MANAGED HEALTH CARE IMPROVEMENT TASK FORCE

SPECIAL BUSINESS MEETING

Held on

Saturday, December 13, 1997

8:30 A.M. until 5:00 P.M.

at

1201 K Street (Chamber of Commerce Building)

12th Floor Conference Room

Sacramento, California

Reported by:
Beverly D. Toms, CSR No. 1662

COMMISSION MEMBERS PRESENT:

BERNARD ALPERT, M. D.
Bernard S. Alpert, M.D., Inc.

RODNEY C. ARMSTEAD, M. D.
United Health Plan

REBECCA L. BOWNE.
Continental North America

BARBARA L. DECKER
Southern California Edison

ALAN C. ENTHOVEN, Ph.D.
Stanford University

NANCY FARBER
Washington Hospital

JEANNE FINBERG
Consumers Union

The Honorable MARTIN GALLEGOS
California State Assembly

BRADLEY GILBERT, M. D.
Inland Empire Health Plan

DIANE GRIFFITHS
Assembly Speakers Office

TERRY HARTSHORN
PacifiCare Health Systems

WILLIAM HAUCK
California Business Roundtable

MARK HIEPLER
Law Firm of Hiepler & Hiepler

MICHAEL KARPF, M. D.
UCLA Medical Center

CLARK E. KERR
ConsumerFirst

PETER LEE
Center for Health Care Rights

J. D. NORTHWAY, M. D.
Valley Children's Hospital

1 MARYANN O'SULLIVAN
Health Access Foundation
2
JOHN A. PEREZ
3 UFCW Region 8 States Council

4 ANTHONY RODGERS
L. A. Care Health Plan
5
HELEN RODRIGUEZ-TRIAS
6 Pacific Institute for Women's Health

7 LES SCHLAEGEL
Bank of America
8
ELLEN SEVERONI
9 California Health Decisions

10 BRUCE W. SPURLOCK, M. D.
California Healthcare Association
11
DAVID J. TIRAPELLE
12 Department of Personnel Administration

13 RONALD A. WILLIAMS
Blue Cross of California
14
ALLAN S. ZAREMBERG
15 California Chamber of Commerce
16 STEVEN R. ZATKIN
Kaiser Foundation, Govt. Relations
17

18 EX-OFFICIO MEMBERS PRESENT:

19 KIM BELSHE
Department of Health Services
20
MICHAEL SHAPIRO
21 California State Senate

22 DAVID WERDEGAR, M. D.
Office of Statewide Health Planning

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Sacramento, California

December 13, 1997

8:30 a.m.

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CHAIRMAN ENTHOVEN: Please take your seats. Good morning.

All right, we have an awesome schedule this morning, so let's get going. Mr. Lawrence. The Task Force will call roll.

MS. SINGH: Good morning, guys. It's another day.

Alpert.

DR. ALPERT: Present.

MS. SINGH: Armstead. Bowne.

MS. BOWNE: Here .

MS. SINGH: Conom. Decker.

MS. DECKER: Here.

MS. SINGH: Enthoven.

CHAIRMAN ENTHOVEN: Here.

MS. SINGH: Farber.

MS. FARBER: Here.

MS. SINGH: Finberg.

MS. FINBERG: Here.

MS. SINGH: Gallegos. Gilbert.

DR. GILBERT: Here.

MS. SINGH: Griffiths. Hartshorn.

COMMISSIONER: He's here.

MS. SINGH: Terry, are you appearing --

COMMISSIONER: I'm sorry.

MS. SINGH: Hauck. Hiepler. Karpf.

DR. KARPF: Here.

MS. SINGH: Kerr.

MR. KERR: Here.

MS. SINGH: Peter Lee.

MR. LEE: Here.

MS. SINGH: Northway.

DR. NORTHWAY: Here.

MS. SINGH: O'Sullivan.

MS. O'SULLIVAN: Here.

MS. SINGH: Perez. Ramey. Rodgers. Rodriguez-Trias. Schlaegel.

MR. SCHLAEGEL: Here.

MS. SINGH: Severoni. Spurlock.

DR. SPURLOCK: Here.

MS. SINGH: Tirapelle. Williams.

MR. WILLIAMS: Here.

MS. SINGH: Zaremberg. Za tkin.

MR. ZATKIN: Here.

MS. SINGH: Ex-officios: Belshe. Berte. Knowles. Rosenthal. Shapiro.

MR. SHAPIRO: Here.

MS. SINGH: Werdegar.

MR. WERDEGAR: Here. I was here yesterday, too.

CHAIRMAN ENTHOVEN: All right. A quorum -- a quorum is present. First let me say that yesterday we accomplished a great deal. The following papers were

adopted: Physician-Patient Relationship. Financial Incentives for Providers in Managed Care. Academic Medical Centers. Expanding Consumer Choice. Improving the Dispute Resolution Process in California's Managed Care System.

In addition, recommendations one through four in New Quality Information Development were voted on.

Members must still consider the fifth recommendation and the findings section. Also I'd to like to note that members voted to allow the Public Perceptions and Experiences with Managed Care paper to be included in the main report without the requirement that it be adopted by the Task Force. Therefore, that paper will not be voted on today.

We have a -- a very demanding schedule today. Some members have told me that they must leave by 4:00 in order to catch a plane that gets them to where they're going. So, I'm afraid that as we get to about 4 o'clock we're going to suffer some defections. So, I want to try very hard to see if we can get this done by then, recognizing that it's not going to be easy.

The staff distributed yesterday the proposed adoption schedule. I've been kind of adjusting as we go here. What I'm proposing is that we try now quickly to finish up the New Quality Information.

First, if there are members of the general public who want to speak and haven't exhausted themselves yesterday, then we perhaps will do that, also. Then

we'll get to Regulatory Organization, to the Pract ice of Medicine, to Consumer Information and Involvement, Vulnerable Populations, and Integration and Women.

So, that's where we are. Have we received any speakers' comments?

MS. SINGH: No, we have not.

CHAIRMAN ENTHOVEN: Anyone from the general public who wants to address the Task Force needs to fill out a speaker's card which, among other things, says which topic you want to address.

As I said yesterday, to the members of the general public, we have to move fair ly expeditiously and that would involve, among other things, consolidating if different people from the same organization or point of view want to say the same thing, to agree on one person to say it.

MS. O'SULLIVAN: Can you repeat that order again? I'm sorry.

CHAIRMAN ENTHOVEN: Yes. We'll try to finish up quickly New Quality Information, then Regulatory Organization, Practice Of Medicine, Consumer I & I, Vulnerable Pops, Integration and Women.

MS. O'SULLIVAN: Than k you.

CHAIRMAN ENTHOVEN: And we're going to have to -- so, I'd like to -- so, Stephanie -- I'm sorry, Alice, do you have -- and Phil, do you have anything to --

MS. SINGH: I think just -- members, we just need to make sure if you did not pay for your lunch yesterday

that you please pay Lawrence. It's very important. I think there's a couple of people that are outstanding, and also that you pay for your lunch today.

I wrote the check to La Bou today, so please make sure you pay, otherwise I may be visibly knocking on your door.

CHAIRMAN ENTHOVEN: Yeah, we -- we've got your names this time.

And, Phil, do you have -- Alice said what Phil was going to say.

MR. ROMERO: Exactly.

MS. SINGH: Move to tab item 6.

CHAIRMAN ENTHOVEN: Item 6.

MS. SINGH: Members, tab item 6.

CHAIRMAN ENTHOVEN: New Quality Information.

Let me call your attention to the fact that we received yesterday a somewhat revised line in/out version. We're on page 4. The last item was called, "Ensure basic safety standards for patient care."

Clark, would you just talk to us a bit about the reasons for the change since it's a fairly substantial change.

MR. KERR: First of all, I want to mention what you have is not correct. The line item -- the line out is not complete. We should also have lined out B and C.

And so, what we're replacing those with is -- is the new A, which is all underlined, which you have there, passed out what you need. Essentially, what

1 happened is, as we talked about earlier, we have an
2 issue in this country with tremendous variation in
3 adverse events, tremendous variations in surgical
4 outcomes and all sorts of things, very tremendously
5 between hospitals. It's sort of the hidden -- the
6 hidden health care problem.
7 We lose sometimes 100,000 people a year due to
8 adverse events in health care. This may be conservative
9 according to Lusha Leap (phonetic) and others. The
10 issue is the effort to try and establish some basic
11 minimum safeguards so the public will actually be
12 assured of some sort of safety.
13 I was in Orlando giving a speech along with Lusha
14 Leap, who is the guy from Harvard Medical School who's
15 the leader in this area and told him about the idea; he
16 says it's very admirable, but he thought it would not
17 work. And w hat he basically said is that the problem is
18 that these events are tremendously under-reported in
19 health care, and he gave this example.
20 He said one out of ten Americans who are
21 hospitalized suffer an adverse drug reaction. And he
22 said, however, if you go to an academic teaching
23 hospital, which we're, of course, among the best in
24 terms of keeping track of data, the self-report level is
25 point 21 percent -- so, with what the health care
26 industry is doing is reporting about one o ut of 50
27 incidences of adverse events. And basically his concern
28 was if we went ahead at this point to try to establish

1 standards at this time, you have tremendous problems in
2 reporting from the health care industry, and therefore
3 by trying to move ahead, the first step was doing the
4 reporting and moving ahead and we would simply have the
5 health care industry hide what's happening, what's going
6 on.
7 So, he suggested wha t's very important is
8 schedule a study group like they've done in the State of
9 Massachusetts, have an error reduction commission or
10 error reduction coalition that involves everybody,
11 to release a revised study on this issue and try to
12 getting the reporting up to snuff. He said that alone
13 is the first step, it is not enough. He says something
14 like we're talking about may be necessary down the road.
15 But he said that should be a first step.
16 So, what we're proposing here is that t he New
17 State Agency, whatever it's called, set up a blue ribbon
18 panel or Task Force of some sort involving the various
19 stakeholders, as we've discussed here, to look at the
20 issues to try and reduce errors, adverse events and the
21 tremendous differences that we see in the State of
22 California among risk adjusted mortality and morbidity
23 and surgical outcomes. And this is an important first
24 step to take, and then we can see where that goes and
25 where that leads at this point. So, tha t's our
26 recommendation.
27 CHAIRMAN ENTHOVEN: Okay, discussion. Steve
28 Zatkin.

1 MR. ZATKIN: I support the effort. The question
2 I have has to do with who -- who would sponsor this?
3 And it's a question that goes back to a discussion
4 yesterday, and also I think would be relevant to our
5 decisions about the regulatory -- the role of the
6 regulatory agency versus other agencies. So, I would --
7 I guess I'd ask that we cons ider the question of which
8 agency does this in the context of our decision around
9 the role of the agency we're going to talk about later.
10 For example, if we adopt number 1, Alternative 1,
11 or perhaps even Alternative 2, I would argue that --
12 that this kind of alternative you're talking to, I'm not
13 sure which alternative, in the regulatory paper, that
14 this kind of activity is more closely related to D.H.S.
15 which is supposed to monitor safety in health care
16 facilities than it is th e managed care agency.
17 I think there's just not been real clarity about
18 which entity of government should have primary
19 responsibility for protecting the public with respect to
20 the liberty systems. We have D.H.S. which licenses
21 hospitals. Most of what you have in here relates to
22 hospitals, not all of it. And then -- then of course
23 you have the medical group area and then you have health
24 plan regulation, which is really one step removed.
25 So, all I'm saying is that -- let's -- if we say
26 the State agency managed care, and then we go back later
27 and deal with the role of that State agency, we need to
28 make sure that -- that it's consistent.

1 MR. KERR: The argument I think would be this is
2 not taking place in unfettered, unmanaged care and
3 theoretically one of the ideas, one of the theories
4 behind managed care is that we get in and manage these
5 types of events.
6 MR. ZATKIN: It was not taking place in--
7 MS. FARBER: This is all vital, please.
8 MR. ZATKIN: I thought you meant the problem.
9 The problem --
10 MR. KERR: The problem is the health care
11 problem.
12 MR. ZATKIN: The problem is across --
13 MR. KERR: Right, it's across.
14 MR. ZATKIN: It's not just --
15 MR. KERR: But one of the advantages
16 theoretically of managed care, you can get in and try to
17 manage both the good and the bad, and this is one of the
18 major problems.
19 CHAIRMAN ENTHOVEN: Nancy Farber.
20 MS. FARBER: I think that this kind of activity
21 is going on in hospitals in varying degrees. Now I
22 disagree with you when you say it's not happening. It
23 is something that is taken very seriously at the
24 hospital where I work. I worked at Kaiser previously,
25 it was taken very seriously there, and at UCLA where I
26 worked before that, and Hope Memorial Hospital
27 Presbyterian, Newport Beach before that.
28 I agree there are some institutions that don't do

1 a good job of how they handle it. It is something that
2 is already covered by the Department of Health.
3 Patients have recourse that are there now. Probably
4 what is needed is the closing of the loop in the sense
5 that data is shared and reduction, techniques and
6 methodology are shared as opposed to each hospital doing
7 it in isolation from each other.
8 But I disagree with you when you say this
9 activity is not under way at this time. It's m ost
10 definitely under way.
11 There are definitely activities under way. The
12 problem -- the problem is not diminished -- according to
13 the people of Harvard, it is not diminished. In fact,
14 they think it might actually be getting worse. Although
15 there are efforts -- I heard about this, that there's
16 some institutions that definitely do a good job, but
17 overall you have a major problem,
18 MR. ROMERO: Some people might posit the point of
19 view that managed care has made it worse be cause of the
20 reductions in staffing that has resulted from the
21 decreased reimbursement.
22 MS. FARBER: Then that would be an argument for
23 putting in the managed care agency.
24 MR. ROMERO: I think the Department of Health is
25 probably doing a reasonably good job.
26 MS. FARBER: I hope you're not serious, based on
27 the actual statistics in what's happening in the
28 population.

1 CHAIRMAN ENTHOVEN: David.

2 MR. WERDEGAR : I was going to agree to the

3 preceding comments. I think there is a danger of

4 thinking of this new agency, whatever it might be,

5 supplanting the -- the important responsibilities of the

6 private health services, the Office of Statewide Health

7 Planning and a minimum -- for this to be adopted I would

8 say that it should be in coordination with the

9 Department of Health Services and the Office of

10 Statewide Health Management, but I think Steve Zatkin's

11 comments are really quite perti nent. One has to really

12 think carefully about what the functions of the new

13 regulatory agency for managed care would encompass, and

14 what those responsibilities would be vis-a-vis in

15 particular a strong and well functioning Department of

16 Public Health or Department of Health Services. And I

17 include the functions of the Office of Statewide Health

18 Planning along with that.

19 CHAIRMAN ENTHOVEN: Clark, would you accept as a

20 friendly amendment to -- to just substitute for the

21 State's agency for regulating managed care just

22 Department of Health Services?

23 MR. KERR: What about if we did both, that

24 they -- that together they do that. I think it is also

25 for protection of managed care.

26 CHAIRMAN ENTHOVEN: Peter Lee.

27 MR. LEE: That being a way to do State agency for

28 regulated managed care for Department of Health Services

1 and OSHPD. One thing we'd want to encourage is
2 cross-coordination between these so it's mutual
3 conveners.
4 CHAIRMAN ENTHOVEN: Managed care agencies for
5 managed care in coordination with D.H.S.
6 MR. LEE: I wouldn't say coordination; those
7 agencies do the convening. So, I say --
8 MS. SINGH: Why don't we just name one agency and
9 have the other have one agency leading it so we don't
10 have a dispersed function, dispersed accountability?
11 So, one agency leads it and I would -- I go along with
12 Clark's view that the agency for managed care -- because
13 there is a -- the reason that I am an advocate for
14 managed care is because the potential for accountability
15 is greater there, so I'd like to endorse that. And then
16 have the other agencies as part of the Task Force of the
17 blue ribbon panel and having a stock role there.
18 CHAIRMAN ENTHOVEN: Michael Karpf.
19 DR. KARPF: I think we are getting to the
20 fundamental agency issue that this thing is bringing up
21 about this new agency, and that is what is it? If the
22 fundamental princip le for this new agency, the driver is
23 quality, we should then make sure that we don't fragment
24 both the collection and the reporting of data and keep
25 it siloed in different places because you're never going
26 to have a cohesive look and cohesive reporting
27 mechanisms.
28 So, let's not overburden it, but let's also not

shortchange it by keeping some functions in some agencies that have done reasonable jobs, but haven't come to the level of public perception that some of us want.

And I think -- I mean this new agency is involved in quality process improvement, outcomes, reporting and essentially it's centralized those type of functions, and this isn't different than quality issues. Infection rates, you know, how you do these are quality indicators, and nothing more than that.

CHAIRMAN ENTHOVEN: So, would this be satisfactory then, "State agencies for regulated managed care in coordination with OSHPD and DHS"?

MR. LEE: Yes.

MS. SINGH: Is there objection?

CHAIRMAN ENTHOVEN: No objection to that. All right, is there a motion?

MR. LEE: Move adoption.

CHAIRMAN ENTHOVEN: Second?

DR. RODRIGUEZ-TRIAS: Second.

CHAIRMAN ENTHOVEN: All right, seconded by Helen Rodriguez-Trias. All in favor, please raise your right hand.

MS. SINGH: Those opposed? 24 to zero, the recommendation is adopted.

Now we have to go back and complete this by adopting the findings, which is page -- page 1.

MR. LEE: Move adoption of the findings.

MS. SINGH: Mr. Chair, before we go there, I don't know the appropriate way to do it, but I would like to move that we reconsider recommendation 4. Due to the dis-- depleted group that was here late last night to vote on that, I'd like to take a vote to see if we can reconsider it.

MS. DECKER: That was voted on twice.

MS. FINBERG: That was.

MS. SINGH: It was voted on a very depleted vote. Members, for clarification purposes, we had a member making the motion for reconsideration. It requires a second and a simple majority of the total authorized membership, 16 votes to reconsider it. A motion then will have to be made if it is adopted for your consideration to then adopt it, and then we'll again have to vote on it.

So, at this point we have a motion on the floor to reconsider. Do we have a second?

MR. LEE: Second.

HON. GALLEGOS: Mr. Chairman, just for purposes of discussion, one of us was not physically depleted here last night, but was mentally depleted. Like the rest of us.

Did we not vote a reconsideration on this issue last night, and it lost?

MS. SINGH: That's correct.

MS. FARBER: So, we're going to vote on it a third time?

CHAIRMAN ENTHOVEN: Well, because the paper -- because we d id not finish this paper yesterday, it can -- this can be open for reconsideration today. Under other circumstances that would not be the case, any paper or any motion that failed yesterday. But we -- we're now working on the findings. So, we have a second.

Those in favor?

MS. FARBER: I have a question. How many times can you reconsider the same vote under parliamentary procedure?

MS. SINGH: Generally --

MR. LEE: We've already voted on it.

MS. SINGH: Gen erally, reconsideration is asked for once, and if it fails that's it. Yesterday we did it twice to make sure we had a sufficient number of votes. Today we will vote for reconsideration. If it does not get 16 votes, that's it, this -- this recommendation has not been adopted.

MS. FARBER: I just want to clarify that yesterday the motion failed, we requested reconsideration, voted on it a second time, and today we're going to be asked to vote on it a third time?

MS. SINGH : Well, today we'll be asked to consider it for the third time. Members that don't feel it's appropriate can vote against this motion. Those in favor of reconsidering number 4 -- not adopting number 4, but reconsidering -- reconsidering recommendation

number 4, please raise your right hand.

Those opposed?

14 -- or 15 to 10. The motion to reconsider has failed. We now need to have a motion to adopt the findings.

MR. LEE: So moved.

CHAIRMAN ENTHOVEN: Second? Second.

Motion and a second to adopt the findings.

MS. O'SULLIVAN: I have an amendment to ask for. On page 1 --

COMMISSIONER: Use the mike.

MS. O'SULLIVAN: On page -- on page 1, the -- the paragraph just below the bullets, it says, "State's efforts to data collection are limited by legislative micro-management and other things." And I -- I'd like to change that -- the problem with data collection I think ha sn't been so much where the Legislature is coming in micro-management as if they haven't given broad authority. And so, it's been -- we want to refer to the Legislature as being part of the problem. I would say it's limited by a lack of bold action by the Legislature.

MS. SINGH: Get a different microphone.

You have to talk right directly into that one.

MS. O'SULLIVAN: Okay.

MS. SINGH: Needs a little help.

COMMISSIONER: Limited by.

MS. O'SULLIVAN: -- by a lack of bold action by

the Legislature or broad action by the Legislature or comprehensive action by the Legislature, whatever is the group's pleasure. I think micro-management, at least where they're micro-managed, we've gotten some data.

CHAIRMAN ENTHOVEN: All right. Let's just take a show of hands to see if people want to substitute "lack of broad action by the Legislature" for "legislative micro-management.

MS. O'SULLIVAN: All right, Becky. Wait a minute, must be something wrong with this.

MS. SINGH: Those opposed?

MS. O'SULLIVAN: I'd like to reconsider my amendment.

MS. SINGH: You did not secure the majority of the vote.

CHAIRMAN ENTHOVEN: Okay. So, --

MS. SINGH: At this point we do have a motion and a second on the floor.

MR. ZATKIN: I'm going to say I think it's factual that State efforts at data collection have been limited, because each data element i s included in statute.

