SENATE COMMITTEE ON HEALTH CARE AND BIO-ETHICS

March 16, 1993 Hearing Room C 3:00 p.m. Tapes 26 - 27

MEMBERS PRESENT: Senator Bob Shoemaker, Chair Senator Jeannette Hamby, Vice Chair Senator Joyce Cohen Senator Bill McCoy Senator Gordon Smith

STAFF PRESENT: Barbara Coombs, Administrator Dick Shoemaker, Administrator/Assistant Joan Green, Assistant

MEASURES HEARD: Informational Meeting on Managed Competition Proposal

WITNESSES: Alain Enthoven, Professor Dean Kortge, Insurance Management Associates

TAPE 26, SIDE A

006 Chair Shoemaker: Meeting called to order at 3:10 p.m.

VERBATIM TRANSCRIPTION

INFORMATIONAL MEETING

INTRODUCTION OF MANAGED COMPETITION PROPOSAL

010 Chair Shoemaker: As you know from the agenda today we are going to be introducing formally what's being called the Managed Competition

Proposal, which is in LC form at the moment. And I hope most of you in

the audience have copies of it, LC 2132. Has it been given a bill

number?

014 Barbara Coombs, Administrator: Not to my knowledge.

014 Dick Shoemaker, Administrator: It has.

015 Chair Shoemaker: It has?

015 Shoemaker: It's SB . . .

016 Coombs: Oh yeah, you're right, 765.

017 Shoemaker: 765.

017 Chair Shoemaker: 765, okay.

017 Coombs: And the companion is 766. 018 Chair Shoemaker: (Acknowledgement). Today I'm . . . we'll be spending the first hour, approximately, in an explanation of the bill and the

plan that the bill embodies. And then about 45 minutes, I hope, talking with Professor Alain Enthoven, who will be calling us from his home in

San Francisco. He is en-route there now from Sacramento where he's been attending a meeting. And for the last several weeks he's been in Washington meeting with Hillary Rodham-Clinton, and very much in the center of the development of the national health plan. So we're very pleased that he'll be able to comment on ours and on managed competition in general. But let me set the stage by just describing to the Committee and to the audience and to whoever's listening what this SB 765 is all about.

031 Chair Shoemaker: I see this as an extension of the Oregon Health Plan and consistent with the Oregon Health Plan. I think it is very important that be understood. This is the Oregon Health Plan moving forward to accomplish all of its objectives. You will find that we maintain an emphasis on primary and preventative care, an emphasis on prepaid managed care, a continuation of the employer-based system that has operated in this state fairly effectively, and allowing the market to control what is paid for health care services rather than trying to impose that from above.

044 Chair Shoemaker: The Oregon Health Plan, as we now know it, consists of a number of pieces already in place: SB 's 27, 935 and 534, enacted in the 1989 Legislature. SB 's 1076 and 1077 enacted by the 1991 Legislature. The plan will include, I hope, a number of pieces recommended to this Legislature by the Health Resources Commission, pursuant to SB 1077. And the Committee will be considering those. Some as Senate bills, some when they come over from the House, where they are as House bills.

053 Chair Shoemaker: It seemed to me that rather than allowing all of these pieces of the Oregon Health Plan to function somewhat in isolation from each other, that it made sense to pull them together into a framework which would cause them to relate to each other and which would be then a cohesive Oregon plan. The concept embodied in this bill is to construct that framework, starting with the bill and emerging with the framework plan. And I want to emphasize that. What we're thinking about here is a framework, not a detailed plan with all the pieces in place, but a

construct, a set of goals, but also a set of rules that we would live by in delivering health care to all Oregonians. My hope is, or my expectation is that we would deliver this framework plan to the Oregon Health Council to work on in the interim. And the Oregon Health Council would be charged with filling in the details and probably suggesting some revisions. As they work on the details they will no doubt find some places where a different approach is indicated, and we would welcome that. The recommendations from the Oregon Health Council would then be made to the 1995 Legislature, which I hope would adopt a complete plan to be implemented, ideally, July 1, 1995 which as you all know is the date that the employer mandate of SB 935 is scheduled to take effect; assuming of course that we get the waiver in the meantime and that we can implement SB 27.

080 Chair Shoemaker: My hope is that funding for the work of the Oregon Health Council in the interim can be found from a foundation interested in what Oregon is trying to do, and I think that is a realistic expectation. The goals of the Oregon Health Plan I think can be summarized as universal access to an adequate level of high quality health care at an affordable price. The health plan as it now exists goes a long way toward meeting those goals, but we all acknowledge that much remains to be done. The recommendations of the Health Resources Commission and the additional recommendations in this bill are intended to get us the rest of the way as we follow the process that I've just outlined. Universal access, as recommended by the Health Resources Commission. This will be achieved by first requiring that every Oregonian be enrolled in a health plan. And secondly by guaranteeing access to each Oregonian to the health plan of his/her choice. So universal enrollment and guaranteed access. Those are both recommendations of the Health Resources Commission. An adequate level of care, as recommended by the Health Resources Commission. This would be achieved by requiring that every health care plan provide, at a minimum, the Oregon Standard Plan. This will be substantially similar to the benefit package developed by the Health Services Commission under SB 27. And coming to that substantial similarity would probably be done

in much the same process that we used under SB 1076 in developing the Small Group Insurance package, but not necessarily exactly the same people, but many of them. But that process has worked there and I think it would work here, but the substantial similarity should be to SB 27, which is the Medicaid part of the Oregon Plan.

108 Chair Shoemaker: Delivery and maintenance of high quality care is, I think, one of the more challenging aspects of what we're trying to do.

Since we're well on the road to delivering health care as prepaid managed care, that shifts from an incentive to provide as much care as possible, as you do in a fee-for-service system, to providing no more care than is really necessary, as is done under a pre-paid plan. Since you're already paid, the incentive is to be as efficient as you can be in delivering that care. That of course opens the door for quality to slip. Fortunately in this state the quality of health care is high, and the institutions which deliver that care have high standards, which I think we can expect them to continue to adhere to. In this bill I am proposing five specific devices to protect and assure continuance of that high level of quality. Practice guidelines, as recommended by the Oregon Health Resources Commission. A universal data base, again as recommended by the Oregon Health Resources Commission, which would be available publicly, so there would be no secrets. An active peer review system, utilizing either Oregon Medical Peer Review Organization or possibly the Board of Medical Examiners or perhaps some other device we haven't thought of yet. Consumer Advisory Committees within each Health Maintenance Organization (HMO) of self selected members, whose mission would be to look out for the care and feeding of the members of the HMO and to make the HMO aware of what's going on out there and how their services are being received. More in the nature of are they attended to promptly, are the members satisfied with the care they get, do they feel that the outcome is what they hoped, generally are they happy or unhappy with the delivery of care by the HMO. And finally Ombudsmen within each HMO, whose mission is to be the advocate of the patient. Ombudsmen selected, I'm suggesting, by the Oregon Health Council, paid for by the HMO, but removable only by the Health Council. And the Ombudsman would be available to the patient; and if the patient, or the patient's physician with the HMO isn't comfortable with the level or the quality

of care that is being delivered. The Ombudsman would confer with the patient and be the patient's advocate, if that was indicated.

