarded to a trio of health care systems—all provider-driven—comprising the majority of physicians and hospitals in the Des Moines area. Iowa Health System is a PHO, and SecureCare Health System is an integrated delivery system half-owned by Mercy Hospital. CHPC also contracts with the John Deere Health Care System's primary

care clinics. CHPC hopes to expand to six or seven PSOs by year's end.

Most utilization decisions are left to the systems, says Jones, because the idea is to empower the physicians. Like BHCAG, CHPC pays a TPA to process claims, handle enrollment and eligibility and transfer funds. The TPA also collects data from providers. Jones says the fee "is very reasonable compared with what our employers have paid in the past for these services."

Unlike their Minneapolis counterparts, however, the Des Moines group's self-insured firms want to start sharing risk and rewarding providers for beating budget targets, says Jones. The employers are working with the state insurance commissioner to avoid running afoul of insurance laws or losing ERISA exemptions.

With a single plan design and direct access to patient data, the employers can "really evaluate the provider performance," says Jones, instead of basing purchasing decisions on prices alone. Even without hard data on savings or improved quality, CHPC employers have begun to change the shape of the Des Moines market, she reports, noting that indemnity insurers have had to decrease their rates "by double digits" just to stay competitive.

Memphis: Motivating the veterans

PSO contracting has spurred competition in the Memphis market, as well, says Cristie Upshaw Travis, CEO of the Memphis Business Group on Health. MBGH has 58 self-insured members, including FedEx and the Tennessee Valley Authority, and represents about 150,000 workers and dependents.

Travis says that Memphis, which also has little managed care penetration, has been dominated by hospitals. MBGH contracts directly with two PPOs—both PHOs, one dating from 1987—an HMO and a point-of-service plan. Most of its members use TPAs, which Travis says makes sense for small employers. They also have

more control over a middleman such as a TPA rather than an insurance carrier, which has to make many clients fit a single mold.

Although MBGH employers have been satisfied with the price of their health care, they've been wary about quality and have tried to keep close tabs on providers through data collected by their TPAs.

MBGH, aware that hospitals tend to dominate alliances with physicians, is trying to bring the doctors into the medical management process. It has monitored acute care quality for four years, says Travis, and identified areas to develop critical pathways that must include physician input. "We are looking at ways to ensure that the physician is actively involved and driving the clinical end of this," she says, noting that employers understand that doctors hold the key to controlling quality and cost.

Local doctors have heard the call: The city's first physician-owned HMO has opened for business. Travis also thinks that the PHOs in Memphis are destined to be supplanted by integrated delivery systems that will incorporate more of a physician-driven approach.

PSOs: Returning to their roots

Most consultants and industry watchers agree that provider-sponsored organizations, whether in Memphis or elsewhere, will end up looking more and more like the broker-middlemen they claim to be replacing. The trend in the health care industry is "clearly toward greater consolidation," notes MED-STAT's Bush. To stay alive, PSOs will become ever-larger and incorporate insurance and underwriting as well as financial and data management expertise. They will face competitive pressure from insurers, which are buying physician practices, and from hospitals, which are attempting to purchase insurance carriers. All this, says Bush, means "the lines are blurring between payers and providers."

For that reason, direct contracting

between employers and PSOs that don't offer the full services of an MCO is "like the search for Eldorado," says Ernst & Young's Kongstvedt. "You can spend a lot of time and energy looking for the city of gold, but you're not likely to find it." While self-insured firms may rush to partner with the nascent PSOs, he notes, they've had to retain a middleman to provide the insurance functions.

Direct contracting might not make sense for PSOs either, suggests Hodapp of Robertson Stephens, noting that it might pit them against their main referral source—managed care plans. That, he says, "is a very precarious strategy unless the HMOs in the market are weak."

The consultants also see other pitfalls in the PSO models. Conflicts in management vision and financial needs are already sinking PHOs. "They've been an unabashed bomb," asserts Hodapp. He thinks physician groups will eventually spin off on their own, providing an opportunity for practice management companies and giving the reins back to doctors. Unfortunately, he's not convinced the doctors are up to the task, noting that many still don't have much management expertise.

The reverse problem is the clinical expertise of employers. Removing the broker-middleman may also take away a layer of insulation from employee lawsuits, says attorney Krane, because the closer employers get to delivering care, the closer they get to being held accountable for medical decisions. (See the sidebar on page 37.)

Coming full circle, Bush concludes that the "inherent conflict between the good of the plan and the good of the patient" seen in MCOs is only heightened in a PSO. "Is the physician an agent of the patient or a manager of the plan?" Bush asks. "Can he or she effectively act in both capacities at the same time?"

Alicia Aull Barnett is a freelance writer living in the Washington, D.C., area who has covered the health care industry for 10 years.

Precipitating factors for pharmaceutical firms

The long-range forecast for managed care anticipates a stationary cold front with occasional blustery negotiations and a diminishing chance of drug rebates. There's a chill in the air, and drug makers are bundling up. ("If you want the price break on one drug, you'll have to list our whole bundle of products on the formulary.") Those thunderclaps you hear are the sound of bluffs being called. ("Go ahead. Kick us off the formulary.") Pharmaceutical detail reps, laid off two years ago, are being brought back in from the cold. The pharmaceuticals have taken careful stock of the managed care marketplace and are planning to engineer some climate control of their own.

"In the beginning, there was fear," explains Steven Shulman, president of Value Health's pharmacy and disease

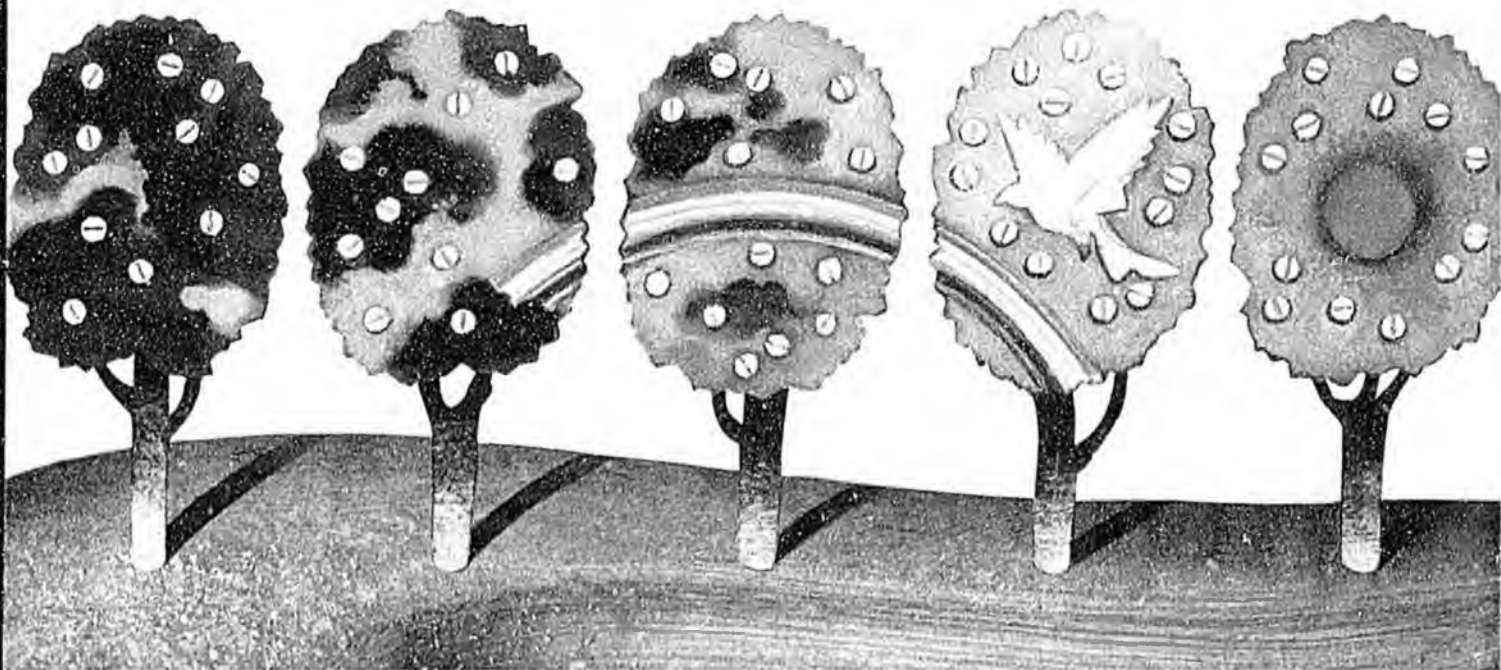
What's the prevailing weather for drug companies and managed care? Conflicting patterns, but still a chance of cooperation.

By Robert McCarthy

management group. "Managed care blew into town, and the pharmaceutical companies lined up to pay whatever rebates it took to get on every formulary. Now they're evaluating what they've been getting for their money. It's a new spin on the old 80/20 rule: 20 percent of the MCOs [managed care organizations] are providing real

value, delivering volume in return for discounted prices. The other 80 percent are getting a free ride. So all those contracts are being redone, and the MCOs that are all noise are being turned off, rebate-wise."

"Bluffs are being called, and products are being kicked off formularies," agrees Mike Miele, president of Capitated Disease Management Services. "The classic fear was that sales would be wiped out. Well, we can now find out what really happens, and it ain't that exciting. Sure, formulary displacement may initially cost you five to 10 market-share points—and that's nothing you want to resign yourself to—but when you compare lost revenue to the rebates you were giving away, guess what? Some companies are doing better off the formulary than they ever did on it. Your sales are down, but your profits are up!"



What's more, pharmaceutical companies needn't resign themselves to the permanent loss of those share points: Detail reps are again going after MCO-network physicians and even making calls on the employers who purchase health care coverage.

"The idea is for the detail reps to convince the benefits manager [of the value of drug X]," says Hewitt Associates consultant Beth Bird, "and then for the benefits manager to prod the health plan to include the drug on the formulary." That strategy strikes industry watcher Patricia Wilson, president of Associates & Wilson, as a bad idea. "For one thing," she says, "corporate benefits managers haven't the time to become surrogate detail reps. For another, why should they do the drug company's job?"

The wisdom of pharmaceutical reps calling on employers isn't all that clear to benefits managers either. "I've had some of the drug manufacturers calling on me," says Alan Peres, manager, health care policy, for Ameritech in Chicago, "but not with any kind of regularity. And quite often the message isn't even about particular drugs, but to talk about how pharmaceuticals can bring down costs in other areas. Which is fine, except I'm not sure why they're telling me. As I tell the reps, I don't make decisions about formularies or about which drugs Ameritech personnel are prescribed."

"We've been contacted by a few drug manufacturers," says David Kasiaz, PepsiCo's director of health and welfare benefits, Purchase, N.Y. "As it turned out, we didn't invite any of them to come in. Basically, they were trying to pitch some very specific, narrowly focused disease-management programs."