MS. SINGH: Use the mike. And would you repeat that language, Mr. Zatkin?

MR. ZATKIN: Instead of micro management --

MR. LEE: Steve, can you use the mike?

MR. ZATKIN: State data efforts at -- State efforts at data collection have been limited because

each data element is included in statute; that's factual.

CHAIRMAN ENTHOVEN: Right.

MS. SINGH: Each data element is included in statute, yeah, that is accurate. That is the problem.

MS. O'SULLIVAN: Yeah.

MS. SINGH: Members, I hate to do this, but since you already have a motion on the floor, I propose that Mr. Zatkin proffers to amend the findings to reflect that language. Can we have a second, please?

MS. SEVERONI: Second.

CHAIRMAN ENTHOVEN: Those in favor of adopting the amendment, raise your right hand.

MS. SINGH: Those opposed? The amendment is adopted. Members, can we vote on the main motion; it's already been moved and seconded. Those in favor of adopting the amended findings, please raise your right hand.

Those opposed?

The motion is adopted 25 to zero. Therefore, the findings are now adopted.

I believe the Chairman wants to move now to Government Regulatory Organization, which is tab item number 6. Is that correct, Mr. Chair?

CHAIRMAN ENTHOVEN: Yes.

MS. SINGH: Governmental Regulation, tab item 6E, members.

CHAIRMAN EN THOVEN: Okay. May I -- okay, thanks.

COMMISSIONER: Could I clarify, what's the time allotted for this?

MS. SINGH: We have an hour and a half delegated to this topic.

MR. ROMERO: Okay. All right, thank you. There was -- there was a great deal of discussion of this paper at the last meeting, and options were flying and I attempted to -- to build a big tent and -- and explicate all those options. Let me note that -- let me turn to the recommendations which begin on page 8 and secondly on page 9.

Number one, streamline regulatory oversight.

There -- while straw votes revealed a very strong support for a new organization, regulatory organization, the scope of that -- the jurisdiction of that organization, we didn't hit that nail on the head. Therefore, I created three alternatives and I apologize for the line-in/line-out, but I found -- I found after I wrote it that I wasn't bei ng -- I, myself, was not being as clear as I wished to be.

To aid you in understanding those three alternatives which I will describe orally in a second, I also have a brief one-page handout. This is not new information, this is just a -- meant to be an aid to comprehension.

Will you pass those around, Alice. Very briefly, Alternative One is in essence to -- to make the scope of this new organization Knox-Keene plans only. In

1 essence, it's a renamed or a reorganized Department of
2 Corporations.
3 Alternative 3, I'm jumping for a moment, is --
4 would be to fold virtually every segment of the health
5 care industry into this new organization. Including,
6 for example, medical groups, individual clinicians,
7 health care facilities, etcetera. I referred to
8 Alternative 3 as the big bang option.
9 The Alternative 2 is a phased approach. In
10 essence, starting from a base of Alternative 1,
11 Knox-Keene plans only. The Alternative 2 calls for the
12 Governor and the Legislature to successively over the
13 course of several years consider expanding the scope of
14 this organization to include first, segments of the
15 industry not currently directly -- directly regulated
16 like medical groups, later PPOs and then finally
17 individual providers and facilities.
18 If -- if my little one-page table has gone around
19 yet, I think it has, okay, again this -- this table is
20 simply meant to provide a graphical summary of -- of
21 those three alternatives. There's no -- no new
22 information here.
23 If you read down the columns, you'll see the
24 left-most column, Alternative 1, under that alternative
25 be scope of the agency would be restricted to Knox-Keene
26 plans only.
27 Under Alternative 2, it would include that
28 initially at one year, segments not directly regulated,

1 like medical groups, would be examined; at two years
2 PPOs and EPOs would be considered, examined -- and when
3 I say "examined," I mean examined for -- for inclusion
4 if the Governor and the Legislature so direct, and then
5 subsequently -- subsequently not being specified, but
6 only three years thereafter individual providers and
7 facilities.
8 By contract Alternative 3, the big bang would
9 call for all to be included initially.
10 Now, let me just make one other procedural
11 comment before I yield the microphone. As was just
12 illustrate d in the new information development
13 discussion, what you decide on this will have downstream
14 implications in many other papers.
15 For example, what organization would be
16 responding or convening a number of each work groups; I
17 will direct your attention to a chart that was just
18 handed out a few moments ago. Margaret Laws, Sara
19 Singer and the folks at Stanford have summarized the
20 list of working groups or blue ribbon commissions across
21 papers that we are -- that we are recommend ing be
22 included.
23 MS. SINGH: So, this is actually a revised
24 version on the request of Peter Lee yesterday, he asked
25 us to consolidate as much as we could to the working
26 group, so it's this smaller number here.
27 COMMISSIONER: Thank you, sir.
28 MR. ROMERO: Who the customer for these blue

ribbon commissions is will clearly be dependent upon the decision you make about the scope of jurisdiction of this new regulatory organization. I would like to note that because of those interdependencies I as long-suffering Executive Director would like to recommend that you authorize me to update any decisions you make about any other working groups to reflect the decisions you make here today as opposed to going back and revisiting all those decisions later. I'll take questions or comments.

CHAIRMAN ENTHOVEN: Bill --

MR. ROMERO: Yeah.

CHAIRMAN ENTHOVEN: Actually --

MR. HAUCK: It's just a procedural question. You know, I feel that PPOs and EPOs --

COMMISSIONER: Use the mike.

MR. ROMERO: He needs the mike.

MR. HAUCK: I think we need to break this down a little bit because one issue is, for example, PPOs and HMOs are two regulated separate agencies and it's a question of whether we should combine them in a new agency.

CHAIRMAN ENTHOVEN: Right.

MR. HAUCK: Medical groups, on the other hand, are not regulated, so you have to get over, I think , the threshold question should they be regulated. What are the pros and cons of that? So, I just don't want to confuse the issues, and I think we need to address them

one at a time.

MR. ROMERO: Good. Fair.

MS. FARBER: I adopt --

MR. ROMERO: Just in terms of --

MR. HAUCK: It's a big difference. And hospitals are regulated, but they're not -- should they be included? So, I think we need to start with t hose. And regulated, it all should have threshold questions, should they be regulated, and the question is where?

MR. ROMERO: In the terms of this chart, treat the second, third and fourth lines as each independent element of Alternative 2 that you can decide upon in turn, right.

CHAIRMAN ENTHOVEN: Alpert.

DR. ALPERT: A question about the individual providers at the facilities. When you're in Alternatives 2 and 3 when they get folded underneath or into the new a gency, does this envision the existing regulatory agencies or -- or sub-groups like in DAA, all the medical board and so forth and so on dissolving and that becoming new under here, or simply taking those subsets and putting those subsets underneath a -- under a new umbrella.

MR. ROMERO: Yeah, just as a purely practical issue, I would assume it would be transferring those organizations to the new one, not re -- not reinventing the wheel.

DR. SPURLOCK: Just again on a pro cedural

question, I'm not sure going back to what Alain was talking about, how we're going to do this. Could you vote for, say, Alternative 1 and then vote for sections of Alternative 2, depending on, you know, fallout on the issues? I actually think we heard some kernel of movement about consolidating the quality functions but not necessarily entire departments. So, if you took out the aspects of quality review from dif ferent agencies and we talk about, you know, the quality audits later in the paper, could that function presented in Alternative 2 be adopted individually without having to adopt the entire Alternative 2?

MR. ROMERO: Sure. I mean, these alternatives are just my attempt to interpret the conversation the last time and subdivide them any way you wish. And I would recommend specifically that you subdivide Alternative 2 at least along the lines of 3 rows on my chart. Otherwis e --

DR. SPURLOCK: Individual sections and any amendments to any section in Alternative 2.

MR. ROMERO: Great.

CHAIRMAN ENTHOVEN: Michael.

MR. SHAPIRO: I just have a comment on the opening paragraph on 1. Agency -- the previous iteration paper indicated an entity that would be under the Governor. Without discussion or support in the paper you've added the Business Transportation and Housing Agency, which is the current situation. One --

one of my experiences the first day I met Gary Mendoza, he brought the General Counsel of DPT&H to approve all business and legislative activities, and that was Keith Bishop.

I don't think we've endorsed the agency level. I would prefer Health or Consumer Affairs, I'm not sure we need to specify what agency it's under or whether it's even under an agency, but simply that we're looking at an office there so we don't have to debate the best agency. But it's a critical factor in your budget, your policy. My view is the business agency shouldn't be dictating to a health agency.

MR. ROMERO: Let me make -- facilitate my limiting recommendation for the purposes of this discussion right now. Why don't you assume that -- that any references to the location of this organization are omitted. When we discuss leadership later, I will recommend you decide whether you want to decide on that issue then.

MR. SHAPIRO: W ell, I'd like to move we take out DPT&H now.

MS. FARBER: I second that.

MR. WERDEGAR: I have the same comments to make, because I think it's going to be important to explore. As we talked about, a commission form of government is one model, having a department that's at agency level, where the Director is at cabinet level. And an agency level or cabinet level department would be a lot more

plausible at comparison than a recreation of what we have now.

MR. ROMERO: Okay, just -- for the sake of clarity, because we've got several independent variables in play at the same time. My recommendation is we try to decide on the -- on what this organization should regulate, then decide if you choose to decide where it should be, personally.

MR. HAUCK: I agree with that and I think this recommendation says where it should be.

MR. ROMERO: And that can be deleted.

MR. LEE: We're all t reating that as out?

MS. SINGH: Without action, I'll just go ahead and delete then Business Transportation and Housing Agency.

CHAIRMAN ENTHOVEN: Nancy Farber.

MR. ROMERO: That takes care of it.

CHAIRMAN ENTHOVEN: Steve Zatkin.

MR. ZATKIN: I have kind of a micro level question.

In Alternative 1 you say, "Current health staff of the DOC may be transferred to the new regulatory authority." And in the first paragraph of Alternative 2 in which case health care service plans also would be regulated, you say, "Appropriate health care of DOC will be transferred to the regulatory authority." I think it ought to be consistent.

MR. ROMERO: You're right.

MR. ZATKIN: And I think it should be "will" rather than "may."

MR. ROMERO: I agree.

CHAIRMAN ENTHOVEN: All right, what do you have in mind? We vote on 3 versus 2 or do you have a --

MS. SINGH: You should pro bably vote on 1, 2 or 3.

MR. ROMERO: Yeah, exactly. That would be my recommendation. Now, if -- given the spirit of Allan's comment, if, Allen, you'd like to discuss 2 first because you know what you're voting on.

MR. ZARENBERG: I'd just like to have a discussion on whether medical groups should be regulated if they're not now and hear the pros and cons before we decide where to put them. There's people with more expertise on this than me, and I'd just like to hear the pros and cons.

MS. GRIFFITHS: I definitely agree with that. Well, I think the thing with the medical groups, there are a number of issues like solvency, quality audits, disclosure of payment methods. There are two or three other issues on that list.

MS. FARBER: Utilization planning standards. Utilization management standard.

DR. KARPF: Can we have a definition of "medical group"? Is there a definition? Are we talking about anyone who calls themselves a medical group? Are we talking about more than five practitioners?

CHAIRMAN ENTHOVEN: Here it is, it's a risk -- Michael, I apologize, we probably don't have a good definition here, but I understand it to be a risk bearing entity that subcontracts from Knox-Keene plans on a risk bearing basis.

MS. FARBER: I think that's an excellent definition.

DR. KARPF: Irregardless of size.

CHAIRMAN ENTHOVEN: It could be an IP A or so-called group.

DR. SPURLOCK: Is it any amount of risk? If they -- take one health plan adds two percent of their income, so they're going to be regulated for that two percent of their income? I mean, is there a threshold for how much a medical group needs to take?

CHAIRMAN ENTHOVEN: Well, Bruce, just to be arbitrary, I think, by law, if they take any from a DOC regulatory, they have to, because already the health plans are supposed to see to those things.

DR. KARPF: That's the point.

CHAIRMAN ENTHOVEN: Right.

MS. FARBER: But the health plans -- the only power they have over the health -- the medical group, in reality, is to say "yes" or "no" to them. And if they are the largest sole provider, you know, to any degree of organization, the chances are in that area they're not going to say no, and they have no regulatory authority over those health plans.

1 CHAIRMAN E NTHOVEN: Nancy, when you say "no," in
2 principle the health plans are supposed to be overseeing
3 the -- the medical groups. You're saying in practice
4 it's not happening?
5 MS. FARBER: In practice, in the Bay area, one
6 medical group that's noticeable that -- where the health
7 plans don't have much impact on how they carry out those
8 contracts.
9 CHAIRMAN ENTHOVEN: Right.
10 COMMISSIONER: You might remember one of the
11 leaders who thinks the relationship between a physician
12 and patient is just about the same as yours with an
13 airline pilot.
14 CHAIRMAN ENTHOVEN: Anyway, I'm just trying to
15 clarify the point you're making is in fact it's not
16 happening.
17 MS. FARBER: That's right.
18 CHAIRMAN ENTHOVEN: Right, okay. Tony.
19 MR. RODGERS: I that any group that bears risk,
20 regardless of the balance risk, has to have certain
21 capabilities and meet certain directives and they should
22 be -- there should be an oversight process for that.
23 Because groups often contract with multiple plans, it
24 creates a problem for the plans and it's to be
25 consistent, that process, and it seems reasonable that
26 this oversight agency would take that responsibility for
27 the purpose of standardization and assurance that those
28 relationships and the risks that's being borne, that

1 those groups have that capability.
2 It doesn't matter whether it's 2 percent or 50
3 percent or 80 percent; you have to have certain
4 capability if you're going to manage medical risk of
5 individuals that have been assigned to you.
6 MR. ROMERO: I'd just like to --
7 CHAIRMAN ENTHOVEN: Warren Barnes, I invite you
8 up to the microphone.
9 MR. ROMERO: I'd like to ask you a question on
10 this point.
11 CHAIRMAN ENTHOVEN: Warren Barnes is -- I don't
12 know your exact title -- Senior Corporate Counsel for
13 Department of Corporations. He's testified before this
14 group before, I think in Fresno and I think el sewhere,
15 MR. ROMERO: Warren, would you mind just
16 summarizing for us how -- how do you see the Knox-Keene
17 plans to oversee medical groups at present and if there
18 are any thresholds you use for -- for determining -- for
19 defining a risk -- the amount of risk that would trigger
20 a limited Knox-Keene or Knox-Keene requirement.
21 DR. KARPF: Or size, too.
22 MR. ROMERO: Right. Risk and size, right.
23 MR. BARNES: I'll divide that into two separate
24 questions. The Department's rev iew of medical plans or
25 IPAs is directly -- is currently non-existent, as you're
26 aware. Our review of the licensed Knox-Keene plans
27 oversighting a medical group occurs at three phases.
28 Initially licensure and in connection with any

1 subsequent material modification that would raise the
2 issue in a natural manner.
3 Secondly, for the medical surveys once every
4 three years and more frequently, if necessary. And then
5 third, in connection with the particular consumer
6 complaint there may be occasions to look at that
7 relationship in that particular context insofar as
8 limited licensure is concerned. The requirement for
9 limited licensure arises only when an entity such as,
10 for example, a medical group wishes to be at risk for
11 all covered health care services, professional and
12 institutional. Does that respond to the question?
13 MR. ROMERO: I appreciate it.
14 MR. ZATKIN: The accountable entity is th e health
15 plan and to the extent that you review the activities of
16 the plan insofar as it has a delivery system, then you
17 are reviewing the medical group. And in the absence of
18 having different standards for the medical groups than
19 you have for the plans, if you license the groups
20 presumably the review would be the same.
21 I mean, I think the issue might go to the
22 standards that are applied, not to the fact that you
23 don't license the groups. Because in order to review
24 the plan s, you have to review the group activity.
25 MR. BARNES: If that's a question --
26 MR. ZATKIN: Then I'm asking, isn't that true?
27 MR. ROMERO: Yes or no, please.
28 MR. BARNES: I wish to re -- my answer is yes and

1 no. In my view, conceptually the Department does not
2 regulate the medical groups or the IPAs. Secondly,
3 there are no specific standards applicable to medical
4 groups or IPAs. However, you're correct to the ex tent
5 that there are reviews of the health plan. If the
6 health plan oversees the medical groups and IPAs in a
7 workmanlike way and results in -- in some degree of
8 compliance on the part of the medical group or IPA.
9 Otherwise, the health plan, itself, is out of compliance
10 and the Department may take action against the licensed
11 health plan.
12 MR. ZATKIN: In order to review the plan, don't
13 you review the activities of the groups when you do your
14 audits?
15 MR. BARNES: We gathe r evidence, yes. To the
16 extent that it impacts on the compliance of the plan.
17 So, it's yes and no, I believe.
18 CHAIRMAN ENTHOVEN: Gilbert. Thank you for that
19 unequivocal statement. Please stay there.
20 MR. BARNES: Sure.
21 CHAIRMAN ENTHOVEN: Brad Gilbert.
22 DR. GILBERT: I think in terms of the practicing
23 reality, in terms of licensure there's essentially no
24 direct regulation -- direct oversight of the groups in
25 the delivery system. At the time of the audit there is,
26 in fact they go to the delegated group and make sure
27 that delegated group is conforming with the health plan
28 requirements related to that delegation.

1 So, I would suggest you have two reasons to look
2 at medical groups. The first is that theoretically
3 there's a benefit to the medical groups because they
4 have 10 to 15 health plans requiring multiple types of
5 quality studies and different types of delegation and
6 different standards. In addition, I think the second
7 reason is that -- that the medical groups have become
8 the -- in many cases the primary decision-maker in
9 delivery of care to members in terms of utilization
10 management decision.
11 So, it seems to me -- and then, Nancy, in terms
12 of dealing with your issue, there are in fact different
13 levels of oversight depending on the particular HMO,
14 ranging from laissez-faire to extremely strict oversight
15 and delegation monitoring. So, we would creat e
16 consistency both at the medical group level in terms of
17 oversight and, two, I think create some standards in
18 terms of their delivery of care.
19 DR. KARPF: Can we move that medical groups are
20 oversight -- get down --
21 CHAIRMAN ENTHOVEN: Include that -- let's do
22 that.
23 I'm sorry, Ron Williams, Michael Schapiro and
24 then Bruce Spurlock, and then I want to just take a show
25 of hands on are medical groups included or not.
26 MR. WILLIAMS: I think there are perhaps several
27 ways of thinking about this one. In relationship
28 between the health plan and medical group there really

are three dimensions; there is clinical and quality dimension of care and that dimension is overseen both through the medical audits of the Department of Corporations as well as the NCQA quality assurance and accrediting agency process that health plans specifically go through.

The second dimension has to do with the administrative capacity and service oriented issues of the medical group, where the health plan has a responsibility to -- to the member to assure that certain things are happening in a very timely and efficient way, from the point of view of our requirements.

And then the third issue is really the financial issue. It has to do with solvency and the adequacy of the reserves of the medical group and their ability to really deliver the level of service that they have need to, to receive the decapitated payment.

I think the -- we talk about medical groups, we're talking about extremely well-organized large entities with 5,000 physicians all the way down to a group with some 10 or 15 physicians in one particular area. That entity -- that medical group may contract with 10 health plans or they may only contract with one.

So, I think that there's an issue of saying that -- that we want this department to regulate all of those entities without re ally understanding those three dimensions and how it applies in a multi-health plan

1 situation to a singular health plan situation.
2 So, I think the take-home conclusion that I would
3 reach is that at a minimum we need to be certain that
4 the health plans have an ability to assure compliance
5 with the clinical and quality, the administrative and
6 the financial.
7 And then there's a second question, if the health
8 plans don't do it directly, then is that something that
9 the department does? But it is -- it is a substantial
10 new function that involves three separate things.
11 MR. ROMERO: If I can just take you back for just
12 a minute. We've heard both public and private testimony
13 from at least one plan that -- that has attempted to --
14 has attempted to use practice guidelines and other
15 techniques to improve clinical quality that they have
16 difficulty getting -- getting sufficient compliance from
17 their medical groups, and a difficulty in simply getting
18 the data they feel they need to ensure quality.
19 MR. ZATKIN: First, it is not necessarily the
20 indictment of the medical group. It may be the
21 practical protocols they're asked to implement are too
22 strict.
23 MR. ROMERO: By all means.
24 CHAIRMAN ENTHOVEN: Michael. Then Bruce.
25 MR. SHAPIRO: Terms of making an effective and
26 lean commission, you might want to consider the Hare
27 Krishnas, when you start isolating medical groups from
28 plans what happens is they point fingers at each other.