148 Chair Shoemaker: Affordable price, which is the hardest of all to achieve, and it is really at the heart of what has come to be called Managed Competition. We are seeing emerging relatively few large, well-financed, integrated health care systems competing vigorously with each other. That's the goal, that they compete vigorously with each other. This is developing in Oregon, particularly in the Portland area, and I'd like to move with that and work with that and not try to change that, and give those emerging systems a lot of freedom to operate and to put their own acts together, each one different from the other. These large HMO's will be offering a full array of health care services and we should do everything we can to help them do that and to help them really compete. A couple of important elements of affordablity that we can, I think, appropriately add to the system: one is community rating of premiums, again a recommendation of the Health Resources Commission. That would mean that each provider or HMO . . . a HMO in a region would set a community rating for that region. There might be some age breaks, there might be a gender break, but except for that it would be the same premium applicable to every applicant, to every member, regardless who the employer of that member is or what that member's health condition is. We'd move from experience rating to community rating. Also speaking to affordablity is who pays and how much? And this bill proposes the following: The employer would pay at least 50% of the least expensive Oregon Standard Plan available in a region, absent hardship, and the Health Council would need to establish the standards of hardship. Hardship employers would pay what they could, but others would pay at least 50%. That's a move downward from the 75% that's presently in law under SB 935 of the 1989 session. An employer could pay more, if he chose, or if in collective bargaining that was what was agreed. The balance of a premium for the family would be paid by the employee, but not to exceed a percentage of disposable income. Now that also was contemplated by SB 935 in contemplating development of a sliding scale of premium participation by employees and their families. And I'm suggesting that sliding scale be developed as a percentage of disposable income, disposable income being that which remains after

paying for the necessities of life: food, shelter, transportation, clothing and of course a few others, and then some percentage of what remains after that could be called upon to pay for health care. The balance of a premium to be paid by the State as a direct support.

216 Chair Shoemaker: I'm proposing that the State's share of these premiums, now this is not the Medicaid population we're talking about,

these are people who are employed or there is an employed family member, the balance of the premium would be paid by the State and collected via, I'm suggesting, although it's not in this bill, it's in a House bill, a premium tax; which would be a tax on these very premiums paid to the HMO or the insurer. That is a very straight forward cost shift. It's saying out front that those who can afford it would put in a little extra to cover some of the cost for those who cannot afford it. And this premium tax would be committed solely to paying premiums and used for no other purpose. A key element of all of this is linking the consumer to the provider. The present system allows each employer to be on his own. As many agents as serve employers, many of them very well, but except for large employers there is not a lot of bargaining leverage available. The system is somewhat chaotic, and I think has another problem in that it can be restrictive of the freedom of choice and the freedom of movement that an individual employee and his family has. You're pretty well, and if you change employers you're liable to find yourself in a whole new health plan over which you have no control. I think we need to find a way to improve that. What is proposed in this bill is a single health purchasing corporation in each of six regions in the State, corresponding to the regions set up under SB 1076. In addition to these single health purchasing corporations in each region, certain large corporations, and we'd have to define what large means, could continue to go their own way much as they do now as self-insured employers. The State would itself be a health purchasing agency for State employees, for the Medicaid population and for early retirees not yet on Medicare and maybe for local employees, local government employees.

253 Chair Shoemaker: And Medicare would continue to be a health purchasing agency for those over 65 and certain others who qualify for

Medicare.

But for the most part, in each region, you'd have a single purchasing agency. Now I see this as either a public or a not-for-profit corporation that would compete to be awarded a franchise, I'm suggesting Department of Insurance and Finance (DIF), to serve a region. And the governance of this corporation would be by representatives of employers primarily and the union, so that these corporations would have a direct responsibility to those who are primarily responsible for paying the bill, the employers and the employees. These now substantial purchasing agencies, I think, would be better able than a multitude of smaller organizations to negotiate with the HMO's and insurers in each region to jawbone them down on their price and up in their quality; and to have the force of their strength of numbers to have some effect on that. Then each of these corporations would offer to each of its members an array of plans, these being the qualified HMO primarily, but also indemnity plans, available in the region. And annually a member could move from plan to plan just as many of us do now. If you change employers it wouldn't matter because you're picking your plan from all the plans available through this purchasing agency. This agency would collect all the premium payments from the employer, the employer's 50% or more, from the employee and from the State and then would make diSB ursements to the HMO's according to each members' selection of a HMO. And these corporations would also serve other consumer needs in the delivery of health care. I think where the main issues that we will be discussing as we move along will be alternative arrangements for this. There are a lot of good arguments for continuing with more brokered type arrangements. Perhaps through Multiple Employer Welfare Arrangements (MEWA), so called MEWA's. And we may want to think about liberalizing the MEWA laws so that they can form. Right now they're quite restrictive, for very good reason. I think we want to consider that as an alternative, although I'm inclined to believe that the single large purchasing corporation is probably going to be the more effective way to proceed.

324 Chair Shoemaker: I think particularly these single arrangements will be effective in rural areas, where you may not have the system in

place to really offer competing health delivery systems. I think if you have a

single purchasing corporation it will be able to be out in that market

putting together health delivery networks, if they're not already

effectively in place. I think a single system could do that where

multiple purchasing agencies could not. I think that is another thing

we're going to want to think a lot about as we move along on this, is

creating the best possible climate for effectively competing HMO's to

emerge throughout the State. So that in rather short summary is the

plan that you'll see in this bill, which I regard as a starting point.

I would expect that we would work our way through it, kind of subject by subject, inviting all who wish to be heard on different pieces of it and scheduling those until we work our way through it. So with that let me

stop talking for a few minutes and invite comments, questions, whatever.