Kasiaz sees nothing inappropriate per se about pharmaceutical companies directly approaching employer benefit sponsors. "But they need to be showing us something that has real value, both for us and for our employees—something that we don't already know about and aren't already doing."

he says. "And I don't mean these narrowly defined programs. In order to make sure PepsiCo is delivering maximum-value care to our employees, at maximum efficiencies, we need to be shown the broader picture.

"You know, we're not clinicians, and we wouldn't feel comfortable making decisions affecting employee health care in a vacuum. That's why we work with insurers and pharmacy benefit managers (PBMs). If a manufacturer wanted to make a presentation to us concerning the clinical specifics of a particular drug, we would certainly want our partners [insurance carriers and PBMs] at such a meeting. And if they wanted to show us anything else, we'd want to see it embedded in the larger context of patient care. And it would have to be new and different."

"Many employers, of course, haven't gotten beyond the passive-payer stage," acknowledges Bob Strader, customer development manager, Pharmacia & Upjohn, "but others, like Digital and Xerox, have developed standards, which they insist their health plans implement. We're also working closely with business coalitions, some of which have gotten into direct purchasing." The bottom line, says Strader, is that "employers are the ultimate purchasers of health care."

Adios to easy money

One thing that all sides can agree on is the imminent demise of easy rebates. "There was a presumption among the manufacturers that if you got formulary placement, volume and market share increases would follow," says Bill Strein, manager of pharmacy programs for WellCare Health Plans of New York and Connecticut. "But it was more blind faith than proven fact. Now you have to show empirical proof that you are shifting share before the manufacturers give you the rebate."

"There's very little rebate money out there just for a formulary listing," adds Otto Wolke, vice president of

pharmacy services, Geisinger Health Plan, an integrated managed-care delivery system based in Danville, Pa. "The pharmaceutical houses are setting market-share targets. If you can reach and maintain them, you get the rebate. Otherwise, no."

Plainly put, MCOs are being asked to earn their discounts. "The imperative to move market share will put some onus on managed care," explains John Hopkins, pharmacy services manager of Rocky Mountain HMO in Grand Junction, Colo. "There will have to be more effort at educating and directing physicians to stay with the formulary. Formulary choices will also have to be restricted. If there are too many options, share movement for selected products will be minimal."

Thus, the trade-off of rebates for market share will almost certainly precipitate the implementation of tighter formularies, for which the pharmaceutical industry as a whole professes a philosophical abhorrence. In addition, managed care's need to police formulary adherence may require a crackdown on off-label prescribing.

"Things like direct-to-consumer advertising and prescribing for off-label indications can be serious formulary-busters," says WellCare's Strein. "If you've based your budget on certain expectations of usage—and especially if you've figured in rebate payments for improving the shares of certain drugs—then you just can't permit anything that would roil prescribing patterns."

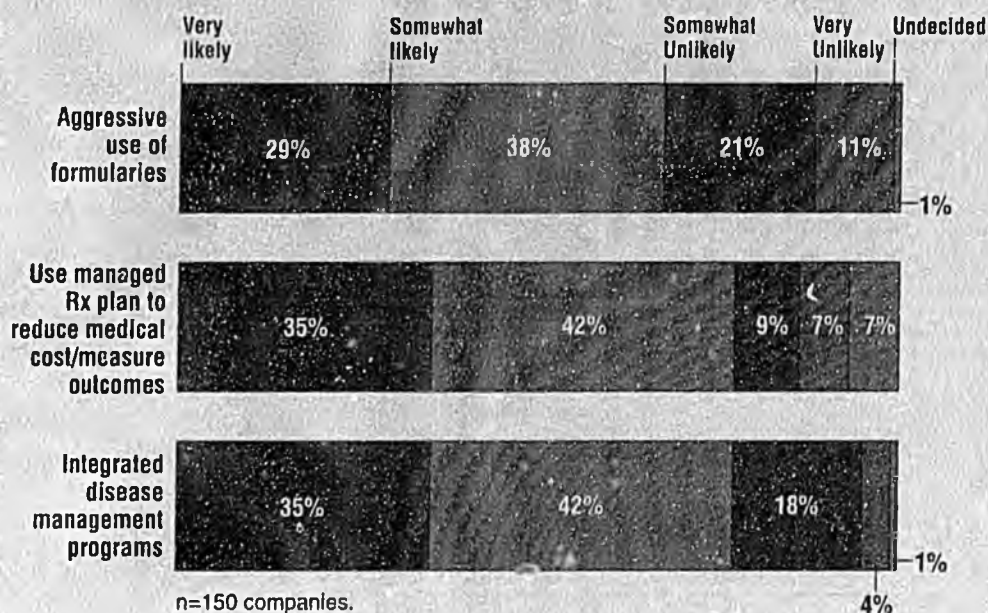
Of pharmas and silos

More tightly controlled formularies, along with the drug industry's attempt to claw back rebates, may make it tougher to sell this season's big message, to wit: Don't "component-manage" the pharmacy benefit. It may well be disingenuous of pharmas to tell MCOs not to zero in on the price of the pill, to look instead at the total cost of care, when they themselves

Riding herd on pharmacy benefits

As prescription drug costs keep rising, employers are looking for more effective ways to manage pharmacy benefits. A national survey on pharmacy benefit management by William M. Mercer found that more than two-thirds of companies say they are likely to use formularies aggressively. More than three-fourths expect to adopt a managed prescription plan, and about 77 percent intend to consider an integrated disease management program.

Employer Interest in Rx-management initiatives over the next 2 years



Source: William M. Mercer.

are so plainly focused on the cost of rebates. Still, there's probably some wisdom in what's been called the "silo story."

"There are still a lot of MCOs out there that view the pharmacy benefit as a revenue generator," says Bird. "The benefit is managed as a bottom-line item, separately from other bottom-line items like physician visits and lab tests. Each benefit or intervention is in its own 'silo.' Managers 'win' when their silos have more revenues than costs. Overlooked in this model is the overall cost of an episode of care or treatment of a disease state. The message the pharmaceutical houses have been trying to get out is that shortchanging the drug benefit can make costs explode in some of those other silos, like physician visits and hospital stays."

Better, more appropriate utilization of pharmaceuticals may indeed ramp up the drug budget, but patient outcomes and satisfaction will improve and those high-cost interventions (especially hospital stays) will be fewer and shorter. Health plans will thus accrue significant, overall savings. That's been the pharmaceutical industry's drumbeat

to managed care for some time now.

There seems to be some evidence that managed care is beginning to get it. According to Pat Pesanello, managing associate with Coopers & Lybrand's Integrated Health Care Consulting division, there's been a significant uptick in MCO drug utilization. "That might indicate a greater awareness among MCOs that you can supplant some of the need for the most costly care by increasing implementation of drug therapies."

But many in the pharmaceutical industry suspect that the appropriate-use message has been poorly understood. "It's like being a school-teacher," says Strader of Pharmacia & Upjohn. "You have to repeat the lesson six times and hope that enough of the students have grasped it."

"In managed care, just as in every other industry, you've got your leaders, who are the early adopters," explains Mario Sylvestri, director, professional education, disease management and medical informatics, Hoechst Marion Roussel. "They are already looking at care in the global sense. Even if the pharmacy budget goes up, there's no outcry because the overall budget is going down. Patients

get better quicker. There are fewer relapses and lower utilization of expensive procedures."

Sylvestri admits that early adopters must be patient for payback, which may take as long as three to five years.

"It's not enough to extrapolate data from other sites, say from Lovelace or United HealthCare," explains Dennis Kenez, managed care customer development manager, Pharmacia & Upjohn. "MCOs want to confirm those results in their own operations. Unfortunately, many MCOs simply don't have the information systems necessary to measure the outcomes of pharmaceutical-based interventions. So they can't generate, as yet, the only kind of proof they would accept."

Bob Browne, MD, a consultant at Eli Lilly and Co. and formerly president of erstwhile Lilly subsidiary Integrated Disease Management, has another explanation for lemming behavior. "Management by component—the pharmacy piece, the doc piece, the hospital piece, etc.—greatly appeals to financial managers," he posits. "When you shift to a structure favoring outcomes management, that comfort level is lost. Plus, the rewards

systems of many MCOs favor those who component manage."

Many MCO pharmacy directors resent the imputation that they haven't gotten the "manage by outcomes, not components" message. They've heard it loud and clear, and they even agree with it—or with most of it. Yes, drugs are typically cheaper than does. But lifestyle changes are even cheaper than drugs. Plus, to grant that drugs do a great job is not to agree that you should always prescribe the newest and most expensive chemical entity.

"Looking past the separate components is a good strategy," says Hopkins, "but it shouldn't mean giving drug companies carte blanche. Yes, spending more money on the pharmacy therapy makes sense conceptually; but you still have to select among a number of meds. That's a whole other question."

To help answer that question, MCOs are asking the pharma companies for quality of life data and for comparator trials that match drug ver-

sus drug in real-world clinical conditions. Does therapy A really outperform therapy B? And is the performance difference significant enough to warrant therapy A's higher cost?

"If the manufacturers want us to look at the total cost of an episode of care or of treating a disease state," says Wolke, "where are the studies that would allow us to measure and compare methods of treating otitis media or caring for an insulin-dependent diabetic? They are few and far between, even though we keep asking for them."

Been there, heard that

Pharmaceutical companies are finding that MCOs have become equally demanding of other concepts that emerged in the marketplace of the mid-1990s.

Disease management. Two years ago, every drug maker had to get into disease management. Some of the pharmas were talking about re-engineering themselves; instead of making medications, they would become

providers of treatment solutions. "That was very poorly received by managed care," says consultant Miele. "MCOs were both offended and somewhat threatened by drug companies stepping up to the plate and saying, 'We can help you manage your hard patients.'"

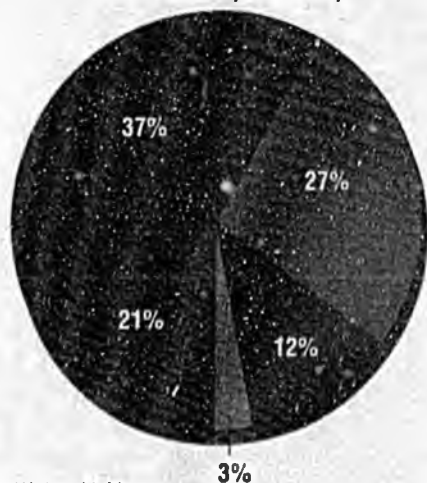
The new paradigm is to treat disease management as a value-add to the sale. "It's not another product, in addition to the drug," says Miele, "and it's not meddling with patients. Rather, disease management is some pretty cogent intervention material that drug makers add on to the sale of disease-specific pharmaceuticals. You might say that drug companies have become 'disease management enablers.'"

Pharmacy benefit managers. "PBMs offer a commodity service—processing pharmacy claims—that many of their big MCO customers are taking in-house," says Wilson. "In addition, PBMs have been largely funding their operations on rebate money; but rebates are going away. So what does that tell you?"