1 The plans say it's the medical group that made that
2 decision; the medical group says, no, it's the plan that
3 confirmed that decision.
4 What DOC has said consistently is the plan you
5 under contract -- and we're not going to look at every
6 one of those contracts, but we hold you responsible for
7 compliance with the law. If the medical group screws
8 up, they fine the plan. And if you want to have this
9 entity have to look at every medical group in addition
10 to just the audits, quality audits, for regulatory
11 purposes, it really is quite a cumbersome regulatory
12 process.
13 And, also, you just open up this can of worms of
14 pitting the medical groups against the plans on who's
15 accountable. So, I would just caution that the DOC
16 principle of holding plans accountable and making plans
17 hold medical groups accountable is a -- an efficient
18 regulatory function and there may be other ways to deal
19 with medical groups, but regulating them directly may
20 not be the best way.
21 MR. ROMERO: Just to clarify a question, like you
22 were saying, you think direct regulation of medical
23 groups would increase the amount of finger pointing
24 between plans and medical groups.
25 MR. SHAPIRO: When you say regulation may be --
26 oversight may be good, but I think basically the plans
27 commit to provide service to enrollees. They can do
28 that in numerous ways. They've had lots of contracts,

1 PBMs and other. The point is to hold the plans
2 accountable, that can be innovative on how they do that,
3 and DOC should have only, I think, limited looking
4 through that veil and hold the plans accountable for
5 that to the extent they can.
6 If there's a -- if there's an enforcement
7 problem, that may be different from actually having them
8 regulate each individual contract.
9 MR. ROMERO: Thanks.
10 CHAIRMAN ENTHOVEN: Well, I was thinking we were
11 talking about specific purposes like a once and for all
12 periodic solvency; a once and for all periodic quality.
13 MR. SHAPIRO: That's fine.
14 CHAIRMAN ENTHOVEN: Disclosure, periodic
15 disclosure. Some -- you know, possibly utilization
16 management standards.
17 DR. SPURLOCK: I think that's where you start
18 having problems.
19 CHAIRMAN ENTHOVEN: What I think I'm seeing is
20 kind of a middle ground here that doesn't alleviate the
21 plans from their responsibility, but it does simplify
22 and streamline.
23 MR. SHAPIRO: If I entered into a contract with
24 you and you subcontract, I'm going to hold you
25 responsible for your contractor. That doesn't mean I
26 won't ask to look at that subcontractor, but I think you
27 have to be cautious about what you're asking the
28 regulator to do in that process. That I'm holding you

1 accountable for your staff and your contractor and you
2 can ask information.
3 CHAIRMAN ENTHOVEN: The problem is it appears not
4 to be working very well, ostensibly.
5 MS. FARBER: Where all of this unraveled is at
6 the hospital's front door, and the lack of coordination
7 between a health plan and a medical group then becomes
8 the local community provider's, namely the hospital's,
9 nightmare. And, you know, this -- this group is
10 contemplating what's good for the goose is good for the
11 gander. You're ready t o push hospital industry into
12 millions of dollars in expenditures to produce data so
13 you can measure their quality, yet this group is not
14 willing to hold a medical group accountable for what
15 they do and periodically inspect them. Not a one-time
16 survey, but, oh, once every three years, like a hospital
17 that has a good rating with joint commission.
18 I mean, there has to be some kind of a level
19 playing field here.
20 CHAIRMAN ENTHOVEN: All right, Bruce.
21 DR. SPURLOCK: Thank y ou, Mr. Chairman. I
22 think -- think we're starting to emerge on the area I
23 have a lot of comfort level with, and it sort of backs
24 off what Michael is talking about. I think there's a
25 lot of confusion of what we talk -- what we mean when we
26 say "direct regulation." I think there are clear areas
27 that would benefit the system and benefit the medical
28 groups and everybody would win. I think you alluded to

1 the first two of t hose, which is solvency and quality.
2 15 times medical groups have to do this 15
3 different ways. Again, the issue is the size of the
4 medical group. The small medical groups can't take on
5 significant risk. I mean, they may take a tiny portion
6 of risk on, but in general they don't take large amounts
7 of risk because they don't have the ability to manage
8 that risk.
9 Larger medical groups do that are much more
10 sophisticated, are able to deal with that pressure on
11 the larger me dical groups. But I think by saying we're
12 going to regulate medical groups and sort of throw that
13 out -- which it really gets to what Michael is talking
14 about, you're shooting arrows in the sky and hoping that
15 something lands down on something.
16 If we say the solvency and quality aspects of
17 those risk-bearing entities are really the core we're
18 getting at, then allow the Governor and Legislature to
19 study any other areas that may evolve to that may be
20 worthwhile to put under that agency.
21 I think we'll accomplish what we're really trying
22 to get at; safety net for the consumer, standardization
23 and streamlining at the medical group/health plan level
24 and allow the DOC regulation to be coordinating all the
25 activities that are in managed health care.
26 CHAIRMAN ENTHOVEN: Also we talked about
27 disclosure. That would go on the list.
28 DR. SPURLOCK: Disclosure. If you want to have

1 five medical group s having disclosure about everything,
2 I think you can do that. I think when you start getting
3 that level they may be not be taking risk or may be
4 taking such a small amount of risk that it's really
5 going to be burdensome many to them. You have 5,000
6 medical groups that are five or smaller. If you have to
7 do that 5,000 times for the DOC, you wrap them up
8 administratively in paperwork, but for solvency and
9 quality if you're taking sufficient risks on, that's
10 something the DOC should be able to do because that's
11 probably, you know, 20 or 30 medical groups in
12 California.
13 MS. FARBER: Define "significant risk."
14 MR. ROMERO: Just a procedural note, this is one
15 of three very, very big issues in this paper, so I'd
16 just like our timekeeper to give us a sense --
17 MS. DECKER: 20 minutes.
18 MR. ROMERO: 20 minutes out of an hour and a
19 half.
20 MR. ZATKIN: I think there are issues around what
21 "significant risk" is. Is it substantially beyond the
22 services you directly provide? I don't think this group
23 has studied that issue.
24 There is -- under Alternative 2 there is a
25 proposal that the Legislature ought to study it. And I
26 think if -- that is the better approach rather than us
27 sitting here and in 15 minutes making a decision about
28 which items and how it should be done. I don't think

1 we've done the work,

2 MR. SHAPIRO: But I think the limited motion is

3 we understand what significant risk is if we're going to

4 regulate medical groups and solvency and disclosures,

5 the big deals for those that are above a --

6 MR. ZATKIN: Knox-Keene already does regulate

7 plans -- I mean, I'm sorry, medical groups that take

8 on --

9 MR. SHAPIRO: Global cap.

10 MR. ZATKIN: -- global cap.

11 CHAIRMAN ENTHOVEN: Hartshorn.

12 MR. HARTSHORN: I think it's important the

13 direction that we take as the Task Force, because I

14 agree with what Michael said in a lot of comments. Let

15 me give you a practical thing that's going on today.

16 There's one IPA in Southern California that has

17 violated some of the HCFA requirements on claims

18 payments. You've got about eight HMOs, maybe more,

19 ten -- that HCFA looks at each HMO to get at this IPA.

20 And we have varying levels of -- of business, you know,

21 one might have 20 percent, another HMO two percent, and

22 the IPA was trying to correct -- correct it, is getting

23 hit from ten different sides on this issue.

24 Now, it does work. HCFA looks to the health plan

25 and we're going to turn around and get this thing

26 corrected, but in the corrective action process it

27 becomes a bit of a nightmare.

28 I -- I think that we don't know enough about this

issue. I agree that we've got to move in the direction, that's why I said the direction of -- of medical groups being licensed or regulated in possibly a couple of main areas. Like the solvency and quality area instead of once and for all -- I don't know what you mean by that. But if it's done right, we can actually streamline the process and -- because now we've got a lot of HMOs trying to get in and look at the medical groups because DOC is requiring that.

CHAIRMAN ENTHOVEN: Let's see, Terry, the wording we have here says, "The Legislature and Governor's office should study and within a year consider the benefit," so --

MR. HARTSHORN: That i s the language.

CHAIRMAN ENTHOVEN: That language is all --

DR. SPURLOCK: Can I -- before you modify that language, I just have a couple of thoughts about adding on -- in B there, where it says "who are not currently directly regulated, who bear significant financial risks on the basis of solvency and quality," other areas should be explored by the Legislature and Governor to determine the best method for regulating medical groups.

CHAIRMAN ENTHOVEN: I'm not sure that rea lly changes things very much, saying other areas should be explored. This is saying all should be explored or should be studied. Is that really --

DR. SPURLOCK: I think what we're trying to say the first thing we're going to study is understanding

1 what is significant risk and solvency and quality audit.
2 Once you accomplish that, if you go ahead and do that,
3 then the other areas, you can do that. It's just the
4 prioritization of the study process.
5 CHAIRMAN ENTHOVEN: Okay. Who bears significant
6 risk --
7 COMMISSIONER: Financial risk.
8 CHAIRMAN ENTHOVEN: -- for solvency?
9 DR. SPURLOCK: And quality.
10 CHAIRMAN ENTHOVEN: And quality.
11 MS. SINGH: Ms. Singer, do you want to read that
12 back?
13 CHAIRMAN ENTHOVEN: I'm not sure the language
14 even tracks here.
15 MS. SINGER: "All entities" -- I'm sorry, from
16 the second line, "All entities in the statute who are
17 not currently dire ctly regulated bear significant
18 financial risks for solvency and quality to the extent
19 they can shown to be contributing to medical decisions."
20 MR. LEE: Can I --
21 MS. SINGER: Financial risk for quality.
22 MS. BOWNE: No, it's financial risk, solvency,
23 quality.
24 DR. SPURLOCK: I think it's "who bears
25 significant risk on the basis of solvency," regulating
26 the basis of solvency and quality. So that -- that's
27 the group, here's what we're looking at.
28 CHAIRMAN ENTHOVEN: Oh, bears the risk on the

basis of --

MS. SINGH: -- solvency and --

MS. SINGER: -- "who bear significant financial risk on the basis of solvency and quality."

DR. NORTHWAY: No, excuse me, it's not "financial risk on the basis of solvency and risk," it is "risk on the basis of solvency and quality.

CHAIRMAN ENTHOVEN: Who bears significant --

DR. NORTHWAY: Solvency and quality are two different --

CHAIRMAN ENTHOVEN: On the basis of solvency and quality, right. Okay.

MS. FINBERG: I don't know you want "significant." I think you're talking about studying the issue. Why limit it to significant?

CHAIRMAN ENTHOVEN: Okay. Alpert. Gilbert.

DR. ALPERT: I endorse this: The concept of risk only exists if you are accountable. So, with regard to quality, if you are not regulated you have no risk with regard to quality because whatever qualitative decisions you make will not be held accountable and so you're at risk for nothing.

So, the regulation is internally, the -- the accountability part of what this is. The quality part is what has been considered as much here. If -- if you allow no regulation for any entity that potentially impacts quality, then you have -- then you have a hole in the system. And finger pointing is something that

1 goes on all the time when -- when people are accused --
2 are accused of things. But I think everybody wants
3 who -- who or whomever were really responsible to be
4 held accountable.
5 CHAIRMAN ENTHOVEN: Gilbert. We really need to
6 wrap this one up.
7 DR. GILBERT: Just a quick statement that small
8 groups in fact do take significant risk. In fact
9 they're often the groups that want significant risk
10 because they want the entire dollars for that medical --
11 for those medical services, and they're the groups that
12 in fact ne ed the most oversight by far compared to the
13 larger groups. I wouldn't want -- Bruce mentioned, I
14 wouldn't want -- there are many small groups taking very
15 significant risk.
16 CHAIRMAN ENTHOVEN: Okay.
17 MR. LEE: Alain, I had my hand up for a while.
18 CHAIRMAN ENTHOVEN: All right. All right.
19 MR. LEE: As I understand -- I'm somewhat
20 confused about how we're cutting across alternatives 1
21 through 3. As I understand, we're talking functionally
22 just about medical groups as it 's phased in or now? And
23 before we jump to saying let's just study it, no one has
24 commented much upon 3.
25 What I'm hearing is a lot of agreement that there
26 should be direct oversight of medical groups. The
27 question is what's the scope of that oversight and
28 regulation? And I'm a little concerned with saying the

recommendation is only a study recommendation and I -- if what we're sort of merging across is a discussion of Alternative 2 and Alternative 3, saying what's the scope of regulatory oversight, I think it's important that we -- that if our recommendation is that this Department have authority to oversee and regulate medical groups, but the scope of that regulation needs to be studied, I'd support this.

I'd be concerned if it's just what I've, you know, called a GAS, Get Another Study. Is that how -- is this the end of our discussion on medical groups or are we going to come back to talk about Alternative 3?

CHAIRMAN ENTHOVEN: Well, let's just try to deal with medical groups here and say --

MR. LEE: Uh-huh.

CHAIRMAN ENTHOVEN: Well --

DR. KARPF: Alain, is it possible we can eliminate Alternative 3 from the discussion if there's a straw vote that says that that's too big a bite for this new group and let's not even consider that? That way we can -- we can consider 1 versus components of 2.

MR. LEE: What I think we can do is just a straw vote just on medical groups. Are we saying that there should be some authority and then the question is, what's the scope of it. I mean that's the gist of the recommendation, I think.

CHAIRMAN ENTHOVEN: Let's make it even a little stronger; there should be some authority in the areas of

solvency and quality.

MR. LEE: I'm fine with that.

Let me just have --

MS. FARBER: What part of the alternatives are you putting that in? Which one?

CHAIRMAN ENTHOVEN: Alternative 2.

MS. SINGH: 2.

CHAIRMAN ENTHOVEN: If we adopt Alternative 3, then we will come back and put the same thing in. Now, it would say, "The Legislature and the Governor's office should study and within a year consider the benefit to the consolidated direct regulation by -- of all entities in the state who are not currently directly regulated who bear significant risks on the basis of solvency and quality to the extent that they can be shown to be contributing to medical decisions, et cetera. So, let me have a -- have a straw vote.

COMMISSIONER: I thought you said you were going to strengthen --

MR. LEE: Strengthening that would --

CHAIRMAN ENTHOVEN: Just -- okay, let's have a straw vote. All in favor of --

MS. FINBERG: We don't understand what you're doing.

MS. BOWNE: Are you studying it or are you doing it?

MS. SINGH: No, we're studying it. That's what it says, we're studying it.

MS. FINBERG: Does that mean we can't vote for this alternative later?

MS. SINGH: I believe what the Chairman is attempting to do at this point in time is simply get a straw vote on recommendation 2B as amended to include the significant risk language. It is a straw vote, it's not an official vote, and that's all.

So, it would read exactly how it is with that significant risk language , so they'd be studying it.

MR. ROMERO: Studying --

MS. FARBER: I think the question in a lot of Commissioners' minds at this point is if they vote for this it means they do not get to later vote for the stronger alternative.

CHAIRMAN ENTHOVEN: Let's come back right back to the stronger alternative, okay. All in favor of doing this much, raise your right hand.

COMMISSIONER: At least this much.

CHAIRMAN ENTHOVEN: At least this much.

COMMISSIONER: At least this much and more.

COMMISSIONER: And more.

CHAIRMAN ENTHOVEN: All right. Now, does somebody have words that would take this up a notch?

MR. LEE: I would suggest that we introduce B before we get to the "study" with "medical groups who bear risk should be regulated directly by the OSO for quality and solvency," period. And then carry right on, "The Legislature and Governor's" -- the language we

1 already had. But it's an endorsement of direct
2 regulation for quality and solvency and then we modify
3 with what's being looked at.
4 DR. SPURLOCK: Pete, do you accept "significant,"
5 so that significant is zero? The group says zero is
6 zero. That's the part that goes in. I think there is a
7 difference between somebody who accepts a tiny little
8 bit of risk versus somebody who accepts 20 percent risk,
9 for example.
10 MR. LEE: My concern is I didn't vote for the
11 last one in terms of why we --
12 DR. SPURLOCK: I'm not sure that "significant" is
13 defined.
14 MR. LEE: I'm saying you're clear and out --
15 below 20 percent or whatever.
16 CHAIRMAN ENTHOVEN: Let's leave a little room for
17 the Legislature and the Governor to sort out that
18 detail.
19 DR. SPURLOCK: It actually does that.
20 MS. BOWNE: You'll hear from the chiropractor.
21 CHAIRMAN ENTHOVEN: Okay. All right.
22 MR. KERR: I have a question. If the State does
23 that, let's say they look at the quality issue, let's
24 say there's a real screw up in quality, does that mean
25 the health plan is off the hook?
26 CHAIRMAN ENTHOVEN: No.
27 MR. LEE: Absolutely not. This does not remove
28 health plans' responsibility.

MS. FARBER: But it allows some measure of accountability for the plan.

CHAIRMAN ENTHOVEN: Allan Zaremberg, then Helen Rodriguez-Trias.

MR. ZAREMBERG: Alain --

COMMISSIONER: Allan, use the mike, please.

MR. ZAREMBERG: When you vote to definitely create an oversight or study, one of the questions I have is are we assuming that the only thing we're regulating is the existing practice of medical groups today? Or are we creating something that exists somewhere between a Knox-Keene licensure or the type of situation today that will allow medical groups to contract directly with employers to provide health care services? And I just want to know what we're voting on.

MS. FARBER : That possibility already exists today with the Knox-Keene.

COMMISSIONER: That's a PSO.

MR. ZAREMBERG: -- under a Knox-Keene. And I want to know if we're creating another --

MR. LEE: I'll propose, if I could --

MR. ZAREMBERG: I just want to know what the intent --

MR. LEE: -- the intent of my language, which I'll be happy to amend to try to move us along from our discussion, is that not to be foreclosed on what we currently have, but it be open and I propos e the language read, "medical groups or other entities who

bear significant risk should be regulated for quality and solvency." Period. And then it continues on with the study language.

MS. BOWNE: Second.

MR. ZARENBERG: I'm not sure that answers any question.

CHAIRMAN ENTHOVEN: Actually, "and other friendly entities."

MR. LEE: Fine, "other provider entities."

CHAIRMAN ENTHOVEN: Let's just -- Helen . We're really running way over time.

DR. RODRIGUEZ-TRIAS: I like Peter's language but, Peter, what I think it doesn't say is it goes on to say within a year consider the benefit, and I would like to change that, make a friendly amendment, "within a year recommend to the public that the direct regulation" -- that is to study and within a year recommend to the public how to do it.

MR. LEE: We didn't make the following language somewhat consistent. I think that's friendly .

MS. SINGH: Where is that, I'm sorry?

DR. RODRIGUEZ-TRIAS: That would be, "The Legislature and Governor's office should study and within a year recommend to the public the consolidated direct regulation by -- of all entities in the state not currently regulated."

MS. DECKER: We've used up 45 minutes, we're halfway through.

1 CHAIRMAN ENTHOVEN: I'd like to -- let's take a
2 vote on that version of it
3 MS. FARBER: Repeat it.
4 CHAIRMAN ENTHOVEN: Okay. "Medical groups or
5 other provider entities that bear significant risk
6 should be directly regulated for solvency and
7 quality" --
8 MR. LEE: Regulated by OSO.
9 MS. FARBER: This agency.
10 MR. LEE: At the point.
11 CHAIRMAN ENTHOVEN: Regulated. Do we need that,
12 "at that point"?
13 MR. LEE: I think so.
14 CHAIRMAN ENTHOVEN: Is that ambiguous?
15 MR. LEE: Yes.
16 CHAIRMAN ENTHOVEN: Okay. -- "are regulated by
17 the State's regulatory agency."
18 MS. SINGER: Alain, we have just been using the
19 bracketed term for the moment, "Medical groups and other
20 provider entities that bear significant risk should be
21 directly regulated by OXX for solvency and quality. The
22 Legislature and Governor's office should study and
23 within a year recommend to the public consolidated
24 direct regulation by O of all entities in the state that
25 are not currently directly regulated, that bear
26 significant risk on the basis of solvency and quality to
27 the extent they can be shown to be contributing to
28 medical decisions," i.e., et cetera.

CHAIRMAN ENTHOVEN: Okay.

MR. WILLIAMS: Does direct regulation mean it could be done with health plan? When you say direct regulation --

CHAIRMAN ENTHOVEN: Well, I think that needs to be sorted out. What we've been saying is there's certain things that would be done more efficiently and effective ly if the -- if the DOC could deal directly, and we get to that later on, to deal with streamline solvency and streamline quality, the once and for all periodic inspection, if you like.

MR. ZATKIN: Well, wait a minute. I think that confused it. I thought the intent -- Peter's amendment was to provide for --

MR. LEE: Direct.

MR. ZATKIN: -- new direct regulations, which I oppose --

MR. LEE: Fine.

MR. ZATKIN: As opposed to --

MR. LEE: We'll grab people.

MR. ZATKIN: Not that it matters -- as opposed to streamlining what currently occurs. And so, I just wanted to -- to make that clear.

MS. FINBERG: There's no motion yet.

MS. FARBER: If we vote on that, does that mean the new regulatory agency can deem it --

MR. LEE: We have a separate vote on deeming later. There's a proposal on deeming.