348 Sen. Cohen: Well I guess Mr. Chair I just have . . . having read some of your first iterations that had Multiple Purchasing Agencies in them, you've kind of settled down on a franchisable single purchasing agency

for a region. Could you sort of explain why you've kind of came back

this route, or do you care?

360 Chair Shoemaker: No, I'd be glad to explain it. I think that, first place you've got to answer the question "Why do you need more than one?"

374 Sen. Cohen: Right, that's one of my questions way back in (unintelligible).

375 Chair Shoemaker: . . . start with that "Why do you need more than one?" Because if more than one doesn't deliver what we're talking about more

efficiently than a single one, than there is no reason to do it that

way. And I don't see, at this point why we do need more than one,

because the plans are going to emerge from the HMO's, from the

integrated health systems that we have. And they will have to pass

muster with the Department of Insurance and Finance, in terms of the

quality that they're delivering and the financial strength behind them. So those are going to be in place. The purchasing agency isn't going to be a part of that exactly, except maybe in the rural areas. The choice

is going to be up to the individuals so all that you need to bring to

them is a description of the different choices they have, then that's their choice. So what you need is an agency to collect the premiums, to disperse the money and to just kind of administer the process. One other thing that these can bring to it is helping the, each HMO will be setting its own community rates on an annual basis. Once set, that rate would then apply, I'm suggesting a year, it could be six months, so there won't be price negotiation in the usual sense, but there will be, I'm calling it jaw boning, to encourage those HMO's to get those prices down as far as possible. And I think a single organization could probably do that more effectively than a lot of different ones out there. Similarly quality, because a very important part of each HMO's plan is going to be the quality of what it is delivering. And if that quality is being commented upon by a single purchasing agency I think that might have a little bit more impact on keeping that quality up or improving it where it drags a bit. It would be true if there are multiple voices out there receiving different information and imparting different information. 426 Sen. Cohen: Thank you.

TAPE 27, SIDE A

006 Sen. Smith: Mr. Chairman, I have three concerns I would like to get from this process. The first one is my concern over whether or not our residency requirement to qualify for this is sufficiently careful, so as not to invite the 47 other contiguous states to move here in the event the federal process gets bogged down. And I see the potential for enormous occlusion, in the overall cost getting away from Oregon taxpayers, if it does in fact, and there is some evidence and studies to suggest that won't happen, I understand that, but it could. And I'm concerned about that. The second thing . . . if we . . . I do frankly favor the policy tax as opposed to the employer mandate as a way to help fund some of this. However, many employers who do have health insurance right now I know will be looking to some reduction in health care costs because others will now be paying customers. I think there is some real sensitivity that there is an offset in exchange for the tax, for some savings in their billings.

028 Chair Shoemaker: Right, and this is something I would hope the interim committee could be able to develop and get some figures and some models that would tend to show that would happen.

034 Sen. Smith: My final concern is that there be a limited, though

some small business exemption, if we don't go with this other approach for

those businesses who simply have historically small margins that cannot account for growth of 15% in health care costs. I don't know how to

include them without bankrupting many of them.

037 Chair Shoemaker: And I certainly share that concern. In the first place I'm hoping this approach will work that 15% down substantially and secondly we do need to develop a hardship formula so those employers,

large or small, which honestly cannot afford a 50% level of contribution will get some relief from that.

038 Sen. Smith: I've felt for a long time that this is a good plan, a conservative plan that addresses that we are in an age of limitations,

financially, but I have . . . I'm resistant to anything that will take . . . to say "this is a great health care plan, but it comes with an

unemployment plan" and that's why I think we need to be sensitive that

we do not destroy or eliminate jobs from this State just on the basis of health care costs. And I can indicate from personal experience, I do

not have a single cost that is more out of control than this one.

042 Chair Shoemaker: I clearly agree. We're still half a hour away from hearing from Dr. Enthoven. I'm surprised I was as concise as I was.

General laughter and banter.

048 Chair Shoemaker: We could call for a recess and have people come back. Although I . . . if anyone of you would care to comment at this time and give us any preliminary observations this would be a good opportunity to hear from anyone in the audience. I don't know whether you've had a

chance to collect your thoughts and it is a little bit unusual, but I

would invite that.

General comments.

053 Dean Kortge, Insurance Agent in Eugene and President of the Local Life Underwriters Association Associates: I would be curious, we've had this discussion, but to pursue it, to take a look at the MEWA law changes.

You mentioned that and we had the discussion previously about opening

that up. Is there any way perhaps that could be looked at to be done on any kind of pilot basis or . . . I feel that two things: One I think

there are some ways to regulate that so that something could be done. I think it accomplishes overall what you're saying to do. And of course I

feel very strongly, as those of us who spend most of our lives being representatives, that we provide a lot of service to people. Even in the system you've provided somebody is going have to be there to help people select from among these different plans. That's what we do. Can not the system that we have in place do that as efficiently, as effectively, without a public body, or in some way. I'm arguing for myself, admittedly. I'm not ashamed to say that. But I think we do a pretty doggone good job of that.

070 Chair Shoemaker: Well I think that's the question. And I think we need to explore that.

071 Sen. Cohen: I have a question. Wouldn't it sort of . . . there is no reason in the world why your profession shouldn't organize itself like a HMO and kind of be prepared to deliver X amount of clients to somebody, with a certain range in making sure that you understand what community

rating is, and you understand . . . you can be an outreach service to a variety of HMO's and any purchasing authority, whether it be the State directly. I mean it seems to me that you've got to reorganize yourself too.

076 Kortge: Well I think that's . . . there's a bunch of us who have had discussions and foreseen that, absolutely. The problem is, the issue I

see is that if there is some restriction that the health purchasing coop, whatever we call that, has to be a private non-profit as opposed to some other form.

080 Sen. Cohen: They still need to provide . . . you still need to work with somebody.

081 Kortge: Sure, we have to work with the HMO's and we have to collect people. That's why I'm suggesting to form MEWA's might be a way to . .

. because that is essentially what a MEWA does.

083 Chair Shoemaker: I agree, we need to explore that as probably the logical alternative.

087 Sen. Cohen: They may not be mutually exclusive, the two ideas. General comments.

087 Sen. Smith: I only have one other comment I should have included. This all comes at a time . . and it is somewhat embarrassing that

the

Clinton administration may well grant these waivers and we will be in a position as a State to do something with it. It comes at a time when

we're also wrestling with . . . how do we get beyond Measure 5? And we

know, at least at this point, there is still resistance to tax measures. And this represents a very real tax increase. No matter how we craft

it, it will ultimately reach taxpayers. We're suffering a timing

problem and (unintelligible) I'm wrestling with how to proceed with a

very worthy plan in a way that people will pay for it.