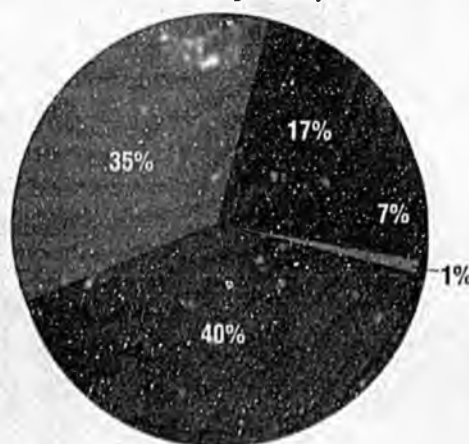
Up close, but not too personal

Pharmaceutical company representatives no longer can rely simply on good relationships with physicians. Beyond the budding partnerships they are forging with health plans and pharmacy benefits managers, some drug companies are testing the waters for potential collaboration with employers. A William M. Mercer survey found employers willing to cooperate but wary of direct contracting.

Employers interested in collaborative partnership



Employers interested in contracting directly



n=150 companies.

Source: William M. Mercer.

It perhaps tells us why big PBMs like PCS Health Systems and Medco are frantically trying to transform themselves into disease management vendors, hoping to add enough value to their claims-processing service to keep customers satisfied.

Pharmacoeconomics. "Yes, the MCOs want outcomes studies that measure cost and quality; they want quality of life studies; they especially want head-to-head comparison studies—drug versus drug," says Jean-Paul Gagnon, director of health economic policy, Hoechst Marion Roussel, but that sets up a puzzlement over who will fund and perform such studies.

Gagnon hypothesizes a scenario wherein his company sponsors and conducts a comparator study involving one of its drugs and a rival therapy. "If the results are positive for us, MCOs would say the study was biased. And they wouldn't buy the drug. If the results were negative for us, and we still published, MCOs might be impressed by our honesty. But now they wouldn't buy the drug because it lost the trial."

Still, Gagnon, who is the current president of the Association for Pharmacoeconomics Outcomes Research, believes such comparator trials have value. He expects third parties to emerge that will perform sufficiently objective studies, and managed care can hardly wait. In fact, a recent survey conducted by the Fallon Clinic, in Worcester, Mass., found that what managed care pharmacists want from manufacturers are real-life answers to such questions as: To what extent does the drug therapy cut down on the need for lab tests? Does drug A get patients out of the hospital faster than drug B? The first pharmaceutical companies to the table with reliable answers should have no trouble making friends and influencing purchasers.

Robert McCarthy is a health care journalist based in West New York, N.J.

Compliance: Big problem, bigger opportunity

The Task Force for Compliance, a study group commissioned by the National Pharmaceutical Council and 20 brand-name drug manufacturers, estimated that 1993 costs of noncompliance topped \$100 billion. In 1995, a University of Arizona study estimated that costs associated with negative therapeutic outcomes resulting from poor compliance were between \$30 billion and \$137 billion.

"It's a huge problem," says Otto Wolke, vice president of pharmacy services, Geisinger Health Plan, Danville, Pa. "Just among hypertensives, it's estimated that 40 percent go off their medication after one year or less."

"Compliance is the ethical high ground," says Steven Shulman, president of Value Health's pharmacy and disease management group. "Sure, improving compliance would increase pharmaceutical revenues, but it would also make for better patient care and would help lower overall medical costs.

"This is where a drug manufacturer, a PBM, and an HMO might get together and invest some dollars," he continues. "Potentially, these programs might increase the pharmacy budget. Fair enough. But compliant patients have better outcomes and utilize fewer expensive resources—like hospital emergency rooms."

Pharmaceutical manufacturers have long been cognizant of compliance problems and opportunities. But rarely have their responses extended beyond efforts at improving patient awareness. Some PBMs have shown more initiative. Eagle Managed Care, the Rite Aid pharmacy chain's PBM subsidiary, is attempting to address the compliance problem by means of a program called "Compli-Line," a compliance telecommunications center that tracks unfilled prescriptions and identifies patients due for refills.

"Compli-Line has 96 outcall workstations and 50 call-in workstations," explains Dennis O'Brien, Eagle's vice president of marketing. "Think of the latter as a customer-service help desk manned by pharmacists. A patient with a pharmacological question doesn't even have to come into the store now. . . or wait until we call them, which is what the outcall stations do."

Pharma companies like Hoechst Marion Roussel also are applying technology to the compliance problem. Hoechst is working on a three-dimensional, CD-ROM version of a human heart that can be programmed and customized so that it simulates exactly an individual patient's very own heart after, say, a myocardial infarction. Then, as the patient recuperates and stays on medication, improvements in the state of his heart, based on periodic cardiographies, can be programmed into the CD-ROM model.

"When the patient can actually see his or her own heart, see the necrosis, and then see the benefits of therapy," says a Hoechst spokesperson, "it's an enormous reinforcement of therapy compliance."

Bridging the consumer information gap

or consumers, managed care is a lonely option. Most are not really sure what it really means or how it differs from traditional fee-for-service care. Asked to choose among plans, they find that coverage information is inaccessible or overly complicated and that there is no standard format or common language to allow useful comparisons.

This disparity is managed care's "information gap," a problem widely acknowledged in the health care community. Some protest all the fuss and argue that indemnity plans are just as guilty of leaving customers in the dark. But it is the special nature of managed care that creates a new urgency for consumers to be better informed about a range of factors that can affect the quality of their care—and their lives.

In many ways, 1996 marked a turning point, as the prophecy of a growing consumer voice in health care policy took on substance. The message that numerous advocacy groups have doggedly promoted in the face of the managed care juggernaut was reinforced by tough legislative proposals in several states, a barrage of negative media coverage and a clearer partnership of interest between patient groups and large employer coalitions.

Fresh support came from physicians as well. At the annual meeting of the American Medical Association last June, AMA president Daniel H. Johnson, MD, discussed myths that exist in conventional medical wisdom, hammering away at the one that disturbs him the most: "The patronizing view that patients are too stupid to decide for themselves has led to a reduction in choices for patients and a marked disruption of the patient-

physician relationship.

"There is an important area where the law, ethics and the patient-physician relationship come together to dispel the myth about patient wisdom," Johnson continued. "That area is the legal doctrine of informed consent." He said that the AMA wants to see patients rewarded for using the health care system in a cost-effective way, but that this depends on "being able to give patients both the opportunity and the responsibility to make wise decisions for themselves."

A great deal of research supports the contention that consumers have difficulty grasping most of the information currently available to describe plan services and quality of care—a problem that may extend to benefits managers as well. A recently published survey of 300 benefits managers conducted by the GCI Consulting Group reported that 40 percent said their biggest challenge is understanding what their plans offer.

A national survey for the Kaiser Family Foundation and the Agency for Health Care Policy and Research (AHCPR) released last October measured the role of quality information in health care decision making. It found that most people identified quality of care as their biggest concern, but only 39 percent said they have seen quality comparisons in the past year, and a mere third of those have actually used the information in choosing a plan.

Seven out of 10 consumers said they would rely upon the recommendations of friends and family. Furthermore, when choosing a doctor, more than eight out of 10 Americans are more concerned with how well a doctor communicates with patients and

whether or not the doctor shows a caring attitude than whether the physician is board certified or rated highly by an independent organization.

"There is a huge information gap between what consumers know and what they should know about managed care, including all of the things about managed care that are good and that represent valuable improvements to the way care is delivered," says Shoshana Sofaer, associate professor at George Washington University Health Center in Washington, D.C. Sofaer co-chairs the AHCPR Consumer Assessment of Health Plans study and has been working with a number of organizations to "develop the next generation of consumer decision-making information.

"What is absolutely clear is that consumers need a first-rate, objective source for information," she says. "Most of the media information about plans is negative, and the marketing material produced by the plans isn't credible. We're working to develop methods to measure and make relevant consumer information on all forms of health insurance, and we're doing it from the consumers' perspective."

While it is readily apparent that a majority of people have great difficulty making informed health care choices, two complex questions remain unanswered. What information do patients really need to be empowered consumers? And how can that information be molded to meet the vastly diverse comprehension and interest levels of the population?

Why managed care is different

To answer the first, consider how managed care has fundamentally changed the relationship between doc-

Patients haven't been getting the whole story about treatment options and how doctors are paid. Now there's a movement to loosen the gags and fill in the gaps.

By John Burke

tor and patient. Under the much maligned fee-for-service system, patients selected their own doctors. If the chemistry wasn't right, they could simply move their business to another practitioner. The patient was the customer, even though payment most often came from insurance companies. There was an inherent understanding that most doctors would err on the side of caution in diagnosis and treatment, and the reimbursement structure made it in the doctor's financial interest to do precisely that.

The incentives of that system are now described as "perverse," but the managed care alternative burdens doctors with divided loyalties. Technically, the patient is no longer the customer, and the doctor now works for the managed care organizations (MCOs). They get their patients through the MCO. They are compensated by the MCO. Their decisions are reviewed and approved by the MCO. Their productivity is dictated by the MCO. And termination by the MCO means the loss of their patient base—their livelihood.

To participate in a managed care system—as approximately 75 percent of the nation's physicians now do—they must subject themselves to a

range of financial and operational policies and incentives that many suggest can routinely create ethical dilemmas. While the doctor is still primarily (and legally) responsible for deciding what is in the patient's best interest, the pendulum has swung far from the "excesses" of fee for service.

The system is designed to constrict the doctor's ability or willingness to err on the side of caution when that means spending more. The economic rationale is understandable, but the system clearly demands greater and more informed participation than patients have traditionally provided. And, instead of helping patients through broadened education or communication efforts, much of the industry has chosen to remain closemouthed about policies and to discourage or prohibit doctors from discussing the constraints they are under.