1 MS. SINGH: This is just straw votes, members, no
2 one has made a motion.
3 MS. BOWNE: I'd like to make a motion that we
4 adopt 2B as amended to date.
5 CHAIRMAN ENTHOVEN: Okay.
6 MS. SINGH: So, just alternative 2B?
7 MS. BOWNE: Yes.
8 MS. SINGH: It has been moved and seconded.
9 Those in favor of adopting 2B as amended?
10 DR. ARMSTEAD: What's the current amended
11 language?
12 MS. BOWNE: We just read it.
13 MS. SINGH: It was just read into the record by
14 Ms. Singer.
15 Those in favor please raise your right hand.
16 DR. SPURLOCK: The one with the amendment?
17 MS. SINGH: The one with the amendment.
18 COMMISSIONER: Does it say study --
19 MS. SINGH: No, it does -- do you want to read
20 it.
21 MS. SINGER: "Medical groups and other provider
22 entities that bear significant risk should be directly
23 regulated by the O agency for solvency and quality. The
24 Legislature and Governor's office should study and
25 within a year recommend to the public consolidated
26 direct regulation by the O agency of all entities in the
27 state that are not currently directly regulated that
28 bear significant risk on the basis of solvency and

1 quality to the extent they can be shown to be
2 contributing to medical decisions."
3 MS. SINGH: Those in favor, please raise your
4 right hand.
5 Those opposed?
6 Recommendation B is adopted. 20 to 6.
7 MS. FARBER: Alice, is there any chance we can
8 get a copy of what it actually looks like now, sometime
9 later t his morning?
10 MS. SINGER: We could get it for you in an hour.
11 MS. FARBER: That's fine, just sometime later.
12 MR. LEE: You're not going to revote on
13 something?
14 MS. FARBER: I might, you never know. It seems
15 to be the thing to do.
16 CHAIRMAN ENTHOVEN: We have to -- I think now
17 it's appropriate to consider the big picture,
18 Alternatives 1, 2 or 3. I suggest we first put
19 Alternative 3 to a vote, the big bang.
20 Do I hear a motion?
21 MS. SINGH: Mr. Chairman, if I' m correctly
22 understanding, you're asking members to make a motion to
23 adopt Alternative number 3 as proposed, is that correct?
24 CHAIRMAN ENTHOVEN: Yes, right.
25 MS. SINGH: Mr. Chair --
26 CHAIRMAN ENTHOVEN: I'm expecting that it's not
27 going to succeed, but I think we just have to deal with
28 it. We have to vote on it.

1 MS. FARBER: For the sake of making a motion.
2 CHAIRMAN ENTHOVEN: Thank you, Nancy.
3 MS. SINGH : Is there a second?
4 DR. RODRIGUEZ-TRIAS: Second.
5 CHAIRMAN ENTHOVEN: Those in favor of adopting
6 Alternative 3 in its entirety as proposed, please raise
7 your right hand.
8 MS. FINBERG: So that included the additional
9 language, too, because that seems like a separate issue,
10 the clinical oversight.
11 MS. SINGH: It's Alternative 3 on page 10.
12 MS. FINBERG: The whole thing.
13 DR. KARPF: One fell swoop.
14 MR. ROMERO: If you recall my chart, the
15 right-most column h as "big bang."
16 CHAIRMAN ENTHOVEN: All right, please raise your
17 right hand and we'll count them.
18 MS. SINGH: Those opposed.
19 17 to 19.
20 CHAIRMAN ENTHOVEN: The recommendation has
21 failed.
22 JEANNE FINBERG: What's a patient coaching
23 organization?
24 MR. ROMERO: That's right.
25 CHAIRMAN ENTHOVEN: Jeanne, you don't know? I
26 thought everyone knew what a patient coaching operation
27 is, but don't ask me to explain it.
28 Now, let's consider Alternative 1, which is --

DR. KARPF: We already eliminated it once we adopted part of 2.

MR. KERR: I so move to eliminate 1.

MR. PEREZ: Might I make a recommendation; why don't we take a quick straw vote on 1, because what I hate to have happen is just to have a narrow majority on 1, and then really want to tinker with it to make it something we can all believe in. So, why don't we just take a straw vote and if we're not anywhere clos e, then we can move on to 2 and tinker with it.

CHAIRMAN ENTHOVEN: All right. Fair enough. Straw vote. All in favor of one.

All in favor of one?

MR. HARTSHORN: Where?

MS. SINGH: Alternative 1 on page 9.

MR. LEE: Essentially doing what it does now with the new agency.

MS. SINGH: A straw vote. All those in favor, please raise your right hand.

Those opposed.

Obviously, the majority of this body is opposed to Alternative 1.

CHAIRMAN ENTHOVEN: Okay.

MR. LEE: Can we maybe move quickly, we've done B, if there's any changes to A, and if not move on. I guess there aren't. So, if we could jump to --

DR. SPURLOCK: Actually no, no.

MR. LEE: We're tinkering with a "no" vote.

DR. SPURLOCK: I don't want to tinker with it. I have another -- I have an amendment.

MS. SINGH: To which one, Mr. Spurlock?

DR. SPURLOCK: A new C. Or a new letter in addition to C, and then reletter the rest of them.

MS. SINGH: So, to substitute --

DR. SPURLOCK: No.

MS. SINGH: So, a new C.

DR. SPURLOCK: I don't want to wait till the end, I want to do this sooner rather than later.

CHAIRMAN ENTHOVEN: Okay, what is it?

DR. SPURLOCK: It's that the Governor and Legislature study within one year the feasibility and benefit to consolidating the quality review functions of all governmental agencies within the new agency.

DR. KARPF: Second that.

DR. SPURLOCK: Did you get that, Sara? I couldn't say anything twice.

MR. KERR: It's a study, right?

DR. SPURLOCK: It's a study.

DR. KARPF: But it's a consolidation.

MS. SINGER: Governor and Legislature should study within one year the feasibility and benefit to consolidating the review functions of all governmental agencies --

DR. SPURLOCK: Quality review.

MR. ROMERO: Quality review.

MS. SINGER: -- feasibility and benefit to

consolidating the quality review functions of all governmental agencies within the new agency.

DR. SPURLOCK: Great. Great. Sure.

MS. BOWNE: Don't you mean health care quality?

MS. SINGER: Okay, the health care quality review functions.

CHAIRMAN ENTHOVEN: Bruce, is that --

MS. SINGH: Is there any objection to that amendment?

MS. BOWNE: There has to be a second.

MR. KERR: I second it.

MS. SINGH: It's not formal -- there's no objection. Okay.

MS. FARBER: Why don't we make a motion that it become a formal amendment.

DR. SPURLOCK: I actually move the amendment.

MR. LEE: Wait, wait, before it's seconded, can I just suggest we finish C and D and move the whole back page?

DR. SPURLOCK: There's things may be voted down.

CHAIRMAN ENTHOVEN: Mr. Spurlock has moved this new amendment, which will be the new C. Can we have a second, please?

MS. FARBER: Second.

MS. SINGH: Okay. Those in favor of the new amendment, please raise your right hand.

Those opposed?

25 to zero. Dr. Spurlock's amendment is adopted.

CHAIRMAN ENTHOVEN: All right. Let's see, have we been working our way through here -- let's just go back now. Have we got A?

MR. LEE: I move adoption of A.

CHAIRMAN ENTHOVEN: Okay.

MS. SEVERONI: I'll second.

MS. SINGH: Is it po ssible that we can just make a motion to adopt the remaining recommendations without us having to go A, D --

MR. LEE: I would be happy to move -- no, Bruce?

DR. SPURLOCK: You know, we can but --

MS. O'SULLIVAN: Let's do straw votes.

CHAIRMAN ENTHOVEN: Let's use straw votes. We'll use straw votes to go through them and then we'll have one formal vote on the package. Okay.

MR. ROMERO: The reference doesn't question the principals of the board or --

MS. SEVE RONI: I just want to make sure.

MR. ROMERO: OXX is a generic title, until we decide --

COMMISSIONER: Can I ask a question?

CHAIRMAN ENTHOVEN: We resolved B, the old C.

MS. SINGH: Mr. Chairman, I think that they've asked to take a straw vote on each, A and then the -- and so forth.

Okay, straw vote on A, please. Raise your right hand if you're in support of A.

A majority supports that.

1 CHAIRMA N ENTHOVEN: Okay, we've done B already.
2 MS. SINGH: A straw vote on D, that used to be C.
3 Please raise your right hand if you are in support.
4 MR. LEE: This is a study?
5 MR. ROMERO: Study of PPOs and APOs.
6 MS. SINGH: Okay, majority supports that. The
7 new D. Those in favor -- it used to be D, it's now E.
8 Those in favor, please raise your right hand.
9 Majority supports the new E.
10 Members, the new F that used to be E. Those in
11 favor -- it's page 10 at the top. Pl ease raise your
12 right hand.
13 MR. ROMERO: That's the current E?
14 CHAIRMAN ENTHOVEN: E.
15 MS. SINGH: It's the new F. We've -- top of page
16 ten. Okay, members, those in support please raise your
17 right hand. This is straw vote only.
18 A majority supports the -- the new E; the current
19 F.
20 MR. LEE: Before moving adoption of all, I'd like
21 to do one technical amendment which is a cleanup on A.
22 The second line, where it says "to regulate health care
23 service plans current ly regulated" --
24 CHAIRMAN ENTHOVEN: Mr. Lee, would you please
25 speak into the mike.
26 MR. LEE: All right.
27 -- to regulate health care service plans
28 currently regulated by the DOC and to phase in other

1 entities consistent with these recommendations -- or
2 phase in the regulation, other entities consistent with
3 these recommendations.
4 CHAIRMAN ENTHOVEN: I'm just --
5 MS. BOWNE: Could I ask a clarifying question?
6 Is that to permit the one -- the pieces of the ones we
7 want in and the studies of the other?
8 MR. LEE: Exactly.
9 MS. BOWNE: And then the other as appropriate?
10 MR. LEE: That's exactly what it's intended to
11 do.
12 Ms. Singer, can you read that back?
13 MS. SINGER: Yes, "to regulate health care
14 service plans currently regulated by the DOC and to
15 phase in the regulation of other agencies consistent
16 with this regulation over time."
17 MR. LEE: Recommendations over time.
18 MS. SINGER: I'm sorry, recommendations over
19 time.
20 CHAIRMAN ENTHOVEN: Okay.
21 COMMISSIONER: Where does that statement go?
22 MR. LEE: That goes in A.
23 MS. SINGH: Now may we have a motion to adopt
24 Alternative 2 in its entirety as amended?
25 MR. LEE: So moved.
26 MS. SINGH: Many times.
27 MR. KERR: Second.
28 CHAIRMAN ENTHOVEN: All in favor of Alternative

2?

Those opposed?

22 to one. Alternative 2 has been adopted.

CHAIRMAN ENTHOVEN: All right. Now we move to -- to provide appropriate leadership. As I touched upon yesterday, I think the fact is that the Task Force is very closely divided on whether it ought to be a board or a single appointed leader. My guess is that it would go 16-14 one way or the other. And on something that has a lot of political overtones, I mean certainly is influenced by who controls which branch of government and all that sort of thing. And I -- I really would prefer to see the Task Force not get involved in that kind of political crossfire. I think it would be wise and appropriate for us to cut through all of this by having a recommendation in which the Task Force takes no action as to which it should be, because the members are approximately evenly divided on this issue.

And so, I would like to propose that we first consider to say a new oversight organization should be led either by a part-time board comprise d of five or more individuals having specified qualifications, you know, just pick up the language of Alternative 2 or -- by an individual of stature in the health services field who can command respect and exercise strategic leadership.

The leadership of the organization should have a sympathetic understanding and in effect just -- by

1 treating these two alternatives equally through all of
2 the wording, just have the Ta sk Force decline to take a
3 stand on the issue. I don't want to do anything that's
4 thought of as undemocratic. We can vote on that; if
5 people say no -- I'd rather have a vote the other way,
6 I'm not trying to preclude going the other route, but I
7 would like to put forward that we -- we test that.
8 DR. KARPF: I vote on that -- on that proposal.
9 My only --
10 MR. KERR: Do we want to be that --
11 CHAIRMAN ENTHOVEN: Why don't we say OXX ought to
12 have leadership, period. All ri ght, we have a motion;
13 Diane Griffiths is seconding the motion.
14 MS. FARBER: What is the motion?
15 MS. SINGH: I want to make sure -- Ms. Singer, do
16 you have that language?
17 MS. SINGER: Yeah.
18 MR. HAUCK: Discussion?
19 CHAIRMAN ENTHOVEN: Discussion.
20 MR. HAUCK: Mr. Chairman, I'm going to support
21 the motion even though I think it's clear that my
22 preference here would be that we have an office headed
23 by a single individual appointed by the Governor,
24 whoever he or s he might be. I do believe that what you
25 have just said is accurate, that we are closely divided
26 on this question and in many respects you could argue
27 that really this is a decision that is the prerogative
28 of the Legislature and the Governor and it ought to be

done directly between them rather than have us try to dictate, which we wouldn't be doing anyway, but have us try to push hard on one or the other of these alternati ves. And I'd leave it at that.

CHAIRMAN ENTHOVEN: Thank you. Other discussion? Diane Griffiths.

MS. GRIFFITHS: Mr. Chairman, as you know, we've had a lot of conversation amongst the membership and you and I have had conversations, as well, and --

COMMISSIONER: Would you get closer to microphone.

MS. GRIFFITHS: There's been a lot of discussion on this issue between and amongst the membership and as well between the Chair and various factions, if you will.

MS. SINGH: I think you need to speak closer to it.

MS. GRIFFITHS: When I get closer it makes noises.

MS. SINGH: Sorry.

MS. GRIFFITHS: It's my hands, oh.

COMMISSIONER: Barbara, pass her your mike.

MS. GRIFFITHS: Find out if it's the mike.

While I don't have quite as many years in government service and around as Mr. Hauck, I do have a fair number myself, and I've seen various agencies operate in the single administrator format and also in the multi-memb er, and it's my belief that both of those

formats, they're as good as the people who run them.

And I have no hesitation, unlike Mr. Hauck, in believing that a multi-member board could be effective in running this organization. But like Mr. Hauck I believe that -- and like the Chair, I believe that -- that this is an issue where it is best left for negotiation between the Legislature and the Governor because of the inhe rent political nature of it. And I thank you for making an effort to compromise in this.

CHAIRMAN ENTHOVEN: Thank you. Let me just say I've enjoyed that discussion and others working with you, and I -- I greatly appreciate your constructive conciliatory search for the middle ground. It's been very helpful in making this Task Force work.

Any other discussion? Bruce Spurlock.

DR. SPURLOCK: I want to echo what Diane Griffiths just said about the political nature of this , and I think this body is very important for giving advice both to the Legislature and the Governor about multiple activity I think on this one issue because of the extreme political nature of it. If we're giving advice about how to drive through in the fog that we just experienced in Sacramento, I think it's sort of good advice, but it's not going to go anywhere. It's going to be meaningless no matter how it comes out, one side or the other, whatever your views are on it. It's -- of all the issues that this body is going to recommend, it's the least significant for it to go

1 forward, and for that reason I think we should send a
2 statement that we think it should be done in an
3 appropriate place, which is the Legislature.
4 CHAIRMAN ENTHOVEN: Helen Rodriguez-Trias and
5 then --
6 DR. RODRIGUEZ-TRIAS: Thank you, Mr. Chairman. I
7 agree with your motion and I do thank you for -- for
8 bringing it up, because I think it would lead to endless
9 discussion, perhaps, to really take it on. But I do
10 think we have to somewhere in this Governor's plans, and
11 it should be part of our Executive Summary, as well,
12 make a very strong statement that we want a powerful
13 governing entity that is -- has some kind of authority
14 over the various functional elements, DHS, DOC,
15 DOI -- that have to be accountable to the public.
16 And -- and somehow that -- that we in a way make a
17 statement of pri nciple, if you will, as to the kind of
18 leadership we are -- we are supporting.
19 MR. SHAPIRO: Mr. Chairman, I will support the
20 motion. I would like to be recognized, I was holding my
21 hand up earlier.
22 I appreciate it, because I don't know who has the
23 16 votes and who has the 14 votes, number one.
24 CHAIRMAN ENTHOVEN: I don't, either.
25 MR. SHAPIRO: I think it's a close question. I
26 think there's merit to both alternatives. I think
27 there's flaws in both. I only have two technical
28 requests, in essence.

One is that the reference to the board reflect the Gallegos' proposal, that's Alternative 2A --

CHAIRMAN ENTHOVEN: Yes.

MR. SHAPIRO: -- which references things like legislative appointees, which is the one that got the plurality vote. In fairness to what -- Alternative 1 got the plurality. The second --

CHAIRMAN ENTHOVEN: That would be mentioned first.

MR. SHAPIRO: Bu t when you -- when you gave your shorthand, I didn't hear the whole explication of it.

CHAIRMAN ENTHOVEN: Alternative 2, little a.

MR. SHAPIRO: Right. And not the alternative that was put --

CHAIRMAN ENTHOVEN: Not the --

MR. ROMERO: Not the one in italics.

MR. SHAPIRO: The other thing -- point I'd like to make is relative to what Kim Belshe said yesterday with regard to the paper and the position on 51 to 100. There's very little in this paper in support of a bo ard that -- Phil has been very busy and I talked about this and put a passing reference in continuity and stability, but in most cases the original papers supported an individual Director with an advisory board for many reasons.

I'm not suggesting we reopen the findings and try to do that, but as Kim said yesterday, it's hard to find support for the 51 to 100 recommendation which we

adopted in the choice paper, it's hard to find support in this paper for the board. And in the appendices I would welcome the staff sanitizing my more inflammatory arguments and taking Bill's arguments and -- and just building the background on that issue so that the people who read this report have the pros and cons of both of those in a more balanced fashion, and we not try and edit the findings of this one.

But I think since we have two competing close alternatives, we should have pros and cons for both in the body of the paper. And with that I -- I welcome your compromise.

CHAIRMAN ENTHOVEN: Okay. I think we're ready to vote. First we can vote on the larger proposition, then we'll ask for authority to do what Michael said, and what we would attempt to do would be -- with about equal space and even-handed justice, lay out the main points.

MS. SINGH: Without objection.

CHAIRMAN ENTHOVEN: Without objection, staff will do that.

MR. HAUCK: I would like to see a draft.

CHAIRMAN ENTHOVEN: Okay. All in favor of --

MS. FARBER: What are we voting on?

CHAIRMAN ENTHOVEN: The voting is the new oversight organization should be led --

MS. SINGER: Can I go? -- by a part-time board comprised of five or more individuals having specified qualifications, with at least one member each appointed

by the Assembly and the Senate and any remaining individuals appointed by the Governor and a chairman of the board, or an individual of stature in the health services field who can --

MR. SHAPIRO: Where did the Chairman of the Board come from?

MS. SINGER: That's the combination. It's --

CHAIRMAN ENTHOVEN: She is making up what's in 2B.

MS. SINGER: That's from Gallegos.

HON. GALLEGOS: She was appointing Chair and two other members.

MS. SINGER: Okay -- individual stature in the health services field who can command respect and exercise strategic leadership. The leadership of the organization should, et cetera.

CHAIRMAN ENTHOVEN: Instead of the "leadership" it should be "the leadership of the organization should have a sympathetic understanding of the patient's" -- "problems of patients and their families as well as their understanding of economics and the employer-based market for medical health care."

MR. LEE: I've got --

CHAIRMAN ENTHOVEN: That's the motion that we're voting on.

MR. LEE: -- an amendment to it. And then a request, I think is important. I don't think this --

MR. ROMERO: I think we've lost our microphones.

1 MR. TIRAPELLE: Turn them over.
2 CHAIRMAN ENTHOVEN: Okay, Peter.
3 MR. LEE: I'm very supportive of doing this. I
4 think we're at the point really of voting pretty much on
5 this block.
6 Given that, I want to do two -- a couple of other
7 technical amendments. I think we'll be able to then do
8 a whole vote.
9 CHAIRMAN ENTHOVEN: Okay.
10 MR. LEE: One of the things that got added in
11 between the last draft and this one, the "as well as an
12 understanding of economics and employer-based market for
13 health care."
14 With all due respect to Dr. Enthoven, I think
15 economics are important, but there are a lot of other
16 factors that are important in understanding consumer
17 protection, itself, and there's also non-employer based
18 coverage. I would just suggest we st rike that. I think
19 stopping at "families" is fine.
20 CHAIRMAN ENTHOVEN: Okay. All right, that's
21 fine.
22 MR. LEE: I would also --
23 MS. SINGH: Without objection from the body.
24 MR. WILLIAMS: I would object that there need --
25 I would agree, Peter, that the level of perhaps focus on
26 economics, et cetera, but I think in an understanding of
27 business market, I think a broader understanding of
28 patients and their problems and families are extremely

1 important.

2 MR. LEE: "Understanding of the health care

3 market" I think would be fine.

4 CHAIRMAN ENTHOVEN: Understanding of the health

5 care market.

6 MR. LEE: The health care market.

7 MS. SINGH: Is there an objection? Without

8 objection.

9 CHAIRMAN ENTHOVEN: Understanding of the --

10 MR. LEE: The health care market.

11 CHAIRMAN ENTHOVEN: -- the health care market.

12 MR. LEE: The other is -- and this really is --

13 is quite important to me in terms of the -- since we

14 don't know how this is going to come out, to have -- I'm

15 looking at the top of page 11, what was C, and it really

16 relates to either version, the importance of a -- of a

17 well-functioning advisory committee. And I'd like to

18 propose alternative language that would follow in this

19 proposal, and I'll read it. "An Advisory Committee" --

20 should delete "health care service plan advisory

21 committee," and say "include" --

22 MS. SINGH: I'm sorry, Peter.

23 MR. LEE: C, at the top. "An Advisory Committee"

24 should be deleted and note, "include the leaders of

25 other regulatory agencies as ex-officio non-voting

26 members, health care experts, representatives of

27 consumers and vulnerable populations, health plans,

28 purchasers and providers." That is not the composition

of the current health care plan advisory committee. I think our sense as a body is that we want to have that sort of collaborative mention and that would be very important for whatever structure we have.

MS. SINGH: And then striking "others, should be established"?

MR. LEE: Right. "Should be established" should stay, I'm sorry.

MS. SINGH: Just striking "others."

MS. BELSHE: Peter, would you make that recommendation to similar advisory boards.

MR. LEE: Whether there's a five-member board or a single person, it would have the advisory board.