099 Chair Shoemaker: Calling for this to be effective in 1995 I think helps in that regard. I would hope and pray that by that time the State has

found its way out of this Measure 5 morass that we're in. And that the

economy is healthy enough that people are willing to do what it takes.

I would also hope that as we develop this kind of a plan and the savings that it will bring about, by wringing out unnecessary parts of the

present system, unnecessary administrative payments and a number of

things like that, as well as probably some level of compensation to

providers, that the total cost may not be greater. I don't think it's . . . I don't think we can reasonably expect it to be less, because we are going to be bringing more people into the system who are not now served, but I think it should cost substantially less per person. So I'm hoping that those things will sort of sort themselves out in the ensuing two

years. And the '95 Legislature will be the one that will really have to decide that, "Is it now the time to put this into effect, now that we've kind of got a plan together in all its detail?" Just a couple of other

comments suggested by your comments. The federal government, of course, is working on a plan and it could well be that they will come up with

something before we're ready to go with this one, that would preempt

what we've done. I guess that's a risk, maybe that's something to be

looked forward to. It also could be that if we do our work well we may

provide some help to the federal government in developing its plan. And I shouldn't let it pass without mentioning that this . . . we all

recognize that to do this we do need some help from the federal

government, at least in getting ERISA out of the way. So we will have

to entreat the feds to back off from ERISA so that states like Oregon

can try their own thing. And I know that they're thinking about that.

Recessed at 3:49 p.m.

Reconvened at 4:15 p.m.

140 Chair Shoemaker: Dr. Enthoven is delayed in traffic.

Recessed at 4:16 p.m

Reconvened at 4:53 p.m.

157 Alain Enthoven, Professor: Can you hear me?

159 Chair Shoemaker: Yes, yes we can, not very loud, but that is not within your control, that's within ours. Welcome to our hearing. I understand

that California traffic treated you badly. I'm sorry to hear that.

163 Enthoven: I'm very happy to participate in the hearing Senator. I apologize for the delay.

165 Chair Shoemaker: It's alright.

166 Enthoven: I'm Chairman of the Health Benefits Advisory Council for the California Public Employees' Retirement System (CalPERS). We run, down

here, a large purchasing cooperative for some approximately 800 local

government agencies, as well as for the State for the employees,

retirees and dependents. And I had to meet in Sacramento today with the President of the PERS Board and the Executive Director from 12:00 to

2:00. If everything had gone according to plan, I left there at 2:00, I would have been here by 4:00, but a big rain storm intervened and there were several frustrating accidents on the freeway and I spent a lot of

time just tied up in traffic.

177 Chair Shoemaker: Well I'm just glad that we never have to face that sort of problem in this State!

General laughter.

179 Enthoven: (Unintelligible) the State of Oregon. But I have prepared an outline of remarks and I would be very happy to begin when you are

ready.

180 Chair Shoemaker: We're ready, with pleasure.

181 Enthoven: Okay. I very much appreciate the opportunity to communicate with the Committee on Health Care and Bio-Ethics, and I have a number of ideas I've outlined. First, the set of ideas that we called Managed

Care and Managed Competition could well be considered an Oregon idea.

Certainly a lot of what I've learned about these ideas, in the early

years that I was working on them, I learned from experiences in Oregon. For example I came up to study Project Health, that was created by

Multnomah County, as a way of caring for county indigents by contracting with several alternative organized health care delivery systems. My

good friend, David Lawrence, was Commissioner of Health in those days up there. And then I studied some of the (unintelligible) competitive

interactions between Kaiser Permanente and Physicians Association of

Clackamas County and I could see how the competitive pressures on each

one were stimulating them to do a better job than they would have done, if they hadn't had their competitors. And I became good friends with

Congressman Al Ulman, who introduced into the Congress legislation that would have begun to implement some of these ideas. It is just a shame,

frankly, that his legislation wasn't adopted in 1980. If it had been we wouldn't be in some of the mess we're in now at the national level with health care costs.

207 Enthoven: Secondly, let me just briefly sketch the main ideas of this total reform strategy, if you like, that we sometimes call the Jackson

Hole proposal or the Jackson Hole initiative. There are really five

interlocking ideas. The first idea is that the traditional system of

fee-for-service, solo practice and remote third party payment is at the heart of much of the economic failure in our health care system. The

incentives are all wrong. It doesn't reward providers for finding less

costly, but equally effective ways of treating patients. It pays more

for doing more, whether or not more is beneficial. It doesn't create

accountability for quality or for cost of care. And what America needs

to do is to restructure the delivery system into what we sometimes call accountable health plans, which are publicly accountable for quality and cost of care; all of which would be required to cover uniform, effective health benefits, as determined in our Jackson Hole proposal, by a

National Health Board. All of the health plans would play by the same

rules. And the goal is a reformed delivery system, made up of

integrated financing and delivery systems with providers, that is

doctors and hospitals, at risk for the cost of care and the cost of poor quality, that are paid on a per capita, prepayment basis instead of on a fee-for-service basis. Now we would allow them complete flexibility

within these organizations as to exactly how they wanted to pay the doctors and the hospitals, but there would be an accountable organization that would be paid on a per capita basis.

244 Enthoven: The second main idea is what we often call "managed competition". And here the idea is, that today and in the past most employers have not structured health benefits offerings to their employees in such a way that the health care organizations have to compete to provide value for money. In the typical employment situation the employer offers a fee-for-service plan in which the incentives are all cost increasing and pays for the whole thing, or pays for 90% of it or 80% of it. Then when a HMO comes along the typical employer says "we'll offer that as long as it doesn't cost anymore than the fee-for-service plan and pay for 100% of that, or 90% or 80% of it." But the key point is that it's not structured in such a way that the alternative health plans have to compete on value-for-money. It's not typically structured in such a way that an efficient health care organization can take customers away from the inefficient provider by cutting its costs and offering a better deal. In "managed competition" the first essential idea is that whatever help the employee gets from the employer or from the government, through the taxes, tax remission, or through subsidies; whatever help would be limited to the price of what we call the benchmark plan. The lowest priced plan in the area providing high quality comprehensive benefits. And anyone who chooses a more costly plan would be expected to pay for the difference with his/her own net after tax dollars. Now that idea is the exception in this country, unfortunately, rather than the rule. Then "managed competition" seeks to level the playing field; to apply the same rules of socially responsible behavior to all health care financing and delivery plans that receive tax subsidies or government subsidies for health care.