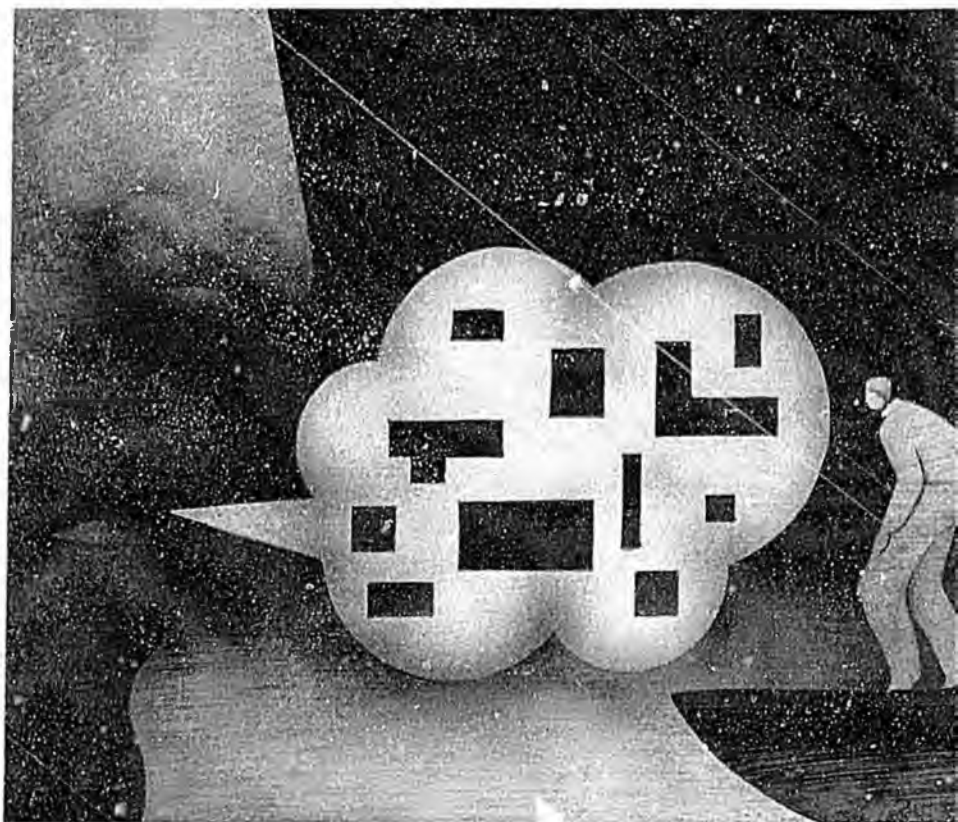
Legislation and regulation by the bucketful

The results could have been predicted. Media coverage of inflammatory anecdotes raised public awareness of objectionable policies and restrictions that had not been apparent in promotional material. One-day maternity stays and "drive through" maste-

tomies offended public sensibilities, as did "gag clauses" in provider contracts that prohibit doctors from bad-mouthing the plan or, in some cases, even telling patients about treatment options that are not offered in the plan. Legislators reacted by crafting consumer protection mandates. State insurance commissioners turned their attention to revising the generally spartan managed care regulations to guarantee consumer access to information.

The gag clause is the issue over which the health care consumer protection movement has had its most significant victory. Here the interests of physicians and patients have clearly converged, and MCOs have had great difficulty defending such clauses with conviction. A number of plans dropped them completely.

In early 1996, Rep. Greg Ganske, MD (R-Iowa), introduced the "Patient Right to Know Act," which would prohibit plans from restricting or interfering in any "medical communication" between patients and providers. The bill's definition of medical communication covers a number of policies and practices that have concerned consumer advocates. These include financial incentives and disincentives linked to service utiliza-



tion, the processes and criteria used to authorize or deny services, alternative tests, consultations and treatment options as well as quality and outcomes data.

Hearings on the bill produced dramatic testimony from physicians and patients concerning the harmful effects of gag clauses upon patient-physician communication and, ultimately, upon the quality of care provided by plans that use the tactic.

The bill attracted over 100 co-sponsors and passed in the House of Representatives, but bogged down in the Senate as the election approached. Ganske's staff predicts it will succeed when reintroduced this year, and President Clinton is on record calling for enactment of anti-

gag clause legislation.

Echoes of these legislative thrusts reverberated late last year as a directive by the U.S. Department of Health and Human Services Secretary Donna Shalala required all plans serving Medicare patients to eliminate gag clauses. In a letter to 300 plans contracting with Medicare, Shalala said that "contract clauses limiting what physicians may tell Medicare beneficiaries violate federal law." Bruce C. Vladeck, administrator of the Health Care Financing Administration, said that HCFA is working on a similar policy clarification for state Medicaid programs.

Shalala's action was the first dose of what will likely be the biggest boost to consumer protection: the

growth of Medicare managed care. The industry has dismissed highly publicized tales of individual woe as merely anecdotal and not reflective of the overwhelmingly fine job that managed care is doing. When news reporters and consumer advocates seek information about complaints, coverage denials, comparative outcomes data or other information that might provide verification, the material isn't available. Many state insurance departments do not share complaint data, claiming that disclosure would violate confidentiality.

But with Medicare entering the managed care arena, there will be an infrastructure already in place to address complaints and improve patients' understanding of their rights and responsibilities within that system. Most observers predict that protections mandated for Medicare patients are likely to be adopted for other plan members as well.

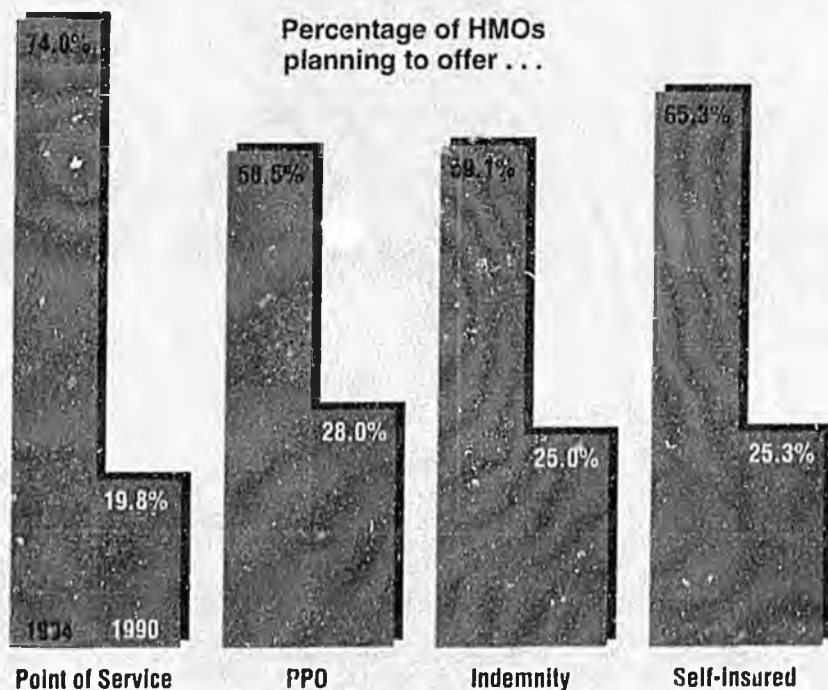
Government agencies are also tapping the power of information systems to monitor patient experience in managed care. Some are accumulating data on complaints and appeals in order to identify practices and policies that generate conflict and member confusion. Others are trying to standardize and simplify plan information to permit easier selection and better informed choices once inside.

For example, according to Spencer Shrone, project manager in HCFA's Office of Managed Care Beneficiary Access and Education, work is well under way on a comparability database that would permit Medicare beneficiaries to identify plans best suited to their individual needs.

Shrone expects to have a prototype interactive disk by this summer and beneficiary satisfaction data by the end of the year. He estimates that quality data will be available by early 1998, coming from a Medicare and Medicaid beneficiary satisfaction survey to be conducted this spring. To address the lack of uniformity of plan marketing materials, the agency has

What health care customers want

Consumer and employer demands for greater choice have prompted managed care organizations to offer more diverse coverage options. From 1990 to 1994, the number of HMOs offering point-of-service plans more than tripled, and those offering preferred provider organizations, indemnity and self-insured options more than doubled. What remains to be seen is how these moves will affect employer premiums.



Source: American Association of Health Plans and Ernst & Young.

drafted guidelines on marketing and is working with both industry and beneficiary advocacy groups to simplify and standardize the material.

HCFA and the Administration on Aging share funding for information, counseling and advocacy programs at the state level. The programs underwrite counselors to help beneficiaries make decisions about health insurance. Efforts are also in motion to make the programs more relevant to the growing managed care population. Because they involve direct communication and personal advocacy, the programs have been described as effective patient empowerment efforts.

Private-sector catalysts

In the private sector, the American Association of Health Plans (AAHP), the MCO industry trade association, announced in December an industry-wide initiative embracing many of the provisions contained in the Ganske bill.

Called "Patients First," the program is designed to ensure that consumers in AAHP member plans are provided clear information on a number of important subjects that previously were closely held by the plans. According to AAHP president Karen Ignagni, patients will now be able to request information on physician compensation, utilization review procedures and approval criteria, drugs available on plan formularies and criteria used to determine when treatments or procedures are experimental.

Diane Archer, executive director of the Medicare Rights Center in New York City, is an outspoken advocate for patient empowerment. She is a consumer adviser to the National Association of Insurance Commissioners and regularly testifies before Congress on patients' rights and the information gap. Under contract with the New York State Office for the Aging and HCFA, her organization operates a telephone hot line offering direct assistance to more than 6,000 people annually. At present, 20 percent of the calls her group receives

⁶⁶Purchasers and consumers have not spoken with one voice about what they want to know when they're making critical health care choices."

concern managed care.

According to Archer, "Basically, what patients tend to know is only the information that the plans provide them. This has mostly to do with the amount of money they are going to pay and the benefits that are offered by the plans. We believe they need to know significantly more than that. For one thing, they need to be informed about the basic differences between managed care plans and traditional indemnity plans. And they need to know about differences in care management and financial structures that bear on the delivery of care.

"They also need to understand that just because their doctors are in an HMO they might select does not mean they will necessarily receive the same care from those doctors that they would under a traditional plan," Archer adds, "because the whole idea behind a managed care plan is to oversee the way care is delivered. That means there can be financial and medical treatment constraints as well as communication and time constraints upon the provider that can bear on the type of care the patient receives."

Archer joins other patient advocates calling for MCOs to publish their treatment protocols and provide

measures for the appropriateness of care so the services that plans provide can be compared.

National Research Corp. of Lincoln, Neb., is another organization that regularly measures the attitudes and understanding of health care consumers. According to NRC president Michael Hays, the importance of a patient's trust in his or her physician is a critical factor in the perception of the quality of care. But he speculates that "as more quantifiable outcomes data for specific conditions become available, consumers concerned about particular conditions will gravitate rapidly to plans that they feel provide better care."

It is precisely this belief that led to the creation of the Foundation for Accountability (FAcet), an independent organization of payers and consumers that, according to president David Lansky, is developing comparative performance measures in "terms that matter to consumers, patients and purchasers.

"Purchasers and consumers have not spoken with one voice about what they want to know when they're making critical health care choices," explains Lansky. "We're trying to unify that voice and articulate what the public wants."

Such initiatives define the private sector's response to the "information gap"—and, one might add, the "leadership gap" in health care reform. "Neither Congress nor any other broad public body has taken the lead in defining a set of expectations for the health care system," says Lansky, "so it's hard to know what we really mean by quality. There is a responsibility we all share to define more strongly what we are looking for from the health care system."

John Burke is a founding director of the nonprofit National Patient Empowerment Council, Blairstown, N.J., and a member of the adjunct faculty at Johns Hopkins University School of Public Health.

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Unintended consequences

*I*t's been said that no good deed goes unpunished, and the thought certainly applies to our ongoing attempts to build a new health care delivery system in the United States. Every action we take has consequences, some of which we don't think about very much. Here are a few that deserve our attention.