MS. SINGH: Is there an objection to that amendment? Seeing no objection --

MR. LEE: The board is not an advisory board.

MS. SINGH: Seeing no objection, we'll consider that a technical clarifying amendment.

Members, there's a motion on the floor to adopt the language that's been read into the record with the amendment by Mr. Lee. It's been seconded by Ms. Griffiths.

MS. SINGER: B I think now needs to come out.

MR. LEE: Yeah.

CHAIRMAN ENTHOVEN: Yeah, right. Thank you. Yes.

MS. SINGH: Yes, need to delete B.

CHAIRMAN ENTHOVEN: Yeah, we have to delete B.

MS. SEVERONI: Page 11.

MS. SINGH: Are members ready to vote?

MR. HAUCK: What are you taking out now?

CHAIRMAN ENTHOVEN: The top of page 11.

MS. FARBER: We're talking about the deletion of B.

MS. SINGH: There's discussion. Ms. Farber.

MS. FARBER: I'm having trouble understanding why you would delete B. I'm not sure I' m even looking at the right B at this point.

CHAIRMAN ENTHOVEN: It's at the very top of page 11, because that's part of arguing for -- for stating and arguing for the case for the single leader.

MS. FARBER: You know something, I must have the wrong draft.

MR. LEE: There's a redraft.

MS. FARBER: I must be in the wrong draft.

CHAIRMAN ENTHOVEN: It's changed for page 11.

MR. LEE: You're probably in the version of 12-4-97.

CHAIRMAN ENTHOVEN: Also --

MS. BOWNE: The December 10th version.

MS. FARBER: I don't have the December 10th version.

MR. LEE: It's in your folder.

CHAIRMAN ENTHOVEN: The item C that Peter amended, you should go to the bottom and replace the other C. It's duplicative.

MR. LEE: Absolutely. The other C deals entirely with the other alternative.

MS. FARBER: Right. Right.

CHAIRMAN ENTHOVEN: Sara, perhaps we could print this later on and at the end of the day come back and --

MS. SINGH: So everyone is clear what they voted for --

CHAIRMAN ENTHOVEN: No, we vote now.

MS. SINGH: Okay, members. Those in favor of adopting the new amendment, please raise your right hand.

MS. FARBER: Wait a minute, what are you voting on?

MS. SINGH: Those opposed?

MS. BOWNE: Either/or.

MS. SINGH: 26 to zero.

MS. GRIFFITHS: I don't know what you voted -- we adopted the language that - -

CHAIRMAN ENTHOVEN: Read the record -- Sara, read it into the record.

CHAIRMAN ENTHOVEN: We adopted what I proposed as amended by Peter.

MS. FARBER: In other words, we're taking no stand on the leadership?

MS. BOWNE: We are taking a stand.

CHAIRMAN ENTHOVEN: We are taking a stand, which is that we take no action because the members are evenly divided on this issue.

MS. FARBER: No stand.

CHAIRMAN ENTHOVEN: In fact -- Diane, do you want those words in the -- do you think those words ought to be in the text, for members --

MR. HIEPLER: It's already been voted on.

CHAIRMAN ENTHOVEN: Forget it, excuse me. Now we have to go.

MR. PEREZ: Significantly divided.

CHAIRMAN ENTHOVEN: All right, organized for rapid action. Item 3. I don't know whether this has been superseded. Phil?

MR. ROMERO: Yes, just a comment.

No mikes anywhere. I didn't know th at. This was -- the language in number 3, which as you all know, has all been added, was my attempt to characterize and summarize Tony Rodgers' suggestion at the last meeting, which I will invite Tony to comment on.

But my understanding was that Tony's motivation was this -- this new organization will have a lot to do and will need to be able to act in a nimble and agile way. That statement procurement and personnel regulations may constrain that nimbleness, and Tony had a suggestion that this -- that this organization be organized as an authority which would be -- which would not be subject to some of those constraints.

Tony, do you want to add to that?

MR. RODGERS: The thinking was, whether it was a board or an individual appointed, that this organization

would be a separate entity of government and not be constrained by certain procurement and governmental processes that are in the bureaucracies, such as hiring consultants, hiring staff, et cetera. Mr. Mibb (phonetic) has done something like that. They don't -- they aren't as constrained.

I went a little further and suggested that it actually be a separate authority organized in such a way that it would allow the entity to have its own procurement processes and its own personnel processes. And that is what my proposal was.

The concern is that oftentimes even if you have good intentions, due to year to year issues of budget curtailments, freezes or even personnel practices, the leadership is hamstrung by these issues, and is unable then to really deal effectively with either the industry, because the budget is embargoed or because of hiring practices they have to hire people who may be less qualified than they would be able to get off -- say out of the market.

CHAIRMAN ENTHOVEN: Okay, thank you. Dr. Singh.

MS. DECKER: I just want to say that it's now been an hour a nd 15 minutes, so we have 15 minutes left.

MS. SINGH: I just want to mention FYI the State is currently in the process of reforming its procurement process to make things easier and seeking exemption from the procurement laws is a very, very difficult attempt. Since they are overhauling that whole procurement

process, they're actually deleting the existing exemption, so I just want to make you aware of that. This is some thing that's been in the works for several years now, but the Administration is pursuing an overhaul of the entire procurement process.

CHAIRMAN ENTHOVEN: Bill.

MR. HAUCK: Mr. Chairman, I mean, I would suggest we not get into this because it's a matter that's going to get dealt with by the Legislature and the Governor, which they -- when and if they put together an agency like the one that -- you know, we have substantively talked about, governed in whichever manner it's goi ng to be governed. And I think pursuing the -- the discussion today and trying to vote on this is really not going to, you know, be productive for us in terms of the rest of the work we have to do.

CHAIRMAN ENTHOVEN: Tony, do you want to --

MR. RODGERS: I'd just like to get a general feel of what people consider.

MR. ZAREMBERG: I think there are a lot of people around this table who care very dearly about the health care field. If we convened a group of people who ar e developmentally disabled, they would care very much about that particular field. If we convened a group of victims of crime, they would care just about as much about victims. If we convened a group of people who cared about education, they would feel the same way.

I think if we moved everything out of the budget

and take it out of the Governor's roles, we would have advocate groups for everything. And so, I think t his is very broad and I would suggest we -- I would go with Mr. Hauck, that we just -- it's a very difficult thing to get into without a whole lot of ramifications.

We could do this, I think we all agree that this group, this organization, needs flexibility and needs to be effective and that the Legislature should -- and the Legislature and the Governor should assure that it has the appropriate management tools to be effective and -- and et cetera.

CHAIRMAN ENTHOVEN: Okay.

MS. O'SULLIVAN: Could we make a statement like that?

CHAIRMAN ENTHOVEN: Okay. Sara, can you put a sentence in that the Legislature and the Governor go back -- let's just pick up Helen's -- the Task Force believes we should have a powerful effective governing body that has the appropriate management tools to be effective. That's a little repetitious, but Sara knows how to clean it up.

MR. ZAREMBERG: I move that.

DR. RODRIGUEZ-TRIAS: Can we use the language "reporting lines" or "lines of command"? I think it's more than planning and tools, it's connection to the actual --

MR. ROMERO: Authority.

CHAIRMAN ENTHOVEN: Authority and tools.

MS. O'SULLIVAN: Helen also used the word "accountable." Can we get that in there?

MR. ZAREMBERG: I withdraw my motion. I withdraw my motion.

CHAIRMAN ENTHOVEN: All right.

MS. SINGH: It's withdrawn.

CHAIRMAN ENTHOVEN: Sa ra --

MS. SINGER: I don't have the language. I can't hear. It's hard to hear.

MS. FINBERG: We don't know what you're saying

MR. ROMERO: We'll get --

CHAIRMAN ENTHOVEN: We'll get it.

All right, the Task Force believes we should have a -- a powerful effective governing entity with the tools and authority to accomplish its mission.

MS. BOWNE: It needs to be said that --

MR. PEREZ: At the risk of shocking everybody, I agree.

MR. RODGERS: You agree wit h Bill Hauck and Allan Zaremberg?

MS. BOWNE: I agree and Peter agrees.

MR. LEE: Wait a minute. Wait a minute. I think we covered these -- in the next one, 4.

CHAIRMAN ENTHOVEN: Without objection I'm going to drop item 3.

MS. SINGH: We're going to delete number 3.

CHAIRMAN ENTHOVEN: Okay. We move to item 4. Some of these ideas are in item 4, as a matter of fact.

MR. LEE: Move adoption or is there going to be any amendments?

CHAIRMAN ENTHOVEN: I'm having trouble tracking. Regulation conducted in -- as efficient and streamlined --

MR. ROMERO: "Cooperation" is the next word.

CHAIRMAN ENTHOVEN: Yeah. We need you -- we need to go to the top of page 12, you get it all. It's the paragraph at the top of page 12, which is unrevised.

MR. LEE: Ellen has moved.

MS. BOWNE: Second.

DR. SPURLOCK: Which is which number?

MR. ROMERO: Number 4.

DR. SPURLOCK: The new number 4?

MR. ROMERO: The old number 4. I will use the numbering system in the paper -- in the text you have in front of you.

CHAIRMAN ENTHOVEN: Adoption of appropriate principles for regulation.

MR. ROMERO: Right.

MS. SEVERONI: It begins on page 11.

CHAIRMAN ENTHOVEN: It's got -- a line or so got repeated, so it's following "principles should guide regulation, efficient and streamlined as possible. Conducted in cooperation with other public and private bodies," et cetera.

DR. SPURLOCK: Alain, before we --

CHAIRMAN ENTHOVEN: Yeah.

DR. SPURLOCK: It's a little again, a wording thing, I'm not sure that the last line of that -- that "low performers consistently culled from the pool of choices." I think -- I don't exactly know what "culled" means. I certainly think that --

MS. SEVERONI: It's a typo. It should mean "pulled."

DR. SPURLOCK: I think that slow performance should be improved or removed.

DR. RODRIGUEZ-TRIAS: It's removed.

DR. SPURLOCK: You got to get the opportunity for low performance. So, low performance should be improved or removed. How is that?

CHAIRMAN ENTHOVEN: Okay, fine.

MR. LEE: Should be improved or removed from the pool of choices.

MR. LEE: That's great. I didn't like it, but I kind of liked "culled." Cull them from the herd.

CHAIRMAN ENTHOVEN: All right. Is ther e a motion?

MS. SINGH: Without objection.

MS. BOWNE: We're ready to vote.

CHAIRMAN ENTHOVEN: We're ready to vote.

MS. SINGH: Those in favor of recommendation 4 as amended, please raise your right hand.

Those opposed?

27 to zero.

CHAIRMAN ENTHOVEN: Move next to streamline

regulation of medical groups, IPAs.

MS. SEVERONI: Before Chairman, I move approval.

CHAIRMAN ENTHOVEN: What?

MS. SEVERONI: I move approval.

MS. SINGH: She moves adoption.

DR. ALPERT: Second.

MS. SINGH: Second. Any discussion? Those in favor of the new number 5, which was 4, please raise your right hand.

MR. ROMERO: Streamline regulation. Medical groups, IPA.

DR. KARPF: Which are now just regulated.

CHAIRMAN ENTHOVEN: Now we want to streamline it.

MS. SINGH: Those opposed?

DR. KARPF: Getting off to the right start, Alain.

CHAIRMAN ENTHOVEN: Mr. P erez, you oppose?

MR. PEREZ: No, I'm just being slow.

MS. SINGH: 22 to zero. It's been adopted.

CHAIRMAN ENTHOVEN: Okay. Streamline solvency audits.

MR. ROMERO: I'll make a statement, there's a brief, one minor change in B, the -- the words "Request For Proposal" at the end of B were replaced with the word "competitive." That's simply because "Request For Proposal" is a particular term of art and I don't think we meant to be that specific. So, "competitive" was just meant to be a more generic term, capturing the same

intent, less specifically.

MR. PEREZ: Move 6.

MS. BOWNE: Can I make a comment? I just --

MR. LEE: The mike's off.

MS. BOWNE: I'll just say, okay -- I just want to say in regard to this, because it links to the other one, solvency is -- should be reasonably finite. You have the money, you have the resources, you have the proper accounting proce dures. And so, I would speak in favor of this one.

But when we come to the next one on quality, I think that there can be significant differences, significant interpretations. Some plans are more competitive in the market because they want to have higher quality or do certain things or not. So, I wanted to say it -- solvency is a little bit more finite and I'm supporting that one. But when we come to the quality, I have some questions on that.

CHAIRMAN ENTHOVEN: Okay . Rebecca, I agree with the sense of your -- when we get to that, I'll comment, but I -- right, solvency is pretty much cut and dried.

MS. BOWNE: Right.

CHAIRMAN ENTHOVEN: You are -- you do meet the standards or you don't.

MS. BOWNE: Right.

MS. SINGH: Do we have a motion to adopt?

MR. PEREZ: I moved it.

MS. GRIFFITHS: Are we on all --

1 CHAIRMAN ENTHOVEN: No, we are on 6.
2 MR. PEREZ: Streaml ine solvency audits.
3 MS. GRIFFITHS: It's on C. We're talking about
4 the oversight agency, provider organizations and health
5 plans convening a working group to develop new solvency
6 standards?
7 CHAIRMAN ENTHOVEN: Yes, I have some concern that
8 this is a -- these are the industry groups and we have
9 no consumer participation in that.
10 MS. SEVERONI: Can we amend it by saying "a
11 stakeholder working group," because we've agreed that we
12 would define stakeholder as including --
13 CHAIRMAN ENTHOVEN: I just don't think we have
14 them for a lot of --
15 MS. SINGH: Is there an objection to adding the
16 word "stakeholder" after "A" so it's --
17 MR. PEREZ: It's a replacement.
18 MS. SINGER: "The oversight agency should convene
19 a stakeholder working group," is that what you mean?
20 MS. SEVERONI: Yes.
21 MR. HAUCK: What's wrong with the current
22 solvency standards?
23 CHAIRMAN ENTHOVEN: I was going to ask that
24 question, but I thought we missed the meeting . What do
25 we need this for?
26 Warren, can you comment on the state of existing
27 solvency standards for the medical groups.
28 MR. FORBES: Solvency standards at the current

1 time are very amorphous for the contracting medical
2 groups and IPAs. The regulations require that if a
3 health plan capitates the medical group for IPA, the
4 health plan has the obligation to assert itself that
5 that organization has the financial where withal and
6 administrative capacity to form the obligations under
7 the provider contract, essentially.
8 CHAIRMAN ENTHOVEN: Thank you. So --
9 MR. FORBES: But there are no specific
10 requirements imposed by the department on medical groups
11 or IPAs.
12 CHAIRMAN ENTHOVEN: The thing is in order to do
13 what's envisaged here, which is there's a once and for
14 all periodic certification so you don't have different
15 health plans coming in and -- and dealing with solvency,
16 explicit sta ndards would need to be developed --
17 MR. FORBES: Absolutely.
18 CHAIRMAN ENTHOVEN: -- which are different from
19 the amorphous situation. I appreciate you using that
20 word.
21 MR. BARNES: Absolutely. Diane, does that answer
22 your question?
23 MS. GRIFFITHS: It was Bill's question,
24 actually.
25 CHAIRMAN ENTHOVEN: Yeah, Bill. So, that -- that
26 is the intent, and maybe we should say, you know,
27 specific solvency.
28 MS. GRIFFITHS: So, it's solvency standards for

1 the medical groups, not new solvency standards for
2 health plans.
3 CHAIRMAN ENTHOVEN: No, for medical groups and
4 IPAs.
5 MR. RODGERS: Can you say standards and financial
6 documentation? You wouldn't believe what you have out
7 there. You mean you want to standardize that?
8 MR. HAUCK: Well, you need -- you need a certain
9 time of financial reporting to be able to evaluate this.
10 In a lot of these group practices you're dealing with
11 checkbooks.
12 CHAIRMAN ENTHOVEN: Uh-huh.
13 MR. HAUCK: You need to have a certain standard.
14 How about phasing it into the particular group earlier
15 this morning on solvency and quality?
16 MS. BOWNE: It relates.
17 MS. SINGH: Now, do we have the cart before the
18 horse here? Gary, what do you mean and how would you
19 change this?
20 GARY: $$I thought we had endorsed regulation
21 with a working group earlier that was going to, you
22 know, implement within a couple of years and it included
23 solvency and quality. Now we're getting into
24 streamlining solvency. We're either duplicating or
25 starting to do some of the work of the group that we
26 already endorsed. We may be duplicating. Because we've
27 changed what's up front, I agree with that.
28 Because right now DOC doesn't have direct

1 regulatory authority over medical groups and IPAs unless
2 they're a limited licensure.
3 CHAIRMAN ENTHOVEN: Ok ay, we are -- we are
4 recommending -- Dr. Spurlock.
5 DR. SPURLOCK: In the first one we created the
6 standard for solvency and now we're talking about the
7 mechanism and the streamlining mechanism to do it. This
8 is sort of the rationale for creating it in the first
9 place. We're just making it and we've heard there are
10 no standards or irregular standards using different
11 financial mechanisms, and that's what we're kind of
12 trying to figure out, what that looks like. The below
13 global cap. We know what it is for global cap and
14 above.
15 CHAIRMAN ENTHOVEN: Okay. This is a little bit
16 repetitive, but I think item C here is saying something
17 like the oversight agency should convene a stakeholder
18 working group and provider organizations that contract
19 with multiple health plans, and the health plans with
20 which they contract, to develop acceptable specific
21 solvency standards. The solvency standards may vary by
22 size and type of amounts of risk assumed and othe r
23 pertinent factors.
24 MR. RODGERS: Can I just point out for a
25 physician who joins an IPA, a lot of them are getting
26 involved in IPAs that we know are not going to make it
27 because they don't have the solvency standards. The
28 problem also is having standard documentation a

physician can use to validate even that they should get involved with IPAs. That would be a very good benefit in all of this.

CHAIRMAN ENTHOVEN: Yeah, excuse me, I forgot to read that, "develop acceptable specific solvency standards and financial documentation."

MR. RODGERS: Right.

CHAIRMAN ENTHOVEN: I had written it, Tony, I apologize, I forgot to -- in the excitement I forgot to --

MS. SINGH: And "financial."

CHAIRMAN ENTHOVEN: Financial documentation. All right.

MS. DECKER: Can I move the item 6 as amended?

CHAIRMAN ENTHOVEN: Yes. Is there a second?

DR. RODRIGUEZ-TRIAS: Second.

CHAIRMAN ENTHOVEN: Second. All in favor of item 6 as amended, raise your right hand.

MS. SINGH: Those opposed?

23 to zero.

DR. RODRIGUEZ-TRIAS: On item 7, Rebecca, to respond to your very legitimate concerns, the thought here was not to violate the notion that different purchasers or different accrediting agencies or different health plans might want to have different standards, you know, "Plan A" might say we want everybody to be doubly Board Certified and this and that, and "Plan B" may say something. But it is an

1 attempt to express the idea that with -- with respect to
2 the information gathering, they -- they try to agree as
3 much as possible as to what the information content of
4 an inspection should be, and see if -- if -- I mean,
5 it's a goal, it's not a mandate, but it's a goal to try
6 to get everybody to say, all right, if you -- if we
7 gather this data set and audit, then different entiti es
8 will have what they need so that we don't have the
9 parade of different inspectors. Is that -- to respond
10 to what -- I think your concern is a good one.
11 MS. BOWNE: Thank you. I certainly don't think
12 this is cut and dried. Some health plans are going to
13 want to have stronger standards.
14 DR. SPURLOCK: I think it's a floor that can be
15 added on based on individual needs. And it -- we just
16 do the floor once.
17 CHAIRMAN ENTHOVEN: Yes.
18 DR. GILBERT: We don't want the lower common
19 denominator, we really want a floor within standards.
20 CHAIRMAN ENTHOVEN: Let's just read the wording
21 from that point, please, and I'll come back to you,
22 Peter.
23 MS. GRIFFITHS: Mr. Chairman, can you repeat what
24 the amendment is?
25 CHAIRMAN ENTHOVEN: We haven't made an amendment
26 yet, Diane. We're --
27 MS. DECKER: We're reading.
28 CHAIRMAN ENTHOVEN: And then I'm agreeing with

Rebecca's point, w e think we want to reflect, like this is not to say that different health plans may not have different standards.

DR. SPURLOCK: No, I think we want --

MS. FARBER: Yes.

CHAIRMAN ENTHOVEN: Yes, I want to know what current practice is.

It says Knox-Keene standards require the health plans to audit the quality of the provider organizations. Is there any language that mandates to whom they disclose those results to or are the consumers ever made aware of what those a udits show? Does the Department of Corporations --

MR. SHAPIRO: Yes, there are quality audits on a three-year basis that are now publicized and available to the public that deal with the medical groups, implementation of plans, responsibilities.

MS. FARBER: And the general public can access that, that was the law two years ago.

MS. FINBERG: Not very easily.

MR. SHAPIRO: But it's now public.

MS. FARBER: Why is it difficult, Michael.

MR. SHAPIRO: It's becau se, you know, it's not well-publicized and it's not easily -- it's improving. The Department's working on it, but the law now requires three-year audit, the -- and it specifies -- consumer issues and other issues require that audit to be a public document available to the Department of

Corporations.

MS. FARBER: How extensive is the audit?