290 Enthoven: The third main idea, what we have been calling either the "Health Insurance Purchasing Cooperative" or the "Health Plan

Purchasing Cooperative", goes like this. Roughly 45% of the American people

employed in the private sector are in employment groups of 100 or less. Such groups, and even larger ones, are too small to spread risks, too

small to achieve economies-of-scale in administration, too small to

manage competition and too small to offer multiple choices of health

plans at the individual level. We believe that the best way to remedy

this problem is to pool large numbers of small employers into large

"purchasing cooperatives". And the prototype for that is the California Public Employees' Retirement System in which we purchase on a multiple

choice competitive basis health care coverages for our 890,000 people

who are employees, retirees and dependents, either of the State or of

one or another of about 800 local government agencies including small

employers. My favorite example is the Mosquito Abatement District of

Antelope Valley which has two employees, and if you look at it from the point of view of the two employees at Antelope Valley you get a

perspective on how this is working. Once a year we have an annual

enrollment. We have negotiated the premiums with all of the competing

health plans. And those two Mosquito Abaters down there each get a copy of the booklet describing the different plans and the premiums. And

each can take his/her own choice, they don't have to both agree to be in the same plan, one can be in Kaiser the other can be in Blue Shield or

HealthNet, whatever. The premiums they pay are exactly the same

premiums as those paid by anybody else in the system, including state

employees. So the risks are spread very widely. In fact the typical

health plan is covering tens of thousands of lives, so the risks and the administrative costs are spread over large numbers of people. As a

result our administrative costs for CalPERS, that we charge the

employment groups, is one half of one percent of premium, which is a

real bargain for the small employers. We can do that in part because

our total premium revenues are at $1.4 billion and so at one half of one percent we can accumulate $7 million which is enough to pay for

information systems, data processing systems, financial, and we run the financial clearing house, we take the money in from the districts and

parcel it out to the health plans, the negotiators, the whole bit. Now

a crucial element in this is if you want to have effective pooling of small employers you cannot let it be voluntary, because if you do small employers who are having good experience and low premiums this year will want to stay out while those that are sick and having high costs this year, they'll want to be (unintelligible). And so it's like the principle of health insurance generally, health insurance works when everybody, especially the healthy, is paying for the cost of the sick. And health insurance fails when we break up the risk pool into small pieces.

370 Enthoven: The fourth main idea is what we call "pro-competitive regulation". There does have to be a regulatory framework. One of the important things, for example, is we need collective decisions about which medical technologies will and will not be covered. Here, of course, Oregon has led the way for the nation in addressing these issues in a very constructive way involving people generally. And what we're saying is that nationally we need to have a National Health Board that would oversee a process of technology assessment that could lead to authoritative decisions made on science and value, not politics, that would determine that certain treatments and technologies are either not effective or too costly for what they do and that they are too costly to ask people in general, premium payers and taxpayers, to pay for them.

396 Enthoven: The fifth major idea in this reform proposal is universal health insurance. The fact that some 35 million Americans are without coverage, and that number is growing as the system unravels because of the enormous cost, are without coverage and the fact that millions more have what I call pseudo insurance, that is they have insurance that won't be there if they get seriously ill, has many destructive consequences for the health care system. And I know that the legislators in Oregon are very conscious of this because you have studied it so thoroughly and reached the conclusion that you need universal coverage. So I don't need to expand on that idea. That would be preaching to the choir in your case. We need to have rules so that

everyone who can pay must pay, that there are no free riders, and those people who need help get help.

421 Enthoven: Now with that as background, Senator, let me review and comment on some of the points in your memorandum. Generally speaking by the way, I found your memorandum to be very thoughtful and very

constructive and definitely very much on the right track. But let me

offer a few suggestions. First of all in response to the section that's called HMO's, Health Maintenance Organizations. I'm referring here to

your memorandum dated February 22, 1993. My first point would be I

definitely favor coverage of comprehensive benefits, but I do think it

is also very important to be very careful not to kill this with

kindness. For example when you included dental care and vision care I

am . . . I become a little bit concerned about the costs. Of course

that would be very desirable to cover those items, but perhaps we could limit it to children or perhaps to the poor. I think we just want to be very careful not to overload this, but to . . . I mean I think

prescription drugs ought to be included for example because they are a

part of medical care and I think that a HMO is capable of being a far

better purchasing agent about prescription drugs than I can be

individually because they have knowledge and purchasing power to get

volume discounts and so forth. In the same general category I think it

is very important to level the playing field for all players. For

example we cannot have self-insured programs dumping bad risks on HMO's, which they tend to do, one way or another. And we want to be very

careful not to make HMO's non-competitive.

470 Enthoven: The second point I would offer is it is very important in a system of competing HMO's to standardize the coverage contract, to

standardize the benefit package and to get everyone to offer the same

package. We made the decision to do that here at CalPERS, through the

California Public Employees' Retirement System this last summer and it

led . . . it was very instrumental in our getting very impressive

results in the negotiations we went through this winter. In fact in

CalPERS for the coming year our overall weighted average premium

increase is 1.5%; and for the 690,000 people we cover through HMO's next year's premiums will actually be below last year's premiums.

TAPE 26, SIDE B

032 Enthoven: We standardize the benefit coverage contract for the following reasons. First when you have non-standard benefits you . . .

you confuse the customers, you make it very hard for them to make apples versus apples value-for-money comparisons. Secondly health plans can segment markets. That is Plan A offers wonderful vision care and no podiatry and Plan B offers wonderful podiatry and no vision care. Then when the customers get their brochures the people with bad feet and good eyes, they join Plan B and the people with good feet and bad eyes join Plan A and nobody is standing there in the middle saying I'm going to switch from one plan to the other to save $10-20 a month in premium. And what we want, in order to make the market work, is that a substantial number of people are willing to switch to a lower priced plan to save a premium. Another problem with non-standard benefits is that is a tool for selecting preferred risk. There is a whole folklore and methodology in this industry for how to design benefit packages to select risks. There is also a problem of what I call air pockets, or fear of air pockets. If you are in Plan A and it has been working well and Plan B costs $20 a month less and you don't have standard benefits, you're naturally going to be afraid that Plan B is saving the money by some tricky exclusions in the fine print that you don't have time to investigate and understand. And sometime in the middle of the night, to your horror, you're going to discover that something important is not covered. For example when we did our standardization exercise in CalPERS we found one plan in the bold print said it covered organ transplants, but in the fine print said it did not cover the cost of harvesting and transporting the organ. So people are reluctant to switch plans to save money because of legitimate fears of running into air pockets in their coverage. So we reassure them by standardizing the package.