On trust

There is an undeniable breakdown in trust in the system as the consumer is left out of the loop in negotiations about which providers—particularly specialists—and which services will be available. Trust is the major predictor of treatment compliance and the main preventer of lawsuits. If I wanted to know whether you were likely to do what your doctor told you to do, I'd ask you if you trust your doctor. And if you do trust your doctor, you probably won't sue him or her. Thus, erosion of trust leads to more illness (through decreased compliance) and more malpractice suits.

As health care becomes a for-profit business, the controls provided by professional ethics are eroded and must be replaced by laws and regulation. We can establish a whole new industry of watchdogs—lawyers keeping hospitals under control.

As the health care system gets less personal, people feel they have less control and may be inclined to rely too heavily on the easily accessible information on the Internet. There's a proliferation of web sites for diabetes, hypertension and every other health condition. But is it valid information? The Internet is an unmonitored, uncohesive source. Keep in mind that the best market for a charlatan is one in which people feel out of control.

Physicians themselves are not blameless—not every test, visit and procedure that's been billed was really needed—but people trusted doctors to be acting in their best interest. Whether that's true or not, that's what people believed. Now I don't think people believe that of cor-

By Reuben McDaniel, PhD

porations, so now they're willing to regulate.

When you restructure the system into something people don't know, folks don't trust it—and a lot of what goes on in medicine is based on trust. I trust you to prescribe medication that will help me. You might even be a better prescriber with a formulary. Your behavior may be clinically better, but I still don't trust you.

On how we do business

Everything is moving so fast, you're renegotiating every 12 months on a quarter of a cent per patient per month. In this administrative mind-set of rapid-fire responses and continuous re-creation of plans, two separate issues emerge: You can't think much about the long-term effects of your behavior, a classic weakness of business management. Nor can you develop long-term initiatives for complex, multiple-diagnosis health problems.

While we're so busy solving today's dollar crunch, who's paying attention to how we handle chronic conditions like diabetes, stroke and long-term heart problems? Who's figuring out how we bring about behavior changes like eating better and exercising more? Those are the real major issues.

Because there is no slack, because we're pressing so hard on finances, we don't think about new forms of delivery systems or new ways for clinical groups to get together and operate. I doubt very seriously, for instance, that you could establish freestanding surgical centers in today's market. With such pressure, nobody has the resources. Thinking outside the box is fun, but it's hard to do when you don't have any money.

That may explain another strange thing that's going on. Suppose I decide to build a big, integrated delivery system. What I'm trying to do is manage transaction costs across all the component units. But that looks a lot like the big conglomerates of 20 years ago, which we've given up.

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Other industries are establishing strategic alliances, networks and outsourcing. Health care is heading into the past, with strategies that others have abandoned. Is that a good way to do business?

On community and academic hospitals

What's happening to the thousands of dollars of community investment in tax breaks and charitable contributions to hospitals that are now being privatized?

Now hospitals are being purchased by for-profit systems and people are reading in newspapers that these places are swimming in money for trust funds and executive bonuses. Whether the tales are true or not, they reduce people's confidence in the value of charitable institutions. There's a social cost in terms of losing our faith in our ability or willingness to help each other through charitable contributions. We are better communities—better people—with this outlet. That's one reason why people have so much trouble giving up community hospitals, even if they're outdated and killing people.

The hospital has historically been the outstanding nonreligious charity in the community. People worked as volunteers, town leaders served on the board and everyone contributed to build the new wing and buy the heart and lung machines.

Of course, we could do better with fewer medical centers than we've got. Sloan Kettering is struggling, and it's one of the best in the world. And we've got three others in southern Texas that really don't belong out there. We're running all of them on a shoestring, but who's prepared to give one up? We don't have any system that allows us to make rational decisions about which to keep and which to winnow out.

On marketplaces

It's fun to say markets work better, but a market takes more than saying, "Gee, there's something for sale." A market requires information, lots of buyers and lots of sellers. It requires free negotiation, perhaps constrained by law but certainly not by the negotiators. And yet in health care we don't have that. Sixty percent has been bought by one buyer, the government.

Normally we are concerned about too few sellers, so we get antitrust legislation. We don't think about it when

there's only one buyer—called Medicare—and lots of sellers. They don't have any way to negotiate, and the government calls the tune. Imagine the antitrust legislation if sellers did that.

Individuals are just as bad off in our so-called market. When there are high levels of asymmetry in information, you leave the decision maker unable to negotiate effectively. That's the used car salesman phenomenon. He knows more than you do. You have a similar problem trying to negotiate for yourself in the health care system. Thus people negotiate on the one signal they get, and that is price.

A lot of Americans today are convinced, and probably rightly so, that high cost does not necessarily equal high quality, but they are still responding unknowledgeably.

On incremental reform

Incrementalism is a classic problem in clinical care. Cure one disease so you can die more expensively of another. The same thing happens in changing the way we deliver care. There are lots of classic examples. Deinstitutionalizing mental health created a culture of homelessness and a brand-new social problem. We invest in neonatal care, and then we have to care for those with serious problems for the rest of their lives.

Having said this, what should we do about it? I'm a believer in the chaos theory. Sometimes you get really big changes as the result of small actions. Keep trying incremental things, and focus on learning from each change so

you can expand the benefit or reduce the harm.

The best example I can think of is Head Start. Nobody had it right at the beginning, but schools and churches across the country each had a little something that was working. They were able to come together, learn from each other and develop what may be the most effective social program that America ever had.

I'm a believer in incrementalism. But incrementalism is not to be used as a safety valve or a political expedient. It is a way to learn.

Summing up

We must continue to seek change in health policy and in the way health care is delivered. But if we are to succeed, we must be prepared to deal with the unintended consequences of each solution that we implement.

*Incrementalism
is not to be used
as a safety valve or
a political expedient.
It is a way
to learn.*

What for a while with health educators who create "self-care" programs and it won't be long before you hear the phrase "Win-Win." Is this idealistic cheerleading for an industry chilled by harsh economic realities? Or does putting consumers in charge of their own health needs truly reduce waste?

The tools of self-care programs are startlingly simple: Often the core component is an easy-to-read but authoritative handbook that guides consumers on how to deal with minor problems and recognize symptoms that require a doctor or emergency room visit. The books also suggest questions to ask doctors about medications or procedures, explain treatment options for various conditions and encourage a patient-physician partnership in care. A number of programs add 24-hour phone lines staffed by nurses. Others provide workshops or give information and advice on-line.

The programs go by various names. While "self-care" is a common descriptor, many educators prefer some variant of "self-management" to keep the focus on consumers choos-

The consumer as health care manager

"Self-care" programs are showing you can cut expenditures by teaching consumers that they are in charge of their own health.

By Emil Vernarec

ing appropriate care rather than self-treating. Whatever name the programs go by, they stress taking responsibility for one's health and choosing health care resources wisely.

Such concepts may be old news to health educators, who have long known that an office visit is just one small part of the health care delivery process. But consumers are newly voracious for guidance, as the explosion of health-related magazines, books and web sites testifies. In turn, employers, impressed by a steady accumulation of evidence that self-

reliance reduces both demand and costs, are increasingly willing to satisfy the public's appetite for autonomy.

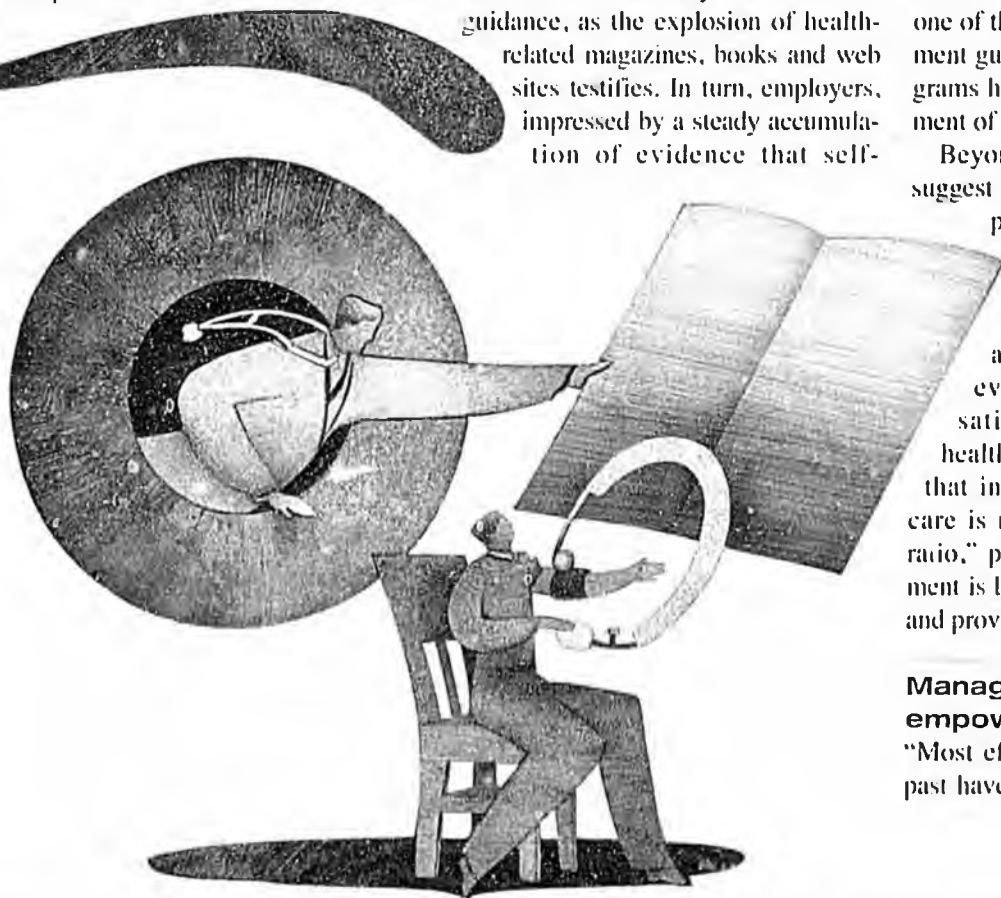
"With a book alone, studies prove that you can reduce office visits by seven to 10 percent and reduce visits for minor conditions by up to 17 percent," says James Fries, MD, professor of medicine at Stanford University and author of *Take Care of Yourself*, one of the earliest health self-management guides. "Generally, the best programs have shown a return on investment of six to one."

Beyond cost savings, studies also suggest these programs help improve patients' health status, boost

compliance and prevent costly complications by encouraging early, appropriate intervention. Some studies even found increased patient satisfaction with doctors and health plans. Little wonder, then, that in a world where delivery of care is measured as "medical loss-ratio," patient-centered self-management is being embraced by purchasers and providers alike.

Managing demand or empowering patients?