MS. FINBERG: I have looked at this a little bit because I've been trying to get that for different plans, and the consumer has a choice of five plans, and it's very difficult. Some of the audits are done, some of them are not. The Department isn't able yet to tell you what they have and what they don't have.

MS. FARBER: Is there any penalty for not doing the audit?

MR. SHAPIRO: We're going to move it out of DOC.

MS. FARBER: Is there any penalty now --

MS. FINBERG: And it costs a fortune.

MS. FARBER: -- when the plans don't do the audit?

DR. GILBERT: We're talking about two different things.

MR. SHAPIRO: The DOC does the audit.

CHAIRMAN ENTHOVEN: Warren, you want to comment?

MR. BARNES: Yes. I'm not sure that everyone is talking about the same thing. The medical surveys that Michael is referring to are surveys of the health care service plans that may or may not include a specific look at any particular medical group or IPA that the health plan contracts with.

Moreover, if it were to lo ok at a certain percentage of the particular medical group, the medical groups or IPAs that are reviewed would not be reflected

in the report, so a consumer would be reviewing the report of the health care service plan but would not be reviewing a report that consists of sub-reports of its contracting medical groups.

We do have the medical survey reports available at all four offices of the Department for public viewing, and if someone wishes to receive a copy, they may either have their copy service do it or we'll be happy to copy it for them at the -- the price provided for in the Department's regulations. It is true that they're not brief. You do have to pay for them, but people are welcome to come in and look at them.

Obviously, we can't produce the medical survey report unless the survey has been conducted and unless it's been drafted. However, the prior survey report would be in th e file.

MS. FARBER: Can I ask another question regarding this? If I'm a consumer in Alameda County and I want to decide between ABC Medical Group, and XYZ Medical Group, both under the same health plan, I can't readily determine based on reports that may be available through the Department of Corporations which medical group has a better track record.

MR. BARNES: You are completely correct.

MS. FARBER: That is a problem.

CHAIRMAN ENTHOVEN: Bruce, Lee and then --

DR. SPURLOCK: I'm not going to deal with that issue because I think it's a separate issue. I'd like

1 to go back to what Rebecca is talking about and maybe I
2 have some language that may be able to help us and,
3 again, I'm willing to sort of modify this.
4 In order to facilitate the collection of -- and
5 here's an addition, I strike out "information" and I put
6 "of standardized data," so we're talking about -- we're
7 not talking about any potential data but the stuff that
8 is standardized, which I think is what we're looking
9 for.
10 Then you go down, "necessary to audit quality in
11 an efficient manner provided an organization should be
12 able to request the State agency for regulated managed
13 care oversee one quality audit of that data." So,
14 that's an insertion, on a periodic basis, and it goes
15 down the list.
16 Then after the last sentence I put "When
17 standardized data is not available, health plans should
18 be allowed to use other criteria for their -- for the
19 purpose of maintaining high care -- high quality of
20 care." And the example I'm thinking about now,
21 personally, is -- is this new thing, this new rotoblade
22 device that goes in coronary arteries and actually reams
23 out the plaque.
24 There are only a few people who are able to do
25 that, and a health plan needs to be able to credential
26 those people using a lot of data that does exist, you
27 know, their amount of training, who they had -- so that
28 they know that that's going to be done in a high quality

1 way. When that gets standardized 20 years from now or
2 ten years from now we have a way to audit and evaluate
3 all people doing that procedure, that they no longer
4 need to use additional methods. We can have a
5 standardized process for that review. Until that point
6 health plans need to have the flexibility to look at
7 additional areas in which w e don't have standardized
8 data.
9 CHAIRMAN ENTHOVEN: Rebecca, can you read your
10 last citation.
11 MS. BOWNE: When standardized data is not
12 available, health plans can use other information to
13 ensure the delivery of high quality care.
14 MS. DECKER: I'd just like to mention we're now
15 at one hour and 40 minutes, ten minutes over.
16 CHAIRMAN ENTHOVEN: Health plans may use --
17 MS. BOWNE: -- may use other information to
18 ensure high quality care.
19 CHAIRMAN ENTHOVEN: Okay .
20 Ms. Singer, do you have that?
21 MS. SINGER: Yes.
22 CHAIRMAN ENTHOVEN: Okay, that would replace
23 different wording that I tried to get at the same thing.
24 All right. Yes.
25 Peter, did you have --
26 MR. LEE: I was in line.
27 MS. BOWNE: Go ahead, I'll be in line.
28 MR. LEE: Two things. First, I don't have a

1 problem with that language, but two comments and this
2 is -- I know it's hard to keep track of paper, b ut I
3 gave everyone a copy of a draft amendment, this is
4 really where it comes up, and it relates very much to
5 this area and I'm supportive of avoiding duplication,
6 but not if it means the data, that information and
7 process that would otherwise be public all of a sudden
8 become private. And that's what my proposed language
9 tries to avoid.
10 And I think it's either as part of streamlining
11 quality audit or a separate recommendation without
12 having -- I think it probably should be separate.
13 DR. SPURLOCK: I think it's a separate
14 recommendation.
15 MR. LEE: I'd like to address it; if you're not
16 going to support these recommendations in terms of some
17 other recommendations, let's have private-public
18 partnerships which I think should be absolutely
19 encouraged. They should only be encouraged to the
20 extent they don't all of a sudden blind and make a black
21 box which should be a public process.
22 DR. SPURLOCK: So, you're not favor of having it
23 all public ?
24 MR. LEE: Not all public. It's public to the
25 extent that it would have been public if the public
26 sector were doing it. I'm not trying to sort of back
27 into CCBS or CCI which the State wouldn't be doing, but
28 if the State says here's data elements, then a person in

1 the public should know what's the process that data was
2 collected by and should have access to it at low or no
3 cost.
4 DR. SPURLOCK: You got my vote.
5 MR. LEE: That's what my recommendations are,
6 which are a one-pager that everyone got yesterday and
7 probably lost forthwith.
8 COMMISSIONER: We need a whole page.
9 MR. LEE: I think it does need the language that
10 I propose because it relates both to the data, the
11 processes, the methodologies, that this private-public
12 partnership not impede the public's decisions about
13 what's collected.
14 MR. SHAPIRO: Do you want to read it?
15 MR. LEE: I got only a couple of others.
16 MS. SINGH: I think the Chairman doesn't have a
17 copy.
18 MR. LEE: Pass one down to the chair.
19 MR. RODGERS: Is this the one you're talking
20 about?
21 MR. LEE: That's the one I'm talking about.
22 Striking my introductory editorial remarks, I
23 will read the proposed language which is -- and I'd
24 suggest this be a recommendation, I guess, of 6 to come
25 before this streamlining one -- is the Task Force makes
26 numerous recommendations that encourage State agencies
27 responsible for managed care oversight and for data
28 collection, to make it clear we make recommendations not

1 just for oversight but for the other agencies
2 responsible for data collection to work in collaboration
3 with and not duplicate the efforts of the private sector
4 initiatives and data collection efforts of private
5 purchasers or accrediting bodies. The Task Force
6 endorses these efforts to the extent the following are
7 satisfied:
8 One, there must be full disclosure of all survey
9 processes, methodologies and investigative results.
10 Data collection, protocols and results should be
11 publicly available to the same extent they would be if
12 the effort were conducted by the State agency, itself.
13 DR. SPURLOCK: Can I just make one simple
14 modification? There must be a full disclosure -- can we
15 put in "upon request"? And the reason is --
16 MR. LEE: Absolutely.
17 DR. SPURLOCK: -- we have big booklets in CCRH
18 that has all methodology that we don't publish.
19 MR. LEE: That is fine, upon request. Two,
20 "Private data collection standards, protocols and
21 results of data collected must be available to the
22 public at no or low cost to the extent that data
23 satisfied -- satisfies public oversight requirements.
24 The cost, if any, to the public to be nominal and
25 reflect only the cost of copying and distribution."
26 MR. PEREZ: One other -- right there, if we could
27 also include some sort of referen ce to the timeliness
28 with which it would be made available, so that that's

1 consistent with the timeliness with which the -- the
2 information were -- at least as timely, if not more
3 timely, than it would be if it was being done by a State
4 agency.
5 MR. LEE: I would say "must be available to the
6 public in a timely manner and at no or low cost to the
7 extent the data satisfies," et cetera.
8 Okay. Three, the collaboratio n with private
9 entities about State regulatory bodies should not limit
10 or impede the public processes by the way the State
11 determines which data should be collected and how
12 quality should be monitored.
13 Four, the State agency responsible for managed
14 care oversight -- four, other appropriate agencies
15 ensure that any privately collected results relied upon
16 by the State to satisfy its requirements are valid.
17 MR. RODGERS: This is a substitute?
18 MR. LEE: No, this is not a subs titute. This is
19 an additional -- sort of a new number that would come
20 before "streamline quality audits." It's -- I'm
21 concerned saying, yes, let's streamline without making
22 clear that there's an open window where we're doing the
23 public-private. Really, it cuts out a lot of our
24 recommendations, but I think this is the one that I
25 needed to bring it up in front of.
26 CHAIRMAN ENTHOVEN: Discussion. Diane.
27 MS. GRIFFITHS: Well, actually my discussion is
28 not directly on this l anguage, but I think it's related

1 and --

2 COMMISSIONER: Louder.

3 MS. GRIFFITHS: Sorry. My comments are not

4 related directly to Peter's language but to a related

5 point, and I've been trying to figure out the right time

6 to bring it up, as well.

7 I think that one of the most fundamental

8 criticisms that we've heard is that -- the inappropriate

9 oversight of quality care for HMOs. People can differ

10 about whether that's rig ht or wrong, but that's one of

11 the primary reasons why we're here, because there's a

12 felt lack of detailed oversight to ensure quality of

13 care for HMOs.

14 I have significant problems with recommendation

15 7B which in essence allows -- before we get it right

16 here, before we figure out what it is in a way that

17 satisfies patients, citizens of the State, of the

18 quality of care for health plans, we're right away going

19 to turn around and delegate that to some private

20 organizations wh ich may be doing a great job, they may

21 not be doing a great job, but I have difficulty

22 supporting a delegation of one.

23 Core functions of the agency. So, I -- I don't

24 know that interfaces with Peter's recommendations, but

25 I'd like to hear some more from the supporters of this

26 delegation about the protections that we expect to see

27 that would guarantee that by off-loading this important

28 function we're going to get a better system and not a

1 worse system.

2 CHAIRMAN ENTHOVEN: I think I'd used the word

3 "subcontracting" rather than "off-loading." Bruce.

4 DR. SPURLOCK: I think Diane is right. I think

5 it should be a permissive language.

6 MR. LEE: May.

7 DR. SPURLOCK: So may delegate. And it's -- I'm

8 very, very confident that that delegation will happen

9 simply because they are doing -- but let -- let the body

10 decide that. May delegate.

11 MR. LEE: More appropriate say "may subcontract

12 when appropriate." Would that --

13 DR. SPURLOCK: I think that --

14 MR. SHAPIRO: Can I clarify existing law? This

15 issue was handled two years ago that -- with the medical

16 surveys. The Department of Corporations used to do that

17 in-house. And it was subject to the extreme criticism

18 that Diane just mentioned.

19 Two years ago the administration requested an

20 amendment and a broad bill of medical surveys to allow

21 them to contract out their medical surveys, which they

22 have done, and they did it in a very -- it was

23 controversial, they did NCQA and they did ACMA at the

24 same time and they were damned on both ends of the

25 spectrum for having done it. But the view is DOC is not

26 a medical entity, it really isn't. It's got lawyers and

27 security people and good lawyers, Warren. But --

28 So, they contracted that out and that was with

1 the blessing of the Legislature. And it was in May. We
2 don't know how well that's been done, so it needs to be
3 revisited.
4 But the reason I also mention it in B, they got
5 sole source authority, they didn't have to do it on an
6 RFP. So, I just want to raise the very last line in B
7 takes away something that the administration requested
8 which still goes to Tony's point, that they said, you
9 know, we're going to work collaboratively on this. We
10 want to go ahead and do it, we don't want to go through
11 an RFP, we don't want to be bogged down with two ye ars
12 of appeals.
13 So, I just point out that the Request For
14 Proposal was something that was removed in the last
15 iteration. I'm not sure you want to move one way or the
16 other.
17 I'm just letting you know the State of the law on
18 medical surveys now is sole source, it was basically
19 streamlined fast action, collaborate and then go. It
20 was very controversial; it wouldn't have been any less
21 controversial had they done the RFP, but they got it
22 done quick.
23 I just wanted to r aise that.
24 MS. GRIFFITHS: Michael, is there any sense of
25 what's coming from that process?
26 MR. SHAPIRO: I think you have to ask the plans
27 and the consumer groups. My feeling is the agency, the
28 way it's equipped now, it's not a medical entity. It

1 simply does not have medical expertise. And this was an
2 acknowledgement -- this was based on an acknowledgement
3 by the administration that we needed to go out to NCQA
4 and ACMA and others. Under contract, the final survey
5 has to be signed off by the Department. They don't
6 delegate this.
7 CHAIRMAN ENTHOVEN: They -- basically, they
8 contract out for the survey, they take that information
9 and Warren can tell you, they have to validate it, they
10 have to make sure it is an accurate survey before they
11 bless it, and then it's the Department survey. But they
12 were given that authority to contract out sole source.
13 MS. GRIFFITHS: I don't have a problem with that.
14 I mean --
15 CHAIRMAN ENTHOVEN: Okay.
16 MS. GRIFFITHS: -- the concept being I think that
17 the agency ought to be ultimately responsible for the
18 quality of the quality audits that they do. And I
19 also -- just a smaller point, I don't think it's
20 appropriate for us to list particular accrediting and
21 quality measurement entities. That gives them a leg up
22 vis-a-vis other subcontractors.
23 CHAIRMAN ENTHOVEN: We'll strike that.
24 MS. SINGER: Strike what?
25 MS. SINGH: We're going to go strike such as
26 CCHR --
27 CHAIRMAN ENTHOVEN: I'm going to read it, "The
28 State's agency for regulating managed care may

1 delegate" --

2 MR. LEE: Not delegate.

3 CHAIRMAN ENTHOVEN: -- subcontract. May

4 subcontract.

5 MR. LEE: May contract.

6 MS. SINGH: It wouldn't be a subcontract, may

7 contract.

8 CHAIRMAN ENTHOVEN: -- "may contract when

9 appropriate the authority."

10 MR. LEE: Not "authori ty."

11 MS. GRIFFITHS: May contract for audits of the

12 medical groups.

13 CHAIRMAN ENTHOVEN: Okay. May contract for --

14 MR. ROMERO: -- audits.

15 CHAIRMAN ENTHOVEN: -- audits of medical groups,

16 by contracting.

17 MR. LEE: You can pull that out. With

18 independent appropriately qualified --

19 CHAIRMAN ENTHOVEN: -- with independent --

20 MR. LEE: Qualified.

21 MR. SHAPIRO: Qualified.

22 CHAIRMAN ENTHOVEN: -- qualified.

23 MS. SINGH: They would have to be qualified.

24 CHAIRMAN ENTHOVEN: -- qualified third party

25 organizations and other quality measurement or

26 accrediting organization --

27 MR. RODGERS: That can all come out.

28 MS. SINGH: Just take that out.

1 CHAIRMAN ENTHOVEN: -- that meet standards of the
2 State's agency for regulating managed care
3 establishments." Period.
4 Okay.
5 MS. SINGH: No objection to those amendments?
6 MR. WILLIAMS: I have a question about Peter 's
7 comments.
8 MR. LEE: A ping-pong in between B and my
9 proposal.
10 MR. WILLIAMS: I guess the thing I'm not clear on
11 is if the work is being done as part of a contracted
12 process, that's the idea -- if the work is a
13 collaborative research initiative in which health plans,
14 medical groups, other entities are investing substantial
15 resources and time and effort, applying these standards
16 to me seems to recommend a potential burden to their
17 participation in the activity.
18 If it's truly a contractual relationship in which
19 there is an execution of a function, then I think the
20 State as part of its contractual process has the right
21 to request whatever it requests.
22 MR. ZATKIN: I was going to say the same thing,
23 Peter, and that is collaboration could mean that the
24 State is sitting down with a private group and working
25 on or assisting on the development of -- of a data TIMM
26 or something that may be -- that may ultimately have
27 benefit to the State, and b enefit to the private sector,
28 but the act, itself, is not for a public purpose.

1 And so, I don't have a problem with your list
2 if -- if the preceding language is something to the
3 effect that when the -- when the private activity is
4 being conducted to meet a public purpose.
5 CHAIRMAN ENTHOVEN: Where will you put that in,
6 Steve.
7 MR. ZATKIN: How about saying "the Task Force
8 endorses" --
9 CHAIRMAN ENTHOVEN: Right .
10 MR. ZATKIN: -- these efforts when the private
11 activity --
12 MR. PEREZ: How about instead, in your
13 introductory paragraph, following the colon?
14 MR. ZATKIN: That's where I was trying to put it
15 in, somewhere in there.
16 CHAIRMAN ENTHOVEN: What are your words?
17 MR. ZATKIN: Just say where you want to insert
18 that language and I find that friendly. My concern with
19 that is --
20 MS. SINGH: What is the language?
21 MR. ZATKIN: I mean, "the Task Force endorses
22 these efforts to the extent that the following are
23 satisfied where the private activity is being conducted
24 to meet a public purpose."
25 MS. SINGH: No objection.
26 MR. ZATKIN: That's fine.
27 MS. SINGH: Members, at this point in time I
28 would like -- I'm sorry, I just want to make one quick

statement. I think that you should make a motion to perhaps adopt first the amended version of 7. The amended version would be the amendments in B and then vote on the inclusion of Mr. Lee's amendment.

MR. LEE: I'd really prefer to do mine first. I assume it's going to go right out without major objection.

MS. SINGH: Either way, I think we probably need to vote. We got quite a few recommendations and the time is --

MS. BOWNE: Why don't we do Lee's then?

MR. PEREZ: Nancy has been trying to say something.

CHAIRMAN ENTHOVEN: We'll really have to move forward.

Nancy, go ahead.

MS. FARBER: I would not like to leave the section on streamlining quality audits without addressing the issue that we just discussed with the Department of Corporations. And that is at this point in time consumers have no way of accessing -- accessing providers' specific quality audits. We're mandating these, and I think that one of the amendments that should fall into this "streamline quality audits" is that medical groups that serve -- they're multiple medical groups many times, that serve more than one health plan and that where consumers have a choice, they should have a right to take a look at summary

1 information from those quality audits.

2 MR. LEE: I think that we addressed that in

3 faulty information. There's a specific proposal that

4 the State has an obligation to make sure the information

5 is disseminated, or by the private sector, that cuts

6 across plans and providers.

7 I totally agree with you, Nancy, one of the

8 things that we've fallen short on in the State is not

9 having that information disseminated.

10 MS. FARBER: I just want that very, very clear.

11 MR. LEE: It's in there. I mean, that's a --

12 MS. FARBER: If the health plans are doing the

13 studies now, it is not a mammoth effort to make public

14 summaries available. If they're not doing this now,

15 then they're in violation of the law, right?

16 MR. LEE: Section 6. Again, I do believe we

17 addressed this under 6.

18 CHAIRMAN ENTHOVEN: Quality information.

19 Recommendation 3A. Unfortunately, I don't have the

20 redlined version with me. I've got prior ones since

21 they keep going back and forth.

22 Okay. At this point what I'd like you to do

23 is --

24 DR. GILBERT: I got to 7a and, Bruce, can you --

25 what you were thinking about as standard?

26 DR. SPURLOCK: One of the most important pieces

27 of a non-medical group is the processes, that they have

28 quality processes in place to make sure they're looking

1 at grievances, make sure they're looking at their
2 quality data and making their changes so when you're
3 thinking data standards you are including those
4 processes, all those things that go with accreditation,
5 standardized data and quality processes.
6 MS. SINGH: If we could simply have a motion --
7 could we have a motion to accept 7 as is, a second, then
8 we'll have a motion to adopt Mr. Lee's amendments; we'll
9 go ahead and vote on that.
10 MS. BOWNE: A long time I had my hand up. I have
11 just a question on number C. Who currently pays for
12 this? Are we giving this a new payment or is this how
13 it goes now?
14 DR. GILBERT: We perform the audit.
15 MS. BOWNE: Okay. And how do you feel about
16 this?
17 DR. GILBERT: We perform the audits now.
18 CHAIRMAN ENTHOVEN: Health plans perform the
19 audits now.
20 MS. BOWNE: I didn't know -- I needed factual
21 information in order to v ote.
22 CHAIRMAN ENTHOVEN: My understanding was the
23 health plans pay for it now, Rebecca, and they'd be able
24 to save money if they did that.
25 MS. BOWNE: I didn't know.
26 CHAIRMAN ENTHOVEN: Would you please let us vote
27 here. John?
28 MR. PEREZ: Move adoption of Peter Lee's language

to be.

CHAIRMAN ENTHOVEN: As amended.

MR. PEREZ: As amended. Between the streamlining regulations and the streamlining solv ency audits.

MS. FARBER: Second.

MS. SINGH: Those in favor of the proposed motion, please raise your right hand.

Those opposed?

CHAIRMAN ENTHOVEN: Thank you.

MS. SINGH: 27 to zero.

CHAIRMAN ENTHOVEN: All right. Now streamline quality audits as amended. John?

MR. PEREZ: So, moved.

MS. SINGH: Who seconded? I'm sorry.