062 Enthoven: And finally, just from the point of view of

administrative simplicity, your personnel who are executing the program have an awful

lot easier time knowing what's covered and what's not if you have one

set of covered benefits, one set of definitions and one set of

exclusions. The third point is about guidelines. As a general matter I

think it is very important for physicians to study medical practice

patterns and to reach consensus based on good information about outcomes as to what are the best ways to take care of patients. Guidelines

should be developed mainly by physicians who have accepted

responsibility for the cost of care so that we don't get guidelines that are cost unconscious. That is there are many practice patterns that we

see in the fee-for-service sector. Well first, in the fee-for-service

sector we see wide variations in physician practice patterns, five or

tenfold sometimes. Doctor John Windberg of Dartmouth University

pioneered research in this from way back and found from one hospital

area in Vermont to another there might be tenfold variations in the

incidents of tonsillectomy. And no evidence that the people in the high incidents area either needed it more or benefitted more, in fact perhaps rather the contrary. So I think it is important when physicians develop practice guidelines that it be done by physicians who have accepted

responsibility for the cost of care, understand and value that

controlling the cost of care and treating people in economical ways is

definitely a worthy social value that should be respected and supported.

091 Enthoven: My fourth comment has to do with a Health Resources Commission and certificate-of-need and to say that if you structure the competitive market properly, you don't need a certificate-of-need law.

Across this nation in the 70's we had a lot of certificate-of-need laws and they were generally a failure, and in fact in some cases worse than a failure. I recall examples where people built hospitals in a hurry

and got a certificate-of-need and the certificate aquired a great market value, like the value of a (unintelligible) medallion and also that

sometime certificate-of-need laws were being used by the established

provider interests to block (unintelligible) of competitors.

104 Enthoven: And fifth, this section talks about community ratings, and community rating is a very valuable, important and necessary concept.

That is we do need to spread risks widely and get away from the fractionating of the risk pool we have done. But it needs to be done in a system in which there is, if you like, behind the scenes what is called risk adjustment. That is there has to be some pooling and some way of measuring the health risks enrolled in the different health plans and a way of compensating those that got adverse selection at the expense of those that got favorable selection. And the reason for that is because when competition really heats up it will create an incentive for health plans to find a way to make themselves attractive to healthy young people, but less attractive to older people. If you don't do some form of risk adjustment what I'm worried about is that when I walk into the clinic . . . the HMO that I belong to; they'll be thinking "ugh, here comes that decrepit old 62 year old professor, we sure wish we didn't have him around here, we'd like to have his kid." The older I get the less I like that idea. So I think that it is important that we have a compensatory payment system so that they'll say for me, or for someone with a chronic disease who might be a youngster, that a rational and fair payment system is instituted so that the health plan is paid in relation to the health risks that it is covering.

132 Enthoven: Now let me move on to the next section which is the one that is labeled "Health Plan Coordinators". I have a number of comments here. The first one is why do we need "Health Plan Coordinators", which I take to be an Oregon term for let's say what Congressmen Cooper and Andrews bill is called a "Health Plan Purchasing Cooperative".

137 Chair Shoemaker: Right.

139 Enthoven: There are a number of reasons. First, as I remarked earlier, all employers are too small to spread risks to achieve economies-of-scale in administration, "managed competition", to acquire adequate information to purchase intelligently. They're too small to offer individual choice of plans. If small employers and individuals have to wander around in the market place to try and enroll in one or another health plan without a single point of entry then that leaves open great opportunities for health plans to select risks. Let me just comment on each of these points a little more.

149 Enthoven: First of all with respect to the spreading of health risks. I see the purchasing cooperative as the agency that would

conduct the

risk adjustment process and would manage the process of risk selection. So it goes beyond just doing community rating to actively overseeing the whole process. When I talk about a single point of entry I mean what we need is . . . let's say what I have as a Stanford employee, in that once a year we have an annual enrollment for the several health plans that

are offered to us. I read the brochure, I notify the benefits office

and the benefits office notifies my health plan; and the rules are then my health plan has to take care of me for the coming year. It's not as

if I have to go over to the health plan office and say will you take

care of me and give them an opportunity to frown at me or have the

office closed when I want to get there or whatever. You know we joke

about health plans that say yes we do have open enrollment; our

enrollment office is on the tenth floor of a building without elevators. Anyone who can walk up here is free to enroll.

170 Enthoven: Then there are economies-of- scale in administration. As I mentioned earlier with the California Public Employees because all of

this contracting and moving the money around and clearinghouse, the data systems, all of these things are uniform for all 890,000. We achieve

great economies-of-scale. Another important part of "managed

competition" that relates to this is that "managed competition" means

creating what economists call "price elastic demand" and also it means

managing risk selection. By "price elastic demand" basically what we

mean is creating a situation in which a health plan that raises it

premiums risks losing a lot of members and that lowers it premiums has

the opportunity to gain lots of members. So that there are powerful

rewards for driving down your costs and prices. That's what we have in

the normal competitive economy. That's why generally we think of market economies as motivating efficiency and innovation and quality

improvement and so forth. Now in health care, to date, we have usually

had "price inelastic demand". That is health plans can get more money

by raising their premiums rather than losing a lot of their customers.

To achieve "price elastic demand" we need to do a list of about six or

eight things. That is, when I say "price elastic demand", to achieve a

situation in which lots of people are saying "I'd be happy to move from Plan A to Plan B to get a $10 a month lower premium" so that Plan A is under a lot of pressure to find ways to get their costs down. Okay among the ways of creating "price elastic demand" are these.

203 Enthoven: First we need to have employee premium price consciousness. That is that above the price of the low priced plan the employee has to use his own money. Secondly he has to use his own money with net after tax dollars. One of the serious barriers to "price elastic demand" now is that the way the Internal Revenue Code works, and I suppose the Oregon tax laws as well, is that people can pay the premium differences with pre-tax dollars. That means, for example, that a competing health plan in considering whether to lower its premium by a dollar or not recognizes that if they cut their premium by a dollar the employee making the choice is only going to see sixty cents, or some similar amount, after tax dollars. So that greatly attenuates the incentive for the health plan to cut its price.