"Most efforts to contain costs in the past have focused on the supply side,



through utilization reviews, gatekeepers and higher deductibles," explains Don Powell, president of the American Institute for Preventive Medicine, Farmington Hills, Mich., a provider of custom health promotion programs. "Self-care focuses on the other side of the equation, to manage demand by educating the consumer to use the level of care that's appropriate. 'Appropriate' could mean avoiding an unnecessary office visit, or it could mean getting a patient who is ignoring an important symptom into a doctor's office or the ER."

David S. Sobel, MD, director of patient education and health promotion for Kaiser Permanente, Northern California region, illustrates the latter with this story from a large-scale Kaiser self-care project: "Two weeks after the handbooks were distributed, a chief of medicine received a call from the wife of an elderly male who was complaining of leg pain but denying it was serious. His wife took out the handbook and said, 'Look, it says here we should call the doctor.' It turned out he had blockage of the arterial blood flow in his leg—which was saved by the early intervention. This is as much what self-care is about as not going to the doctor just because you've had a sore throat for a few hours."

Still, when companies that create such programs market their wares, it's the cost-cutting potential that ultimately gets attention. "The advantage to self-care over other demand-management strategies," Powell points out, "is that you see cost benefits in six months."

A growing number of published and self-reported studies by companies investing in self-care support the claim. For example, a pilot program involving 436 employees at Florida Hospital Medical Center in Orlando resulted in 139 fewer physician office visits and 47 fewer ER visits within five months, for a savings of \$85 per employee. Another study, this one of 229 employees in a program at Bell South in Atlanta, found that the company realized a savings of \$40 per

employee by the third month.

Powell and other health care educators are quick to emphasize that savings come from cuts in *inappropriate* use of services. An oft-quoted example is the American Hospital Association's estimate that 55 percent of some 97 million ER visits in 1994 were for nonurgent conditions.

Stanford's Fries stresses that the health promotion component of self-care also reduces the overall *need* for costly interventions, addressing demand rather than supply. "A lot of managed care techniques are hidden rationing," he explains. "It's not a good thing to do, and you already have a backlash."

Self-care at work

Clearly, self-management education works best when it is integrated into a comprehensive program that fosters healthy lifestyles and early intervention. Outstanding examples are recognized each year by the Health Project Consortium, which sponsors the C. Everett Koop National Health Awards.

"Not all health promotion programs are cost-effective," says Kenneth Pelletier, MD, director of the Stanford Corporate Health Program at the Stanford University School of Medicine. Pelletier, who has written extensively on the need to establish a scientific basis for health promotion programs, urges companies to do "careful strategic planning before they deliver a single component of a health management program. The parts should fit together."

"Consider the types of interventions that best fit your employee population," explains Ron Goetzel, vice president, consulting and national practice, with the MEDSTAT Group, "and the extent to which medical, benefits, operations, safety, workers' compensation and human resources departments need to be coordinated."

Pelletier emphasizes that a program must have the support of senior management, and Goetzel suggests "explicitly linking the rationale for employee health initiatives to company performance and

overall employee productivity."

The two agree that health promotion has to be a sustained effort. Goetzel recently co-authored a review of nearly 50 studies and found that individualized counseling for high-risk employees—as part of a comprehensive health promotion program—significantly changed behavior and reduced risks. However, short duration, low intensity programs aimed at increasing awareness of health issues for the entire population did not achieve widespread behavior change among employees.

An example of a company that successfully integrated self-care into a comprehensive health promotion program is Pitney Bowes, Inc., in Stamford, Conn. The program, which was structured around a "Health Care University," earned the company a Koop award last year. Stressing consumer partnership with providers and training in the use of a self-care handbook, the initiative answered an executive challenge to "cut costs, but don't upset the employees," according to Johnna Torson, vice president and chief personnel officer.

In addition to the university, the program provides a free on-site primary care clinic, screenings for common chronic illnesses, ergonomics assessments and fitness centers. Employees attend the university at lunchtime classes or lengthier seminars on such topics as health care consumerism, cardiovascular health, stress and weight management and cancer prevention. Workers use the "credits" they earn to reduce their share of premium contributions.

"The Health Care University grew out of the concept that chronic illness is the key driver of costs," notes David Hom, executive director of corporate benefits and medical services. "Since the program was implemented, medical costs are down, disability cases are down and employees are satisfied with the perceived value of their health benefits."

Indeed, over a three-year period,

Why patients choose expensive ER care

Self-management programs often save money as a result of more appropriate use of services, particularly the emergency room, but many factors beyond the perception of need for immediate care influence a patient's decision to go to an ER. One study monitoring the use of hospital ERs during a 24-hour period found that 37 percent of visits were for nonurgent conditions. While the researchers supported the need to guide patients to an appropriate level of treatment, they cautioned that the ER is still an important locus of care for those who can't easily be treated elsewhere and that differentiating an urgent versus a nonurgent condition can be difficult without a physical exam.

n=6187

Patients could give more than one reason for their visit. Ambulance patients were not included. (Percentages do not total exactly due to rounding.)

Source: Adapted from G.P. Young, MD, et al. *Journal of the American Medical Association*. Aug. 14, 1996.

Clinical reasons	
Emergent/urgent condition	39%
Sent by clinician	19%
Too sick to go elsewhere	6%
Clinical preferences	
Get good care in ER	11%
Get diagnosis and/or treatment	11%
Nonfinancial reasons	
Clinic not open at night/can't get off work	11%
Nowhere else to go for care	11%
No clinic appt./not soon enough	11%
Geographical reasons	8%
Tried to get care elsewhere	4%
Transportation problems	3%
Clinic does not take walk-in patients	3%
Financial reasons	
No money or insurance	8%
Free or low-cost ER care	4%
Insurance or work requirement	2%
Insurance pays for ER care	1%

the university component alone saved \$3 for every dollar that it cost. Actual covered health care expenses among attendees fell 5 percent, while rising 2 percent among nonparticipants. Pitney Bowes credits the class on self-care with cutting ER use by one-half, again yielding a return of about three to one. Among employees who attended a behavioral health workshop, mental health and chemical dependency claims decreased more than 80 percent, compared to a 25 percent drop among nonparticipants.

Companies already recognized for outstanding health promotion programs have also shown interest in self-care. The DuPont Co., Wilmington, Del.—winner of one of the very first Koop awards in 1992—recently launched a consumer health management program as part of its conversion to a managed care plan for its 52,000 active employees and 77,000 pensioners. “We were influenced by seven or eight published reports showing that self-care behaviors could reduce office visits by 7 to 15 percent,” explains

Robert Bertera, senior consultant, prevention and wellness.

On-site workshops stress active involvement in care and train participants to effectively use the decision guidelines in a self-management handbook. DuPont augments this education with extensive preventive care benefits. Employees have responded enthusiastically: 58 percent of workers and 22 percent of retirees took part in the initial phase, says Mimi Kramer, a preventive care competency leader at DuPont. “They come out of these classes saying ‘Yes, I’m in this!’ And they leave very confident about using the book.”

Reaching out to communities

Self-care initiatives have also spread beyond individual companies to entire communities. One of the leaders is the Healthwise Communities Project, which was launched last spring with a goal of making the 275,000 residents of the four counties surrounding Boise, Idaho—about

one-fourth of the state’s population—the “best informed medical consumers in the world.”

The project, inspired in 1988 by Donald Kemper, president of Healthwise, Inc., has drawn on widespread support from community leaders and funding by the Robert Wood Johnson Foundation, Blue Cross of Idaho, MSB Blue Shield of Idaho, area hospitals and local employers.

Each of about 125,000 families was given a Healthwise self-care guide and free access to a nurse advice line. Forty health information stations were set up at area worksites, hospitals and libraries, using a Healthwise software program that covers more than 180 health-related topics. Organized around symptoms, the software walks consumers through the severity and urgency of specific conditions and guides them to the next course of action.

“We don’t tell individuals what to do,” emphasizes Cindy Krieg, director of communication and international marketing at Healthwise. “We pro-

vide information for shared decision making with their providers."

Area health care professionals have also received training as part of the self-care program. "Doctors and nurses have to be supportive," Krieg says, "if people are to step forward, ask questions and move up the continuum to becoming a partner."

Kaiser's Sobel agrees on both counts, based on the HMO's experience with a program involving 1.2 million households. "As we planned our self-care program, we listened to members, who said that the most important aspect for them was that providers reinforce the use of the handbook and that it was an additional resource—not a substitute—for care," says Sobel. "This guided the education for our entire staff: physicians, nurses, pharmacists."

Early results suggest that members are growing more confident about their health care decision-making skills and that Kaiser staff members are satisfied with the results as well.

Bruce Goldberg, MD, who is director of the health education and training center at the Oregon Health Sciences University School of Medicine and associate medical director of the Medicaid managed care plan CareOregon, sees similar acceptance among physicians. "As a practitioner, it helps tremendously," he says, "and allows patients to ask better questions and participate in care."

Is there a danger that consumers will become overconfident and start to self-medicate? "There's always a risk of unintentional outcomes," Goldberg admits, "but you can also see self-care as counteracting self-medication message, from advertisers, because it's not there to sell a product or therapy."

The human factor

A basic principle of engineering behavior change is that information alone won't do the job. It must be reinforced by motivation, role models and a belief that the individual's

efforts will pay off. Health educators are therefore excited that self-care programs help consumers develop "personal self-efficacy"—the confidence that they are capable of taking actions that improve their physical and mental health. The potential for self-efficacy to motivate long-term patient compliance has been demonstrated in programs for those with chronic illnesses such as arthritis, diabetes and high cholesterol. The most successful have paid close attention to patients' thoughts, moods, sense of social isolation and other psychosocial factors.

Kaiser recently completed a five-year study that addressed the psychosocial factors surrounding chronic illness. More than 1,000 patients were taught a core set of cognitive-behavioral skills that included changing pessimistic self-talk, cultivating optimism, learning to relax and communicating feelings more clearly. They met regularly in structured small groups led by lay leaders, many of whom had chronic illnesses themselves.

Sobel says that the training and reinforcement improved patients' functional status and boosted their confidence that they could manage their illness. The data also suggest a trend toward less dependence and need for health care services, including hospitalization. "What helps a patient the most is the feeling that 'I'm in control,'" says Sobel. "Not only do health behaviors improve, but the patients have an opportunity to share and to help others. This reduces the sense of isolation."

The Minneapolis-based Optum Division of United HealthCare has had similar experience explicitly targeting psychosocial components in programs it creates for employers and health plans. "We've found that a significant amount of nondisease-based factors influence patients' health care utilization," says vice president of business services Philip Dell, "and their physicians may not be able to help them on an integrated basis." Optum offers a program that gives

patients access to both a registered nurse and a mental health counselor through a 24-hour health advice line.

Consumer health = consumer power?

The phrase self-efficacy echoes earlier and ongoing campaigns for "patient empowerment," and the twin concepts raise an important question: Will more informed and more confident consumers not only manage their own health but take a more active role in restructuring the entire delivery system?