DR. GILBERT: Does it include the language about quality process in addition to standardized data?

MR. RODGERS: Second.

MS. SINGH: I did, but I didn't hear it. Standardized data and quality of processes.

It's been moved and seconded to adopt amended versions number 7A, B and C.

Those in favor, please raise your right hand.

Those opposed?

26 to zero.

CHAIRMAN ENTHOVEN: The recommendation is adopted.

MR. LEE: I have an amendment proposal on 8 or whatever it's numbered now.

1 CHAIRMAN ENTHOVEN: Promoted to departmenta l --
2 and safety -- eliminate redundancy.
3 MR. LEE: It goes to some of Diane's questions.
4 And I think we have not in this group really talked
5 about the implications of -- of deeming authority
6 granted to private third party entities which is sort of
7 a very big issue and it's sort of mentioned in passing
8 here.
9 The second paragraph, I would propose we revise
10 it to read, "The Department should seek to avoid
11 duplication of audits conducted by independent third
12 party and on gov ernment -- or government-approved
13 auditors," period. And delete the remainder of the
14 sentence, and it picks up where "it remains carriers,"
15 et cetera, et cetera.
16 MS. SINGH: Ms. Singer, do you have that?
17 MS. SINGER: Yeah.
18 CHAIRMAN ENTHOVEN: Should seek to avoid
19 duplication of --
20 MR. LEE: -- of audits conducted by independent
21 third party government-approved auditors.
22 CHAIRMAN ENTHOVEN: Yeah.
23 MS. BOWNE: It gives it more flexibility.
24 MR. LEE: It does, i t gives it more flex. It
25 doesn't say we're granting more authority that we
26 haven't talked about here.
27 MR. WILLIAMS: We're not granting anything, we're
28 making recommendations.

MS. SINGH: Without objection we'll accept that amendment.

MS. DECKER: Move to adopt 8.

DR. KARPF: Second.

CHAIRMAN ENTHOVEN: All in favor please raise your right hand.

MS. SINGH: Those opposed?

Recommendation is adopted . 25 to zero.

CHAIRMAN ENTHOVEN: Okay. Next, complete the challenges presented by accelerating industry change.

MS. DECKER: And we're now at two hours.

Okay, let's hope we do this quickly. Thank you, Barbara.

MR. LEE: Is it too fast to move adoption?

MR. SHAPIRO: Are you moving 9?

MR. LEE: We're about to.

MR. SHAPIRO: At the last meeting I asked for some consult with DOC on the minor amendments, and I just wanted to confirm that the Department was comfortable with how those were being fast-tracked. That's why I'm here with Warren. Maybe he can comment.

MR. LEE: That would be great.

MR. BARNES: One, the Department, to the best of my knowledge, has no concern with minor amendments being aggregated on an annual basis. In order to achieve that, it will require the Department to specify those types of changes that it deems to be minor amendments for that purpose, obviously. I -- the Department is

1 concerned with the timely processing of the material
2 modifications. The important thing I believe for the
3 Task Force members to appreciate is that the Department
4 approves the material modification when the entity
5 submitting it establishes compliance with the statutory
6 requirements and the requirements of the regulations.
7 We don't have the authority to approve it beforehand.
8 Therefore, frequently under current circumstances
9 when material modifica tion is late, it's because of the
10 Department's chronic understaffing. That problem is
11 being resolved.
12 On the other hand, it's beyond the Department's
13 control as to how long it will take a health plan to
14 demonstrate compliance. My personal opinion would be
15 that it's more in the public's interest and I suspect in
16 the interests of health plans and consumers, both, to
17 allow a health plan to have a reasonable period of time
18 to demonstrate compliance rather than having what I
19 would consider to be a premature denial, because then
20 that throws the whole process into administrative ego
21 and could be very costly and time-consuming. I think in
22 many cases would generate unwarranted negative
23 publicity. And I have not seen the current version of
24 E, so my comments are generic.
25 We did talk about it. We did talk about it.
26 CHAIRMAN ENTHOVEN: Can we just take a second
27 here to read this.
28 MS. SINGH: Take a second.

1 CHAIRMAN ENTHOVEN: I think it's fine as is.
2 Okay, Diane.
3 MS. GRIFFITHS: My comments are related to
4 paragraph E, and the essence of this paragraph is that
5 if the Department doesn't act within a certain period of
6 time, then a material modification is deemed approved.
7 I have a problem with that. The failure of the
8 State to provide the -- the Department with sufficient
9 resources to approve those material modifications in a
10 timely fashion should not res ult in an automatic
11 material modification that would harm the patients and
12 the health plans. No categorical endorsement of that
13 proposal seems to me to be -- I have not heard
14 sufficient testimony at any of our hearings that would
15 warrant anything more than like looking at this issue.
16 And I couldn't support a recommendation that goes as far
17 as this paragraph.
18 CHAIRMAN ENTHOVEN: Ron.
19 MR. SHAPIRO: So you might want to explore a
20 study or something. That one has -- it's ver y
21 controversial.
22 MR. WILLIAMS: Yes, I think I would just call to
23 Diane's attention it says that the Department cannot
24 approve it. They can disapprove it, they can suspend
25 it, and the Department can designate in advance whether
26 they need 60 days, 90 days or 180 days to do any of
27 those three.
28 So, I think what -- what we're trying to create

are some time line parameters within which there is perhaps guidance from the Department. Particularly given some of the historical staffing issues, I think we all have great expectations that the Department will now have more resources to do this in a timely way but we don't really know.

So, I think I would agree with you, this said, we're going on, that there needs to be a proposal that basically says some action is to be taken; approve it, disapprove it or suspend it. And if the Department can designate how long it needs to do that.

CHAIRMAN ENTHOVEN: Maryann.

MS. O'SULLIVAN: I agree with what Diane said, that it shouldn't be the consumers may have to suffer because the Department didn't act quickly enough, and what we maybe want to amend this to say is that the governing Legislature should assure that the State's agency of regulating marked care is adequately funded and staffed to act as defined by Knox-Keene.

MR. WILLIAMS: I think also the consumers aren't all exposed to harm, they're exposed to potential loss of new products and new innovation because the process hasn't been available because of limited resources.

MS. O'SULLIVAN: What we want to fix is the agency isn't working fast enough and that ought to be to get physicians -- and the Legislature ought to be watching over itself and make sure they do. And if they're not doing it, they grant staffing and resources,

not saying, "They're not doing their job so we'll j ust get rid of this process."

MS. SINGER: Maryann, that was the purpose of D.

MR. WILLIAMS: I would argue the Department doesn't refer it to the Department. If it does, the Department doesn't have any objections to it.

MR. ZATKIN: Maryann, read the word. The Department just has very broad discretion. It makes them do something.

MS. O'SULLIVAN: If the Department polices --

MR. ZATKIN: They have to approve, disapprove or suspend.

MS. O'SULLIVAN: If they don't, then we've lost our oversight because they don't do their job.

MS. DECKER: There's automatic approval, they have to take action.

MS. GRIFFITHS: It says it shall be considered approved.

MS. O'SULLIVAN: In the second line.

MR. WILLIAMS: They can always come back and disapprove it. They just then can't penalize you because they didn't act as a result of limited resources.

MS. O'SULLIVAN: I think it's a problem that should be addressed. I don't think it's just addressed by getting rid of legislation. It's addressed by making the Department do what they're supposed to do.

MS. FINBERG: I think we should separate out --

CHAIRMAN ENTHOVEN: When we take a vote.

MR. RODGERS: Take a vote on the rest.

MR. BARNES: I would suggest, if I may, that E closely parallels the existing law. However, it doesn't reflect what I think is a necessary responsiveness so plans can do necessary business planning.

The current timeframe within the Knox-Keene Act is the plan must receive something essentially, to paraphrase it, within 20 base days. This allows a longer period of time for the entire process to take, but I believe based on my experience that it affords the Department ample regulatory flexibility to -- to maintain the public interests and at the same time afford plans more predictability in their business planning.

CHAIRMAN ENTHO VEN: Tony.

MR. RODGERS: I think the parameters of the staff's point of view of the Department's prioritization of where their resources ought to be, this allowed them to better prioritize. If they don't have this in place, they have no penalties, if you -- if you will, to not moving forward in a timely fashion. So, I think E should stay in as is. It gives us the predictability we need.

CHAIRMAN ENTHOVEN: Peter.

MR. LEE: I certainly like the State agency -- that is to say, they can still come in and say, "You're wrong," take it back. That's a risk the health plan is

wrong, they can't come back and sue the Department and say you're surprised. I don't care if you're surprised. I'd rather you not be surprised. I'd like to delete the language that says "for certain types of material modification" -- from the very first. If the State's agency -- so, this is -- it cuts across.

I mean, we aren't trying to limit, and there's not any balls being hidden there.

MR. ZATKIN: I think it was probably intended to not include the most -- the largest material -- but it doesn't matter.

MR. LEE: Is that okay? So, deleting that --

CHAIRMAN ENTHOVEN: Without --

MR. LEE: Do that, "If the State's agency" --

CHAIRMAN ENTHOVEN: Delete what -- "for certain types of material modification."

Diane.

MS. GRIFFITHS: I don't like to put us in the position of deeming something to be approved if the State doesn't act. I was going to suggest we take out the introductory clause and "the Governor and the Legislature," et cetera, and simply start on line 2, "The State's agency for managed care regulation should act as defined by Knox-Keene by approval, disapproval, suspending or postponing." Then we go on to say as under current law the order would be issued as follows, and then we go into the sentence as modified by Peter.

MR. WILLIAMS: But without that there really --

there's nothing. There's no ability to introduce a new product. There's no ability to complete programming, to implement finer arrangements. You really can't operate a business successfully.

MS. GRIFFITHS: You get yourself in the third sentence, you're not subject to departmental disciplinary action.

MR. WILLIAMS: If it's not approved, you can't sell it. You cannot sell it until there is a specific approval of each and every new product or feature, whatever, of the material --

MS. SINGH: Might I recommend that you make a motion to adopt recommendations 9A through D, and then we can deal with E.

CHAIRMAN ENTHOVEN: Okay.

MR. ROMERO: Good idea.

CHAIRMAN ENTHOVEN: Is there a motion?

MS. SINGH: There is a motion.

MR. ROMERO: There's a motion.

CHAIRMAN ENTHOVEN: Helen seconded.

MS. SINGH: All in favor of adopting recommendation 9A, B and C and D, please raise your right hand.

MR. LEE: This is A, B, C and D for you audience out there.

MS. GRIFFITHS: Is E separate?

MS. SINGH: Yeah.

Those opposed?

25 to zero. A, B, C and D are adopted.

CHAIRMAN ENTHOVEN: Now, admittedly that's controversial. I think we have to put that to the members.

MR. KERR: Is there any timing, that the Department thinks 180 days wo uld not suffice? Why can't we just say that the -- the Legislature and the Governor requires that the new agency act within 180 days? It just forces the issue, not saying -- I mean, it just says you're going to do it, that's your job, forget this other track. If you didn't do it, it's automatic.

MR. BARNES: The Department would have no problem specifying a 180-day period. In fact, it's the Department's current practice for what I would consider to be a major -- major signif icant material modification such as, for example, a highly significant merger, to answer an order of postponement within the 20 business-day period, typically, because we know that the -- the process is going to go for a long time and the health plan may itself know it, as well, and frequently in those cases the Department and the plan are in at least weekly, if not daily contact, working to resolve the major issues as rapidly as possible.

MR. SHAPIRO: Let me ask the question. The Blue Cross conversion was a material modification that took two years. What happened at 180 days?

MR. BARNES: In that case an order of postponement had been issued.

1 MR. SHAPIRO: I just want you to realize there's
2 flexibility for the big ones.
3 MR. WILLIAMS: That's really about product.
4 It's about running a business. And knowing how to
5 create products.
6 MR. SHAPIRO: And government --
7 CHAIRMAN EN THOVEN: Let's have one conversation
8 at a time, please.
9 MR. WILLIAMS: This is really about running a
10 business and being able to introduce new products in a
11 timely way, in terms of major mergers, those things --
12 there's all types of communication.
13 It's a fairly ongoing process. This is really
14 about introducing a new product and knowing one way or
15 another what you can do with the product.
16 MR. SHAPIRO: No, it said -- it said "material
17 modification."
18 MR. WILLIAMS: B ut it says the Department has to
19 either approve it, disapprove it or suspend it.
20 CHAIRMAN ENTHOVEN: If we said consider new
21 product material modifications --
22 MR. WILLIAMS: That would be acceptable.
23 CHAIRMAN ENTHOVEN: Okay. In the first line, new
24 product --
25 MS. SINGH: To consider new product.
26 CHAIRMAN ENTHOVEN: Material modification.
27 DR. GILBERT: What about like a small geographic
28 expansion, wouldn't that be included?

1 MR. WILLIAMS: It's a new product in that area.
2 Without objection we'll include after consider
3 new product and then --
4 DR. NORTHWAY: I don't know that -- when you ask
5 for something like this, there's no response back from
6 the --
7 MR. WILLIAMS: I think whether it's -- it depends
8 upon the -- what else is going on. The Department has
9 had a very limited amount of data to focus on very large
10 health plans that are constantly creating new products
11 and recommending a challenge for the staff.
12 CHAIRMAN ENTHOVEN: Do I have a motion to adopt,
13 as amended?
14 COMMISSIONER: Did you consider Clark's
15 suggestion or not?
16 MR. KERR: I would like to say we'll do it in 100
17 days. And everybody knows the whole game plan.
18 MS. SINGH: Is there a motion? Or Mr. Kerr's
19 amendment will do it?
20 CHAIRMAN ENTHOVEN: Yes.
21 MS. SINGH: So, we'll have to do a formal motion.
22 At this point, members, can we have a motion to adopt?
23 MR. RODGERS: So moved.
24 CHAIRMAN ENTHOVEN: It's been moved by --
25 DR. GILBERT: Second.
26 MS. SINGH: The time frame is?
27 MR. HAUCK: As it reads.
28 MS. GRIFFITHS: That means the Department gets to

decide what the time frame is.

CHAIRMAN ENTHOVEN: Yeah. Right.

MS. SINGH: Those in favor of adopting --

MR. HAUCK: Maybe I missed something here. The time period says 60, 90 or 180 days. How did that help?

MR. WILLIAMS: I think it's the ability for predictiveness? If the Department says this is going to be 180 days, you plan for the introduction. Again, if they tell you this is going to be 60 days, that you plan, too, for that kind of introduction.

MR. HAUCK: All right.

MR. WILLIAMS: Human Resources roll out advertising media, things like that.

MS. FARBER: Can we clarify how many changes we've had to this? We have the new product in the first line.

CHAIRMAN ENTHOVEN: "For certain types of material modifications" has been deleted. Down toward the bottom.

MS. SINGH: And the fourth line from the bottom, these were the only changes that were made without objection.

MS. O'SULLIVAN: It still allows the plans to consider the -- modifications approved. That first sentence is still there, is it?

DR. NORTHWAY: If DOC doesn't just say we're going to postpone it.

MS. O'SULLIVAN: I think if the agency isn't working in a timely way, we ought to make the agency work in a timely way.

MS. SINGH: Members, I think we're ready to vote. This issue has been significantly debated. We have a motion and a second. Those in favor of adopting the recommendation as amended, please raise your right hand, to E.

Those opposed?

22 to 2. The recommendation as amended is adopted.

CHAIRMAN ENTHOVEN: Okay.

MR. LEE: I've got a numbe r of technical amendments to this, to the findings. Sorry.

MS. DECKER: Just say no. Just say no.

MR. LEE: First on page 6, where it is "improving the regulatory process" --

CHAIRMAN ENTHOVEN: Please, which page, Mr. Lee?

MR. LEE: Page 6. The first paragraph, three lines up where it says before "adding more legislation," I would suggest deleting those three words and just start with "attention, these needs to be focused on."

CHAIRMAN ENTHOVEN: Where are you?

MR. ROMERO: Third line from the bottom on the first paragraph of Roman II.

MR. LEE: Clearly, we're making recommendations that may include needing legislation, so I'd suggest that.

1 CHAIRMAN ENTHOVEN: All right.
2 MR. LEE: The change is --
3 MS. FARBER: Is there any material changes?
4 MR. LEE: I don't think they're material, but I
5 think they're important in terms of communicating what
6 we're trying to communica te.
7 MS. SINGH: Without objection.
8 MR. LEE: Attention needs to be focused on the --
9 MS. SINGH: Next.
10 MR. LEE: Next, page 7, three lines down. I'd
11 request the language reflect what we voted on in terms
12 of the findings. I mean, the recommendation is --
13 which would be "familiarity with the family's concerns
14 as well as market -- the health care market.
15 MS. SINGH: Without objection. Next?
16 MR. LEE: The -- the next is -- we aren't
17 changing these over again.
18 MR. PEREZ: Who says we aren't?
19 MR. LEE: Just delete "recommendations" and say
20 "regulatory organization must."
21 CHAIRMAN ENTHOVEN: Where are you?
22 MR. LEE: Page 7.
23 MS. SINGH: Page 1.
24 MR. LEE: Roman III.
25 CHAIRMAN ENTHOVEN: Delete "recommendations" and
26 say "regulatory organization must consider," and delete
27 "will be most thoughtful" if they include "so must
28 consider not only."

MR. ROMERO: Go od.

MR. LEE: Maybe finally is -- I don't know if the last paragraph on page 8 really makes sense or not there. It talks about what our early straw polls were.

MR. ROMERO: I wrote that. I don't think it's necessary.

MR. LEE: I would suggest that paragraph come out.

CHAIRMAN ENTHOVEN: Without objection, that --

MS. SINGH: Without objection, those two amendments. Mr. Lee, any others?

MR. LEE: One last one, which is the -- the top of page 8, where it says --

MR. ROMERO: Page 8?

MR. LEE: Page 8, the last sentence, "This private sector regulation is suggesting such private sector regulations should be embraced" --

MR. ROMERO: Good.

MR. LEE: -- "and built upon by the public sector to ensure all groups are included," deleting "not duplicated by," which we cover in many places. But it's a building process.

DR. NORTHWAY: Say it again.

MS. SINGH: Ms. Singer, do you have --

MR. LEE: Private regulation should be embraced and built upon by the public sector to ensure that all groups are included.

MS. SINGH: Without objection.

MR. WILLIAMS: I just want to understand it all. I got to read the whole thing.

MS. SINGH: That's okay, that's what it's for.

MS. BOWNE: Is the question, is the concept of this paper that it will reflect the newly adopted recommendation that was the compromise?

MR. LEE: Yes.

MS. BOWNE: So, that if need be, other wording would be changed?

CHAIRMAN ENTHOVEN: Right. Sara will go through it.

MS. BOWNE: Because we're going to be including that, shall we say the -- the how?

CHAIRMAN ENTHOVEN: Yeah.

MR. ROMERO: Let me just repeat a statement I made earlier --

MS. BOWNE: Diatribe.

MR. ROMERO: -- just repeat a statement I made earlier to be clear on. You made some pretty fundamental changes about the scope of the regulator and the leadership. This will have -- this has implications for many recommendations or many statements in this paper and others, so it was staff's responsibility to make sure they're harmonized, and I am requesting your indulgence in some way to not have it -- not to have it come back. You'll see paper, but not to spend meeting time re-debating those changes.

MS. SINGH: Without objection, that authority

will be granted to staff.

MR. LEE: Thank you for your indulgence.

CHAIRMAN ENTHOVEN: Now we can vote on the findings.

MS. SINGH: Do we have a motion?

MR. PEREZ: So moved.

DR. KARPF: Second.

CHAIRMAN ENTHOVEN: All in favor of adopting the findings as amended?

MS. SINGH: Please keep your hands raised.

Those opposed?

24 to zero. The findings are adopted.

CHAIRMAN ENTHOVEN: Okay. We're about an hour behind. We'll take a brief break. Please get back quickly.

(Whereupon a short recess was taken.)

CHAIRMAN ENTHOVEN: Will the Task Force members please resume their seats.

The next paper is called -- the next paper is called Approving the Delivery of Care and Accountability in the Practice of Medicine. A new version dated 12-13-97 is being passed out by Mrs. Vorhaus of Stanford.

Will the members please -- we have a new paper before you.

MS. SINGH: It's a new paper.

CHAIRMAN ENTHOVEN: But it has line-ins/line-outs from the last one you read.

MR. LEE: What's the date in the bottom corner?

CHAIRMAN ENTHOVEN: 12-13-97.

MS. SINGH: Is it only new because it has the line-in/line-out? Is that the only difference?

COMMISSIONER: Yes.

CHAIRMAN ENTHOVEN: So, members can --

MS. SINGH: Members can refer to either one.

MR. LEE: It's the same version we got in the mail then.

CHAIRMAN ENTHOVEN: Same version, not lin e-in and line-out.

COMMISSIONER: No, it has a few minor changes in it.

MS. SINGH: I'm sorry.

MR. LEE: Trying to buy us off with candy.

MR. RODGERS: Give Peter two, it will buy us out.

MR. PEREZ: If Peter gets two, I want two.

MR. LEE: Okay.

MS. SINGH: I did have it the whole time, Alain, and I told you a fib.

CHAIRMAN ENTHOVEN: We will start with recommendation 1 on page 5. Where is Bruce?

DR. ALPERT: Actually, I'm going to start.

CHAIRMAN ENTHOVEN: Gilbert -- Dr. Alpert, You're going to take this one on?