222 Enthoven: Third, to create "price elastic demand" it is important to standardize the benefits package, for reasons that I explained. Fourth it's important to provide consumers with good information about the quality of care and service in the different plans, so that they'll be willing to switch because they're reassured that the quality of care and service in Plan B, that costs less, is also good. Next it is very important to have individual choice of plan and to give individuals a full range of choices. This is an issue of some controversy I have with many people from the insurance industry, for example. They think that the employer should be allowed to make the choice for the whole group, or that the employer should be allowed to limit the choices. From the point of view of price elasticity of demand individual choice is essential. Suppose we have a group of 25 people, they're with, I don't know, let's say Blue Cross and suppose hypothetically that Kaiser comes and knocks on the door and says "we can do the job for 25% less." Well in a group that size it doesn't really work to have multiple choice of plan. So what happens is they are caught in a kind of unanimous consent situation. Essentially everybody in the group has to agree to switch

from Blue Cross to Kaiser or least enough people that they can coerce the rest into doing so. But some of the people with Blue Cross might be very happy to switch to Kaiser to save the 25%, but other people might say "I have my doctor and I've been with my doctor for many years and I want to be able to stay with my doctor so I don't like that." And so in many situations of small employment groups the 25% price reduction doesn't move the business because of lack of individual choice.

259 Enthoven: Next it is important to do what I described earlier. A risk adjusts the premiums because if Plan A's premium is higher than Plan B's, because they attracted all the bad risks and Plan B got the good risks then it is easy for Plan B to raise its price because its competitors price is higher. And finally, seventh, I'd say to create "price elastic demand" we need a single point of entry. And that is where we get back to the purchasing cooperative again, that presents easy to understand, side-by-side comparisons. Insurers who want to create "inelastic demand", you know want you to one day listen to one salesman who tells you about all of the wonderful little features of his plan and three days later you go and listen to another salesman and hear all the features of his plan, and you don't get to sit down there and just look at a valid apples versus apples, side-by-side comparison. If you're trying to maximize "price elastic demand" one of the things to do is to present to each subscriber at the same time, on a side-by-side basis the information on the different plans. Now the other thing in managed competition I mentioned was risk selection. And here there are, I've already mentioned some of the tools for that, a single point of entry, a standardized benefit package, risk adjusted premiums, monitoring specialty care and (unintelligible) care and monitoring dis-enrollment. So Senator Shoemaker had asked me to discuss "Do you need a purchasing cooperative?" and I think you do in order to get a single point of entry, to achieve the economies-of-scale in administration, (unintelligible) side-by-side comparisons, to do risk adjustments. And also the purchasing cooperative can relieve small employers of heavy administrative burdens such as COBRA continuity. Tthat is there's a federal law that when an employee leaves an

employment group he must be given the opportunity to continue his coverage at the group rate for 18 months or 3 years, depending on the circumstances, and that has become a heavy administrative burden for employers. With a purchasing cooperative the small employers can say to the employee that left the group "you go and deal with the purchasing cooperative and they will discharge my responsibility for me."

307 Chair Shoemaker: Dr. Enthoven, let me interrupt a minute and pose a different model which is being advocated here. That we have, not employers doing the purchasing, but multiple employer welfare arrangements which we would legitimize and make sure that they are financially solid enough to be entrusted with peoples health care fortunes. But that each MEWA would offer the full range of Oregon Standard Plans that are available in a region. And each would offer the same community rated premium to all people within the MEWA. So being in one MEWA or another would not change your choice of plans and would not change the premium that you pay for those plans. The argument is that the small industry oriented MEWA's would be, I guess, more attentive to the needs of the members of each of them than would a large bureaucracy, which you have with only one operating within a region. And if you have more than one MEWA, because there would be competition among them, that the most efficient would survive and the less effective would fall away. So I would be interested in your comments, if you have any, regarding that as an alternative.

330 Enthoven: Well, let's see, the first thing to say is in the past the term MEWA's has been used to describe risk bearing arrangements.

333 Chair Shoemaker: And we'd move from that.

335 Enthoven: Okay, so let's just make very clear we understand each other, that the MEWA we're talking about now would not be a risk bearer because the risk bearing needs to be done by the health plans?

337 Chair Shoemaker: Right.

338 Enthoven: Share it with the providers. This is purely a kind of a brokerage arrangement like a . . . frankly like HealthChoice in Portland. I don't know how HealthChoice in Portland is doing these days, but for many years they were trying to do just that. Then I think the . . . let's see . . . last year when the Bush administration proposed multiple competing, what they called HINS, Health Insurance

Networks, I opposed that idea because it seemed to me that the first best way for a MEWA or a HPIC (unintelligible) to compete would be by shrewdly selecting the good risks and rejecting the bad risks. Now the problem is if you say "well, let's see they are all going to be community rated". And the Bush administration sort of admitted this when I pressed them, if every health plan has to be community rated, which is fine, then you have to have some over-arching risk adjustment mechanism. Now perhaps you could structure it so that you have some overall state-wide agency that is conducting the risk adjustment that is running a pool in which people with favorable selection pay in and people with adverse selection receive money, separately from the MEWA. In my view . . . I mean I think there is something which I . . . which reasonable people might differ . . . in my view it would be more effective to have a purchasing cooperative with a territorial franchise. And for the actual administration of the administrative functions they could contract that out to one or another competing private companies who could lose the contract if they performed poorly. I guess it is partly because I've seen . . . I see so much waste in inefficient brokerage arrangements and in small scale purchasing arrangements that I tend to advocate going to relatively larger scale arrangements to get economies-of-scale, and I see the purchasing cooperative as conducting a coordinated strategy to manage risk selection. Let me just back off on that and say the problem of risk selection has to be taken very seriously. The RAM Corporation did a study in which they found that in any given year the 1% of the population with the highest cost is not the same 1% every year, but different people each year. But in any given year the 1% with the highest cost account for 28% of the total cost that year. So it can be very profitable and productive to skillfully select the good risks and reject the bad risks. And in my view you have to pay . . . to make the system work to reward health plans to provide better care at less cost, you have to pay a lot of attention to this risk selection issue. And I've seen the purchasing cooperative as being the ideal agency to execute a comprehensive program for managing risk

selection. If you have smaller MEWA's, one for drug store owners, one for florists, one for barbershops and so forth I would be concerned about two things. One is how do you do the risk selection/risk adjustment process, and I'm not saying you can't do it, but you have to figure out a way to do it. And the other is I would be concerned about some loss in administrative efficiency.