A resounding "Yes" is heard from Dwight McNeill, founding chairman of the Foundation for Accountability and now president of WayPoint, Inc., in Barrington, R.I. "We've never uncorked the potential of the patient to help drive the system," says McNeill. "The consumer was relegated to the back room. It's time to change the underlying assumptions."

Sobel, too, envisions a much broader role for consumers: "We are now seeing a big cultural shift from viewing patients as passive to realizing that through the decisions they make, patients don't just 'get' health care. They produce it." He adds, "Self-management strategies are 'win-win-win'—for employers because of lower costs, for patients because they're getting more appropriate care and for health care organizations because they're not wasting resources."

Is self-care a passing fad or an enduring force? Employers may be the decisive factor. Consider how their rethinking of pension funding has reshaped the investment landscape. The shift from defined-benefit to defined-contribution retirement plans has pumped billions of dollars into mutual funds and made the small investor a big player in the market. So, too, a full partnership between patients, providers and purchasers could bring about radical—and most likely productive—changes in health care delivery.

Emil Vernarec is a senior editor with Business & Health.

With the number of uninsured at 40 million and counting, the perils of buck passing between the public and private sectors are clearer every day.

By Julie Rovner

Remember the uninsured? Concern about the estimated 37 million Americans without health insurance, along with worries about spiraling health costs, energized the unsuccessful effort to remake the nation's health care system in 1993-94. Since then, health care inflation has slowed, but the number of uninsured Americans has continued to grow—to an estimated 40.3 million in 1995, according to U.S. Census Bureau statistics compiled by the Employee Benefit Research Institute (EBRI).

Yet talking about the uninsured has fallen very much out of fashion. "The media decided not to discuss it anymore," says Princeton health economist Uwe Reinhardt, who compares the flurry of public worry about the uninsured in the late 1980s to the public concern over genital herpes earlier in that decade. In neither case was the problem solved, he notes. "We got tired of talking about it, so the problem disappeared."

Nevertheless, by nearly every indicator the problem of the uninsured is getting worse. The proportion of Americans under age 65 without coverage (virtually all older citizens are covered by Medicare) rose from 15

percent in 1988 to over 17 percent in 1995, according to EBRI. And while trends have moderated somewhat in the past three years, the major erosion has come on the private side. The proportion of Americans with employer-based coverage dropped nearly 6 points to 64 percent between 1988 and 1995.

The only reason the problem did not get even worse is that the percentage of people covered by public programs grew from 13 percent to 17 percent over the same time period. Current congressional proposals to slow Medicare inflation are unlikely

The uninsured: An American time bomb



to swell the ranks of the uninsured in the future, since most address the level of benefits rather than who will be covered. But policy analysts have cautioned that most

of the plans to cut Medicaid spending would almost inevitably result in fewer people being covered.

Medicaid coverage has been particularly important for children. Yet even though Congress in the late 1980s and early '90s required states to cover many poor children, the

number of uninsured youngsters is still growing faster than the population as a whole.

In 1994, according to the General Accounting Office (GAO), the percentage of uninsured children reached its highest level since 1987—14 percent of all those under age 18, about 10 million children. At the same time, the number with private coverage dropped to an eight-year low of 46 million, or about 66 percent.

More ominous still is that coverage decreased in 1994 even though more children were in families in which an adult worked full time. A separate analysis by the Lewin Group, Inc., a health care consulting firm, concluded that employer premium increases for family coverage may have made insurance prohibitively expensive for many.

Ominous signs

Even less visible has been the rise of the "underinsured," those who have insurance yet remain at risk for having to spend more than 10 percent of their income on a major medical event. Between 1977 and 1987, the number of underinsured Americans under age 65 grew by half, to an estimated 29 million.

Pamela Farley Short, a researcher with the RAND Corp., theorizes that managed care may have ameliorated the problem by offering comprehensive benefits and capped out-of-pocket payments, but it could end up causing a new form of underinsurance. "Instead of discovering that you have a lifetime limit, you may discover that your HMO is not inclined to cover certain surgical procedures," notes Short, who published major studies on the subject in 1985 and again in 1995.

Short says that one of the biggest dangers of underinsurance is that it is so insidious. "Most people who I would call underinsured probably don't know," she says. "If you ask them questions and then you get their insurance and compare, you find out that they don't have a clue."

Indeed, there are omens that the problem of the uninsured will only deepen. In a recent survey of business owners by the Washington, D.C.-based Economic and Social Research Institute (ESRI), a significant proportion of respondents said employers ought to pay only half of their workers' premium, and that their contribution for dependents should be even less.

Employers currently pay an average of 75 percent of premiums for workers and dependents alike.

"The fact that half the nation's employers think that it's appropriate to pay less for family members than for the worker troubles me," says Jack Meyer, lead author of the study and ESRI president. He's especially concerned about those at the lower end of the income scale, asking "How does a worker with a family with an income of \$20,000-\$25,000 pay half of its premium?"

At the same time that business is looking to reduce its health care spending, so is the government, especially when it comes to the huge Medicare and Medicaid programs.

Medicaid, in particular, has cushioned the trend away from employer coverage, says Georgetown University policy analyst Judith Feder. "Had it not been for Medicaid expansions for low-income moms and kids during the recession, we would have seen a much larger increase in the population without insurance," says Feder, a former Clinton administration health official. Yet if Medicaid reductions come on top of reduced employer coverage, Feder predicts, "We will see dramatic increases in the numbers of people without insurance at the same time that we will see substantial reductions in resources to provide them care."

Why does the number of uninsured matter?

Beyond the moral question of whether or not access to health care is a right, the uninsured have a significant impact on the operation of the nation's health care delivery system.

Until now, they were at least able to receive emergency hospital care, with the bill picked up either by public programs, by not-for-profit hospitals that provided charity care as part of their community missions or by "cost-shifting" that inflated bills for insured patients. But all those sources are drying up simultaneously, with the government looking to balance the budget, payers driving harder price bargains and for-profit hospital chains lessening the supply of charity care. As a result, Feder asserts, "We now have a real threat to access to care."

At some point, predicts Brandeis University health policy professor Stuart Altman, the consequences will be felt by everyone. If funding disappears, but "hospitals and medical systems are forced to still provide services—either because they legally have to do it, or because they morally feel the need to do it—then what happens to the delivery system for those of us who are well-insured?" asks Altman. If providers "get to the point where they're just incurring costs that they aren't getting paid for, they have to make up for it, so they reduce access and quality to the people who can pay as well as to those who can't."

Thomas Chapman, former CEO of the George Washington University Hospital, warns that the day the insured population begins to feel the effects is nearing. "We're going to start seeing some prestigious institutions stumble," he says. "Then there's going to be a local response, at the very least an acknowledgment that something needs to be done."

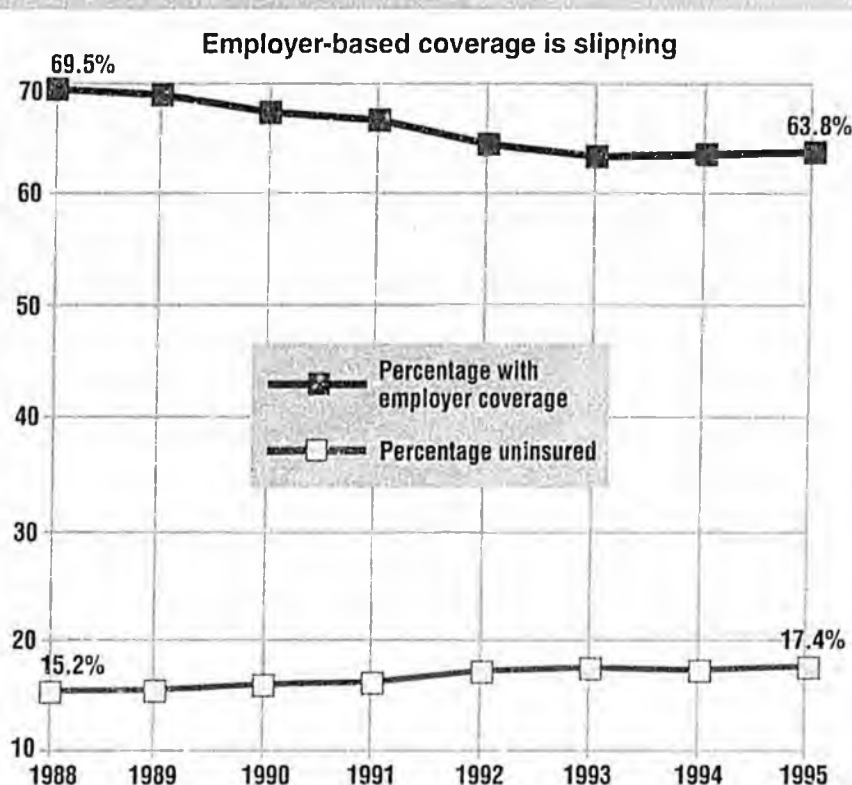
But paying for uncompensated hospital care begs the question of need for insurance. "The notion that we can rely on uncompensated hospital care by voluntary facilities that feel like it at the moment is hardly a way to deal with the problem," says Sara Rosenbaum, director of George Washington University's Center for Health Policy Research.

Paul Nannis, commissioner of health for the city of Milwaukee, agrees: "The safety net will never

Shrinking the employer-based insurance blanket

The growth in the number of uninsured Americans—about 40 million individuals in 1995—shows no signs of reversing. Contributing to the slide are businesses cutting costs through downsizing and shifting toward temporary or part-time workforces. According to the Employee Benefit Research Institute, the percentage of Americans with employer-based coverage dropped from about 70 percent to 64 percent between 1988 and 1995. An American Hospital Association estimate projects that by the year 2002, the percentage of workers and their families covered by employers may decline to about 50 percent.

Source: Employee Benefit Research Institute.



replace the fundamental needs—people need insurance and there need to be places to go to use that insurance.” People who land in the hospital safety net are treated, Nannis says, but they “end up not accessing any preventive or primary care, present in ERs in acute episodes that could have been prevented, end up costing more and are more critical and difficult to deal with.”

In fact, studies have repeatedly shown that insurance—or the lack thereof—is a key indicator of health status. The uninsured are less likely to receive preventive care or have a regular source of health care, are less likely to receive hospital care and are more likely to die when they are admitted to the hospital. A recent survey by the Harvard School of Public Health, the National Opinion Research Center and the Kaiser Family Foundation found that uninsured respondents were three times more likely to report their health status as “poor” than those with insurance.

The study also belied the perception that those who are truly in need can get medical care. “The sickest

people surveyed are most likely to have problems getting the medical care they need,” said Harvard researcher Karen Donelan, the study’s principal author. Uninsured respondents were four times more likely than the insured to report a time when they needed medical care but could not obtain it and three times more likely to report difficulties paying their medical bills.

Indeed, more uninsured respondents said they had been contacted by a collection agency about their medical bills than said they had been able to receive free or reduced-price care.