435 Chair Shoemaker: Thank you.

436 Enthoven: It's a reasonable question on which . . . you know, there are reasonable arguments on both sides. It's not necessarily a make or break issue in the whole context . . . in the whole concept. Should I just go on? I just had a few more comments about the (unintelligible).

441 Chair Shoemaker: Sure.

442 Enthoven: The next section, which was about employers and employees, I saw some reference to income related deductibles and co-pays. Except for people who are really poor I'm inclined to believe that adjusting the co-pays and deductibles for income adds to administrative complexity and it really isn't worth it. I mean we extract more money from higher income people through the tax system and so forth. There are all kinds of problems of deciding what somebody's income is in advance or after the fact. When firms try to do this, you know they might have a secretary and they say if she's got pretty low income so we'll give her one benefit package, but she might be married to a doctor and therefore their combined income might be a good deal higher. I just see it as adding to administrative complexities and think that it would be better to think out what the co-payments should be in terms of the impact on medical practice and the use of medical services rather than bringing income distribution issues into it. I can think of discussions we've had when I was Chairman of the Benefits Committee at Stanford, for example, about co-payments and we'd say for an ordinary doctor visit we want people to be cost conscious so they have to pay $10. For a scheduled pre-natal visit we don't want them to be deterred by money so we have a lower co-pay or no co-pay and so forth.

TAPE 27, SIDE B

038 Enthoven: The other thing under this section that I wanted to

comment on is just I see that you're proposing that tax code would be used to

limit tax free employer contributions. I do think that is absolutely

essential to this whole concept. That is what is so destructive now, is many situations in which the employer contributes substantially more

than half of the fee-for-service plan than on behalf of members in the

most efficient HMO, and that is just the wrong incentive. And I see tax code, I've mainly seen that at the federal level, but it could be at the state level also, as a potentially valuable lever, in effect to say to

employers "in order for your employee health plan to be tax free to the employee you must make a defined contribution that is level with respect to the plan chosen." Finally, just to conclude my prepared remarks, and then let's engage in questions and discussion.

051 Enthoven: You asked about rural areas and I . . . Last week I had the pleasure of being the keynote speaker at a national conference on Health Care for rural areas. And I began by saying "I don't know a lot about

rural health care, but I know enough to know that when you've seen one

rural area, you've seen one rural area, you haven't seen them all." You know there's a lot of uniqueness in circumstances and so forth. But I

think in the proposals that we've offered in our Jackson Hole initiative that there are some tools that could be very valuable to people working on the problems of health care in rural areas. Let me just mention

them. One is the whole idea of "purchasing cooperatives". One of the

reasons that health care has been so inadequate in rural areas is

because the purchasing power is fragmented and you know with each

individual person, without pooled purchasing power. And rural people

usually know about cooperatives because of agricultural cooperatives so being able to aggregate the purchasing power in a region and use it

purposefully, I think is one important tool.

069 Enthoven: The second important tool gets back to the whole idea of accountable health plans for integrated financing and delivery systems. And traditionally what's happened in rural areas, some people have had

insurance, other people have had medicaid and then they kind of pray

that a doctor will fall out of the sky and set up practice in their

little town. And that might or might not happen so they might or might

not have access. If you think in the context of organized systems, then a purchasing cooperative could contract with a system, they could study the needs and define the specifications for a health care system that

they'd like to have, considering the costs and the benefits, and then have a request for proposals and the competition. And you know, maybe Kaiser Permanente, maybe Sisters of Providence, maybe Hospital Corporations of America or PacifiCare or somebody would take the contract and say part of contract would be to recruit and place and support primary care physicians in the following locations to contract for referral care and we'll organize the transportation program and so forth. Something I think is very important if you want get good doctors out into rural areas is that they be a part of an organized system, with good communication, with professional support from the . . . their fellow doctors. Just let me give you an example, or a couple of examples. One, I first saw this in action with Kaiser Permanente in Hawaii, where I visited one of their rural outposts and now the Mayo Clinic has embarked on ensuring everyone within a 120 mile radius of the Mayo Clinic access to a Mayo primary care physician. So when they try to recruit a doctor to practice in a small town, it's a very different proposition from when an individual doctor decides to go out there on his/her own. They'll recruit the doctor and say "now you're going to be a Mayo physician. We'll put you on a salary or otherwise ensure you an adequate income. We'll assure you professional support. If you have a patient who is seriously ill the professionals in the big medical center will answer your phone calls and work with you to talk you through the episode. We'll bring you in to the big medical center for a couple of days of grand rounds and professional stimulation once a month. We'll send out replacements for you when you do come in, or when you're sick, or you want a vacation. In other words, we'll work as a team to make this thing work for you Doctor." And I think that's an enormously more promising approach than simply thinking in terms of insurance.

110 Enthoven: And then a final point about that, and this bears more on the federal law than on state law, that is to do with this question of the taxation of the health benefits. A large employer in Portland may have very extensive and generous benefits for the executives and for the workers, tax free, without limit while a farmer out 20 miles southeast

of Bend, who is self-employed, has to pay for his own coverage, if he can find it with net after tax income. And that has two things wrong with it. One is the company with the big benefits in Portland; those people are not cost conscious in their choices. And the other is, it's unfair that they get a large amount of tax-free employer contribution while the farmer out 20 miles southeast of Bend has to pay for whatever coverage he gets out of his own net after tax income. So if I argue, "well the farmer ought to have the same tax break", which he should than people say, "well if we did, that would break the budget.", and to which I reply "no, just make sure the budget comes out even by limiting the amount of tax-free employer contributions to a level that's adequate to get, you know, a good quality basic plan. And in fact such a limit could save the federal budget say $20 billion a year and it could make things a whole lot more equitable from the point of view of people who are in small employment groups or self-employed, which is what's characteristic of rural areas." That's the end of my organized thoughts. I'd be very happy to continue though with discussion about your questions.

133 Chair Shoemaker: Thank you very much. That was very informative and thoughtful and helpful. We are having a time problem at this end, as well, in that there are both a Republican and Democratic caucus in session now, and those of us on the Committee are late for that. So I think that we probably better wrap it up, although if there are any pressing questions we'll ask them. I see none. We thank you very much for all of your help with this and I hope we may stay in touch as we move along. Adjourns meeting at 5:49 p.m.

Submitted by: Reviewed by:

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