Whose problem is it, anyway?

So why should employers care about the uninsured, particularly employers who already provide coverage for their own workers and their families? “I would argue that it shouldn’t be the employers’ responsibility at all,” says Princeton professor Reinhardt. America’s employer-based health insurance system “simply grew out of World War II as a convenience. No one who would design a health insurance sys-

tem from scratch would ever have created this. It’s just an accident of history.”

Others suggest that business cannot evade a moral issue. “As a nation with such a high-quality health care system, we should seek to make it available to all Americans,” says Pamela Bailey, president of the Health Care Leadership Council, a group of health care industry executives. “It may not be business’ responsibility to provide the coverage, but all of us have a responsibility to find a solution.”

And business may have created a special responsibility for itself, says Georgetown policy analyst Feder, since it has heretofore been footing much of the bill for the uninsured. “To the extent that the cost-shift has been financing care to the uninsured, now that [businesses are] walking away from it—even where they are legitimately pursuing their own interests—don’t they have some responsibility for what happens as a result?”

Policy analyst Meyer says business has an even more self-serving reason to worry about the uninsured: The viability of the nation’s employer-based

health insurance system is at stake. "If they believe it's the best system, as opposed to a national health care system, and the number of uninsured is going up year after year, then eventually the system will implode," he says. "If you want to make this employer system work, the employers have to make a commitment to cover most of their workers who are permanently attached to them and to pay a decent share of the premium."

Meyer says what concerns him most is that while many businesses are appropriately trying to lower their health care costs, too many are doing so in inappropriate ways. "If employers want to preserve this system, they ought to put more of their creativity and resources into figuring out how to properly manage care and control costs, by identifying and rewarding quality, incentivizing workers and their families to get good care and then shifting people into managed care and negotiating hard with those plans," he says. "But my fear is that instead we will have a lot of 'Well, gee, we really should rethink retiree benefits' and 'Gee, do we really want to cover the spouse of that guy? Is it our responsibility to take care of his kids?' To the extent that that's their reaction, the system isn't going to work."

A related question is the appropriate role for managed care. Even though it has been the instrument for reducing the financial surplus that used to pay for care for the uninsured, Feder says that managed care should not be held responsible for solving the problem. "I think that the primary responsibility is with the purchaser. Managed care is in the marketplace, and it's competing for this business. If that's the way it's going to be purchased, it's hard for me to blame them for keeping their costs down."

Altman agrees, but only to a point. Managed care "is there to provide services for people who pay for them, and it shouldn't be paying for people that aren't [paying]," he says. But where some managed care companies

have failed, he notes, is that "they're not aggressive enough in supporting some form of national health insurance. It's one thing for them not to pay for it, but it's another thing when they actually work behind the scenes to prevent passage of legislation that would pay for it."

Rosenbaum concurs that managed care in particular—and for-profit health care in general—poses a significant problem by taking money out of the system that could and should be used to expand access. "The real issue is how do we make sure that if there are savings realized from all these brilliant efficiencies, rather than just making a lot of investors even wealthier, we have a mechanism for recapturing some of the savings that should be occurring now because of the slowdown in health care prices."

What next?

Just about everyone agrees that lawmakers have no stomach for addressing the problem in a single step. "There's certainly no sentiment for a national health plan," says Meyer.

There does, however, appear to be growing support for incremental approaches. The viability of incrementalism appears to have been assured by the hard-won 1996 enactment of the Kassebaum-Kennedy bill that seeks to make it easier for the already insured to stay that way. President Clinton has already proposed expanding coverage by offering special subsidies to the temporarily unemployed.

That proposal notwithstanding, many legislators and analysts are looking at covering uninsured children as a next step. "When we think about how to move forward, kids come up as the constituency that we believe we can get support for," says Feder. Besides the obvious political appeal—and the fact that children's coverage is deteriorating at a demonstrably faster rate than that of adults—here is another important reason to address children's problems first: They are comparatively inexpensive to cover. One analysis done for the

American Academy of Pediatrics suggested that a comprehensive children's preventive benefits package could cost as little as \$8 per month.

But as with all incremental steps, covering children first could create its own problems. For example, at a 1996 forum on the subject, Rosenbaum noted that "children-only" insurance plans could end up raising premiums for adults by removing the healthiest and least expensive population from the risk pool.

Other analysts worry that a new government plan or subsidized proposal will merely shift private-sector costs onto taxpayers. "You can't expect people to take responsibility for people that they don't feel they have any responsibility for," explains Chapman. "That's what the tax debate's about." (See "Viewpoint" on page 49 for some other unintended consequences of reform.)

This question of "Who will pay?" has plagued generations of would-be health care system reformers. Some have suggested that the slowdown in health care cost inflation will make it easier—read *cheaper*—to address the problems of the uninsured. But "easier" is a relative term, says health economist Paul Fronstin of EBRI. "It will never be easy to do something about the uninsured, no matter what health care cost inflation is like," he says. "When you're talking about 40 million people and a major amount of money to cover them, it's going to get caught up in politics."

Brandeis's Altman says it may take another economic downturn to really put the issue back on the front burner. The impetus simply won't be there "as long as the middle class is happy," he says, "but the general feeling I get from talking to people is that there's still a lot of insecurity in that group. I keep saying we're only one recession away."

Julie Rovner is a freelance health care journalist based in Bethesda, Md., who has been covering Capitol Hill for more than a decade.

Should American health care include assisted suicide?

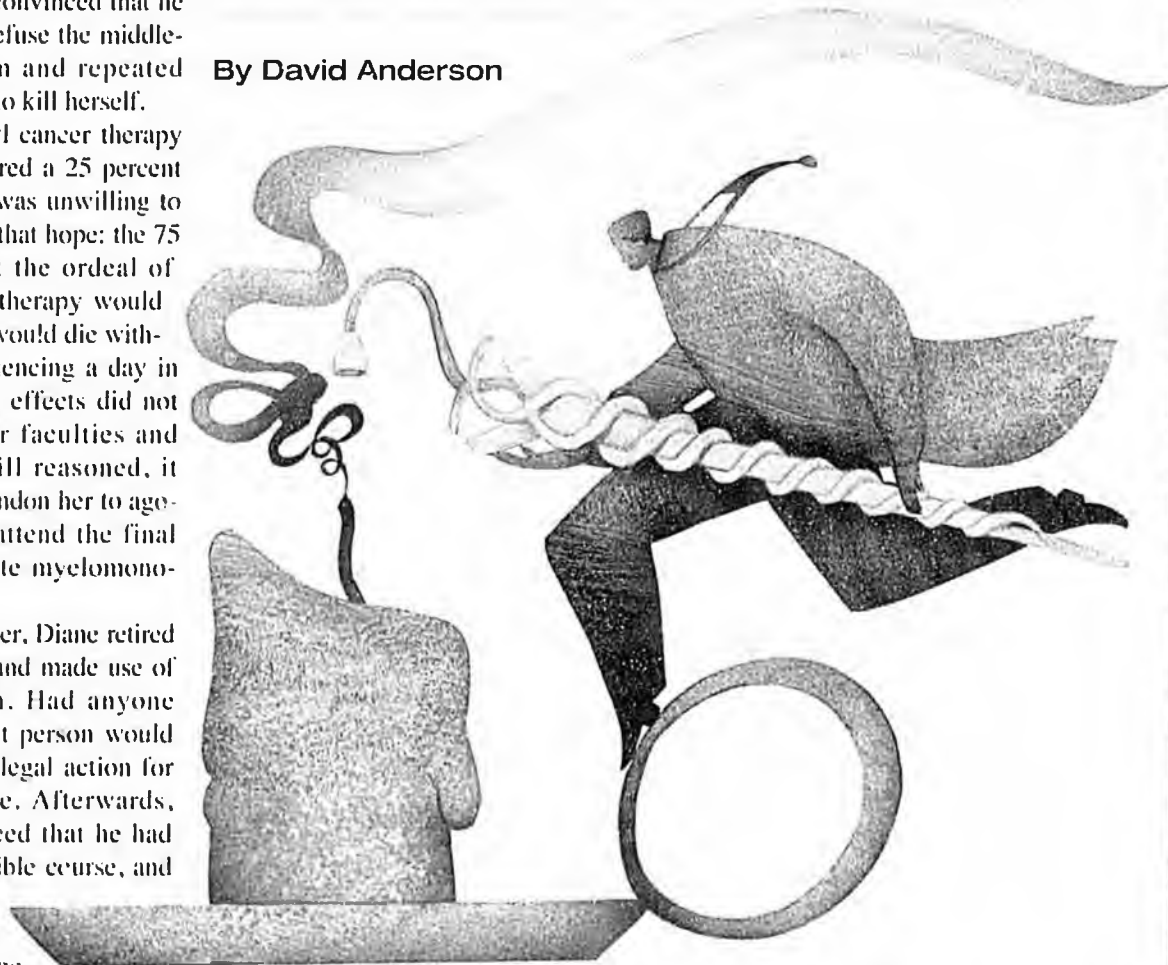
Timothy Quill, MD, wrote a prescription for barbiturates and made sure that his patient knew how much to take to induce sleep, and how much to die. As Quill passed the slip to Diane, he had the uneasy sensation of stepping beyond personal as well as legal bounds. Yet he was convinced that he would do wrong to refuse the middle-aged woman's firm and repeated requests for a means to kill herself.

Diane had declined cancer therapy that would have offered a 25 percent chance of cure. She was unwilling to accept the inverse of that hope: the 75 percent chance that the ordeal of radiation and chemotherapy would be useless—that she would die without ever again experiencing a day in which pain and drug effects did not severely restrict her faculties and energy. Surely, Quill reasoned, it would be cruel to abandon her to agonies such as might attend the final onslaught of her acute myelomonocytic leukemia.

Not many weeks later, Diane retired to a room by herself and made use of Quill's prescription. Had anyone accompanied her, that person would have been subject to legal action for assisting in a suicide. Afterwards, Quill was so convinced that he had taken the only defensible course, and so upset by Diane's ultimate isolation, that he decided to challenge the law. In early 1992, he published his story in *The New England Journal of Medicine*. Soon after, together with two other physicians and three patients, he filed suit to challenge New York's law forbidding any person from helping another commit suicide. In January, the U.S. Supreme Court heard arguments on that suit, along

The wrenching debate pits individual rights against deeply held convictions about the role of physicians. The social, ethical and, yes, financial implications are profound.

By David Anderson



with a second, similar one from the state of Washington.

The proposition to grant physicians a legal right to help patients die obviously has profound ethical implications—none of which is seriously encountered in the well-publicized activities of Jack Kevorkian. Does a person's right to self-determination

extend to the point of self-destruction? Is the injunction "Thou shalt not kill" absolute in all circumstances except for self-defense? Should we tolerate grim suffering—either physical or psychic—without hope of recovery or epiphany?

Ultimately, say many experts, we must consider these difficult issues not