MS. SINGH: He's going to take it on.

CHAIRMAN ENTHOVEN: Dr. Alpert.

DR. ALPERT: Barbara, what's our time on this?

DR. KARPF: Two days.

CHAIRMAN ENTHOVEN: About an hour.

MS. SINGH: As soon as we're finished we will break for lunch.

MR. ROMERO: And not before.

DR. ALPERT: Recommendation 1 on page 5 -- we have no micro phones, is that it?

CHAIRMAN ENTHOVEN: No.

MS. SINGH: Maybe after lunch probably.

DR. ALPERT: Actually, the first thing I want to say about this is just a question. And that has to do -- we asked this yesterday and that had to do with when the Task Force recommends. And here it just says the health plans for -- actually, to the first four. And is there going to be some sort of continuity, recommends to the Governor and Legislature or recommends -- how -- how did that get resolved?

CHAIRMAN ENTHOVEN: Well, I thought the idea in this particular case, Bud, was that for the first few of them we were making recommendation to the health plans and saying this is what they ought to do.

DR. ALPERT: All right. All right, that being the case --

CHAIRMAN ENTHOVEN: Then at the bottom it says if they're not --

DR. ALPERT: Right.

CHAIRMAN ENTHOVEN: -- moving -- significantly moving, then --

DR. ALPERT: So, that's -- okay, that's fine. I don't have any problem with it. I was just looking for the continuity.

That being the case, I just -- in recommendation B I had a one-word change in the third line. In these data sets I wrote -- inserted "may" for "should."

MS. FARBER: Where are you?

DR. ALPERT: Recommendation 1B. That's "data sets may," rather than "should" "form the basis on which alternatives are -- can be based." And that just gives a little more wiggle room for the plans and their -- in their moving towards this change.

And then in recommendation 1D, I reinserted something that was removed -- was removed by vote, it just didn't come back -- wasn't in, and I'll comment on that in a minute.

At the end after "accepted," just in parentheses, "e.g. pediatric oncology." And then --

MS. SINGH: Which one is that?

MS. SEVERONI: D.

MR. ROMERO: D, after the last words.

DR. ALPERT: "e.g. pediatric oncology." And then in E you'll see there's an italics, which is a question and -- and the question wasn't generated by me, and I think it's a legitimate question, and it is the issue of whether or not if this comes to the regulatory agency looking at it, whether or not it should be -- these changes should be a requirement of licensure or

1 accreditation. And I don't know the exact answer, so I
2 would inclu de them both. I would say change is a
3 requirement of health plan licensure, and then I would
4 put "or accreditation." So, both are possibilities.
5 MS. GRIFFITHS: Delete the "or accreditation"?
6 DR. ALPERT: It would be a regulatory -- it would
7 be a decision that regulators do. As an overview of
8 this recommendation, we talked a lot about it last time
9 so I'll keep this brief. The only thing different from
10 last time is that I think of all of the recommendations
11 we make, this o ne potentially will have the most
12 immediate and most profound impact on the level of
13 frustration that -- that people are having with the
14 system -- the 42 percent of people are having
15 frustrations, the 7,000 population. As the repeated
16 data come in to show where people are frustrated and
17 having trouble in the system, this goes right to that.
18 And I can tell you working in the system, my personal
19 experience and as my colleagues would say that, too, I
20 think that -- that it -- we've created trillions of
21 dollars of costs in other areas and so forth; I think
22 this would pale compared to that. I think there's lots
23 of wiggle room in terms of the plans, in terms of
24 evolving it over a couple of years.
25 Even the issue of if plans can be creative in the
26 way they did things, if they already had some systems
27 that they were working on, it's taken into account under
28 E with the wording "an equivalent modification."

1 So, I -- I actually think that we make -- making
2 this recommendation will make a big change with the
3 level of frustration that produced -- essentially
4 produced our creation.
5 Now, just one final comment and that is we
6 received some comments as we have in lots of papers with
7 some criticism, and it was mostly -- it was from several
8 sources, mostly focused at D, which has to do with the
9 catastrophic conditions. 1 and D to me is the Cardinal
10 Bernadine recommendation for our whole -- or for our
11 Task Force.
12 This is the case where you have -- I'll just use
13 the case I presented last time to you. You have the
14 eight-year-old that has cancer being seen by the Chief
15 of Oncology, having a treatment that is recommended,
16 established by national protocol, having a review for
17 medical necessity, a deferral of 30 days, a denial at 60
18 days and an appeal, and finally instituting treatment at
19 120 days. And that should never happen. It just -- it
20 should neve r happen.
21 The problem -- the Cardinal Bernadine's position,
22 one of his big pieces which separates going into K-Mart
23 from going into your doctor's office is that virtually
24 everything that happens to you when you go into K-Mart
25 or General Motors, if you lose all of your money there,
26 that is painful, but it's a reversible act.
27 Money has never reversed the cellular division of
28 what cancer cells do each day. So, no matter what I

1 believe, if somebody backed a truck -- I guess it would
2 take a 747 up to Leonard Abramson's house and emptied it
3 of all the money and took it over to the kid that has
4 three months delay and -- and gave him that money, it
5 wouldn't reverse the -- the cellular division that those
6 cancer cells have. The irreversibility is the
7 difference.
8 And so, that to me is the -- that's the Bernadine
9 piece to this.
10 Having said that, I would move adoption.
11 MS. GRIFFITHS: Second.
12 MR. WILLIAMS: Friendly amendment question. When
13 you say "licensure" or "accreditation," I'm thinking
14 that this is a, you know, kind of complex, many faceted
15 thing that -- experts can judge and say -- you know,
16 just like professors, graduate students' essays, they
17 can say you made it or you haven't.
18 When you say "regulation," I'm just thinking this
19 is not a topic that gives clear level definitions and
20 bright linings in clear terms, and it may be appropriate
21 just to say "a ccreditation."
22 DR. ALPERT: I don't have a problem with that.
23 Regulatory agencies deal with their charge by approving
24 accreditation agencies and reviewing their actions and
25 so forth. So, I don't have a problem with that.
26 MR. ZATKIN: How does that work? The State
27 agency really has no authority over a private
28 accrediting agency.

1 DR. ALPERT: The -- let me interpret -- I guess
2 we should ask the Chair, but my inte rpretation, why I
3 would go along with it in that regard is, for instance,
4 if the medical board, we've been given the charge of
5 outpatient surgery center oversight, and all of the
6 statutes that -- there's one specifically that has been
7 made that -- where there are accrediting agencies, that
8 we then -- Ronald Joseph, I think, is here. He probably
9 has the right line, we endorse or we sanction to give --
10 to go out and look at these places to make sure they're
11 up to the statute and so forth and so on.
12 So, we don't specifically go out, they do, but we
13 see all their standards, then we see their reports on it
14 and so forth and so on.
15 So, the buck ultimately stops with we're the
16 regulatory agency and that's how I envision it.
17 MR. SHAPIRO: Can you be licensed if you don't
18 have accreditation? That's why I don't understand how
19 it works.
20 DR. ALPERT: You can't be accredited without a
21 license, then I think it had to be licensure.
22 CHAIRMAN ENTHOVEN: I don't know how it works. I
23 just know this is not something --
24 MR. SHAPIRO: I just didn't understand why you
25 were proposing --
26 DR. ALPERT: I think either/or works fine because
27 it lets them figure it out.
28 MR. ZATKIN: They don't have -- they don't have

1 the authority to deal with accreditation, period. If
2 they use an accrediting agency to conduct a
3 State-required audit, which is what we were talking
4 about earlier, then it would be relevant. But then it's
5 not accreditation, it's -- it's meeting a State
6 requirement.
7 So, you sort of have to conceptually decide
8 whether it's appropriate to have a State requirement in
9 this area or not.
10 CHAIRMAN ENTHOVEN: Nancy.
11 MS. FARBER: I think at the heart of the issue
12 about pretreatment authorization and denial is the idea
13 that when a physician is seeking authorization to do
14 something, particularly in a catastrophic situation,
15 that they be allowed to talk to another physician with
16 the same credentials and training, and that a
17 neurosurgeon is not talking to a clerk on the phone and
18 spelling bur holes because they don't know what a bur
19 hole is.
20 And I think that I would like language included
21 in the first recommendation that specifically addresses
22 that physicians, when they are being denied by the
23 health plan, speak with a physician who has the same
24 credentials; a neurosurgeon just talk to a neurosurgeon
25 and an oncologist to an oncologist.
26 CHAIRMAN ENTHOVEN: Ron.
27 MR. WILLIAMS: There are several items. One is I
28 think there's some legislation now that requires that

1 the review be done by an appropriate specialist.
2 MS. FARBER: In a given area.
3 MR. WILLIAMS: I think that's how all these
4 health plans operate.
5 MS. FARBER: There's no legislation in California
6 for that now.
7 MR. WILLIAMS: I know how we operate and I'm not
8 sure, but my recollection is that there is a requirement
9 that a review be done by an appropriate specialist,
10 meaning you wouldn't have a pediatrician do some kind of
11 cardiovascular surgery review. But let me come back.
12 MS. FARBER: But that does happen now?
13 MR. WILLIAMS: Let me come back to item C. I've
14 made my comment, but thank you, Nancy.
15 Item C, there are really two items I'd like to
16 raise in -- in the item, I would like to see added or
17 modified in ite m C.
18 CHAIRMAN ENTHOVEN: Excuse me, Ron.
19 Excuse me. I think we need some resolution on Nancy.
20 What words would you change? We need to get resolution
21 of this.
22 MS. FARBER: I would be open to recommendations
23 in wording, but the general concept is that particularly
24 in situations where you have denials in catastrophic
25 circumstances, that the physician requesting approval
26 have the right to consult with a health plan
27 representative from the same basic specialty, i.e.
28 pediatric oncology.

1 DR. SPURLOCK: You know, Alain --
2 MS. FARBER: This whole recommendation isn't on
3 that topic.
4 DR. ALPERT: Nancy, this gets to that because
5 it's -- this is the case where the person is already in
6 the office of a pre-credentialed provider that the plan
7 has established, they're being treated in a way that's
8 been a nationally agreed-upon protocol. And it just
9 lets them --
10 MS. FARBER: No, I want -- my motion specifically
11 deals with having specific language that stipulates
12 before you turn down a provider that's in this health
13 plan, a member of this medical group, and tell him they
14 can't do a procedure, that it's going to -- that that is
15 going to be reviewed by somebody with the credentials to
16 make that appropriate medical decision. One of the
17 biggest criticisms the public has of managed care is
18 that clerks and nurses are practicing medicine without
19 the supervision -- dir ect supervision of the same
20 physicians who would be making that decision, otherwise.
21 DR. ALPERT: It seems to me that's a different
22 recommendation. And that is in the cases where the --
23 as this process goes on in cases where plural
24 authorization exists --
25 MS. SINGH: Ms. Farber, are you suggesting that
26 we add a subsection F?
27 MS. FARBER: Yes, I am.
28 MS. SINGH: F.

MS. FARBER: I am suggesting that you add language.

DR. SPURLOCK: May I make a point?

MS. BOWNE: Just make it.

DR. SPURLOCK: Mr. Chairman --

CHAIRMAN ENTHOVEN: Yes.

DR. SPURLOCK: If we do -- we need to use the language of "appropriately qualified-credentialed person," and the reason is when you use the word "specialty" you open a can of worms that you can't get out of, and the problem is that we deal with in the example of family physicians, another specialty that's identical is not necessarily ap propriate.

Likewise, in the Emergency Departments with family physicians who make decisions, they oftentimes are credentialed and qualified to make those life-threatening decisions or require pre-authorization. So, it's an appropriately qualified as Ron's language mentioned earlier, and I believe that's what most of the time happens in the current practice.

DR. KARPF: I'm very sympathetic to Nancy's position. I wonder if going back to Dispute Resolution chapter, was that not covered in there?

MS. FARBER: No, I want it here and it's my motion to have it -- to have it completely stated here.

MS. SINGH: At this point I suggest we take a straw poll vote on adding Ron's recommendation that basically indicates what Ms. Farber has stated as the

1 concept.

2 MR. LEE: Can I just say what I thought it was.

3 Where prior authorization exists, denials of care must

4 be made by appropriately qualif ied-credentialed

5 individuals.

6 MS. FARBER: That's great.

7 MS. SINGH: Is that --

8 CHAIRMAN ENTHOVEN: Read that again, slowly.

9 I think -- move us along here,

10 MR. LEE: Where prior authorization exists --

11 MR. KERR: Where are you?

12 MR. LEE: I'm wherever you want to --

13 Where prior authorization exists, denials of care must

14 be made by appropriately qualified-credentialed

15 individuals.

16 DR. GILBERT: I would say must include review.

17 MR. LEE: Can we --

18 DR. KARPF: This speaks to eliminating prior

19 authorization in appropriate circumstances where there's

20 an expert doing a study on a defined circumstance.

21 MR. KERR: When A does not exist, then --

22 MS. FARBER: It does not exist.

23 DR. ALPERT: Peter's language I would accept as a

24 friendly amendment.

25 MR. LEE: Where prior authorization is required,

26 is that better? Then Brad's --

27 DR. ALPERT: My only comment was "must be made,"

28 I would change "must include review by," becau se

1 practically what happens, it gets reviewed by an
2 independent organization that has specialists with the
3 credentials necessary, but it still comes back to the
4 Medical Director making the final decision.
5 MR. LEE: Must include review by appropriately
6 qualified-credentialed individuals.
7 CHAIRMAN ENTHOVEN: Nancy.
8 MS. FARBER: Thank you, Peter.
9 CHAIRMAN ENTHOVEN: Mrs. Vorhaus, do you have
10 that language?
11 MRS. VORHAUS: Yes.
12 CHAIRMAN ENTHOVEN: We are going to call that F.
13 MS. SINGH: So, "must include."
14 CHAIRMAN ENTHOVEN: Let's take a --
15 MS. SINGH: Straw vote.
16 CHAIRMAN ENTHOVEN: -- straw poll vote on that
17 amendment.
18 MS. SINGH: Those in favor, please raise your
19 right hand.
20 Okay, a majority would favor that
21 recommendation. So, without objection.
22 DR. KARPF: So moved.
23 CHAIRMAN ENTHOVEN: Ron, I cut you off. We'll
24 come back to you and then we'll take --
25 MR. WILLIAMS: My comments relate to item C and
26 1, and at the end of the third sentence where we speak
27 about automatic approval, and my request is to include
28 something that says "for select procedures for which

1 there are clear objective guidelines that allow for
2 measurement and comparison."
3 Basically, what we're saying is that some form
4 of -- we use the word "automatic." My preference would
5 be "expedited," but tha t's a separate issue. Approval
6 for selected procedures from which there are clear
7 objective guidelines that allow for measurement and
8 comparison. That means we have some evidence base to
9 say this is what you do, these people are doing it.
10 DR. SPURLOCK: Would you accept it friendly if it
11 was procedure, treatment or diagnosis -- diagnostic
12 test?
13 MR. WILLIAMS: Yes, that would be fine.
14 MS. SINGH: Can you read that, please.
15 MR. WILLIAMS: For selected procedures --
16 MS. SINGH: Which place, where?
17 CHAIRMAN ENTHOVEN: At the end "automatic
18 approval."
19 MS. SINGH: Where?
20 MR. WILLIAMS: Item C, third line. Right before
21 the "a." It's the end of the sentence there. For
22 selected procedures, treatment -- and what did you say,
23 Bruce?
24 DR. SPURLOCK: Diagnostic tests.
25 MR. WILLIAMS: Diagnostics for which there are
26 clear objective guidelines which allow for measurement
27 and comparison. Then second comment is --
28 MS. FARBER: Sec ond.

1 CHAIRMAN ENTHOVEN: Wait. Mr. Alpert, you want
2 to discuss these points?
3 DR. ALPERT: It's very related.
4 MS. SINGH: Ms. Vorhaus, do you have that?
5 MS. VORHAUS: I do.
6 MR. WILLIAMS: The second comment, I'd like to
7 make it clear that plans may continue to require
8 providers to attain verification of eligibility and
9 coverage and approval of the setting in which procedure
10 would be performed.
11 That would be - -
12 DR. ARMSTEAD: Could you read that again.
13 MR. WILLIAMS: That would be "plans may continue
14 to require providers to attain verification of
15 eligibility and coverage and approval for the setting in
16 which the procedure is to be performed."
17 MS. SINGH: I didn't get -- Ms. Vorhaus, you got
18 it written down?
19 MR. WILLIAMS: Plans may continue to require
20 providers to require verification of eligibility and
21 coverage and approval for the setting in which the
22 procedure is to b e performed; that's my comment.
23 CHAIRMAN ENTHOVEN: Uh-huh.
24 DR. KARPF: Can I just make a comment? Your
25 first comment, Ron, which -- which I think is quite
26 valid, does speak to the need for defining explicitly
27 what's been -- what is acceptable. What's standard of
28 practice. What is evidence-based, right, because we'll

1 come back to that issue later. If you're not explicit
2 about it, there's -- it has no help.
3 MR. WILL IAMS: Correct.
4 DR. ALPERT: My responsibility to both -- I'd
5 like to respond to each one independently. The first
6 one I'm a little concerned that that might emasculate or
7 lead -- leave it open to emasculate the concept. The
8 fact that the doctor which has been chosen and has now
9 spent two years demonstrating an exemplary practice
10 pattern, to allow that doctor to practice, to take care
11 of patients, to eliminate these problems that we're
12 talking about, will now be -- have an e nd run around it
13 by using -- using this language.
14 And -- and, actually, and I'm open to discuss
15 that, but that if it did that, that would -- I think
16 that would be awful, then it would eliminate all this.
17 DR. KARPF: I think even the expert of voters can
18 mistake their personal opinion with fact, right. I
19 think you have to have some control on that process.
20 That's the two year being unfettered. That's
21 where you can really get confused between facts and
22 opinion.
23 DR. ALPERT: Can we shift to Brad's example with
24 the two-year thing? To begin with, I'd like to know
25 what he thinks about it.
26 DR. GILBERT: I actually have the same concern.
27 The idea here is that we would look at a provider's
28 practice and we would determine they made good judgment

1 decisions about referral for specialty care and
2 diagnostic procedures. And once the decision was made
3 that they were in fact capable over a two -year period to
4 do that, that they would have the ability to have
5 referrals occur without any investigating or approval.
6 I actually agree with Ron in terms of eligibility
7 and coverage, you still need to provide that back check.
8 So, but I do agree with you, I'd be concerned that if
9 this was taken in the narrow view we'd be right back
10 where we were before, because they would say, well, that
11 particular referral doesn't quite fit into an
12 objectively measurable process. So --
13 DR. ALPERT: That's what I'm afraid of.
14 DR. GILBERT: I was concerned about that.
15 CHAIRMAN ENTHOVEN: Where are we now? Rebecca
16 Bowne.
17 MS. BOWNE: I was really looking at this in
18 response to both Dr. Gilbert and Alpert, as putting in
19 the qualifying language is actually more freeing. For
20 instance, you could -- you could -- if -- health plans
21 may not be very willing, or even in my case PPO plans,
22 to say you can do anything. We might want to say if you
23 got a heart transpla nt or something else, we want to --
24 we want to check on that. But things within your normal
25 scope we would grant you authority.
26 So, I think that -- that the qualifying language
27 actually gives the provider more flexibility because you
28 can say "all but." You see.

1 DR. GILBERT: If you could change the language to
2 make it that way, because the problem is if that "all
3 but" -- if the "buts" all become so large that the --
4 MS. BOWNE: No, I meant for the major big
5 ticket -- you know, for major big ticket things, the
6 health plan might be going to withhold that deemed
7 authority. Because what you're trying to do is
8 streamline the process for the routine. Have it go for
9 all the routine kinds of things that that practitioner
10 has shown that they're good practitioners for.
11 DR. GILBERT: I think -- but I think the way it
12 was -- the way it was presented was -- I like that
13 concept, but within -- wit hin their scope and ability
14 there's certain things that are going to need prior
15 approval no matter what, because they're 50 to 100
16 thousand dollar events that require, you know, massive
17 coordination.
18 So, if we can come up with language that defines
19 it, but in a way that allows that open flexibility and
20 leaves some ability to review that, that I would be
21 comfortable with.
22 MR. ZATKIN: What's the effect of the last
23 sentence? What's the effect of the last sentence where
24 it says, "Health plan should develop and implement
25 strategy that allow providers an exemplar practice" --
26 DR. ALPERT: I can address that. If they don't
27 want to do that, they don't have to, but --
28 MR. ZATKIN: If they do --

DR. ALPERT: The point is that they're allowed to continue to check and you don't just -- after somebody has spent two years going through this process, and I'm working for Ron, and he said, "You're doin g a pretty good job, you can do that -- he lets me take care of people, but that's not forever, that's not a life membership. If he wants to come back in a year and review me again, and he's got ways to do that, that's his -- how he wants to do that. And presumably it would be the same way that he evaluated me -- the way I did it before.

MR. ZATKIN: So, the issue is whether it's clear at the front end, what the scope of the -- of the authority is versus saying six months later, "We looked at what you did and it looks like you went outside of where you used to be," is that kind of the issue?

DR. ALPERT: There's two years to look at it. That's the Gilbert probation concept.

MR. ZATKIN: And you're doing fine. You're going doing fine, and now we're going to let you --

CHAIRMAN ENTHOVEN: But what Ron wants is for a defined scope of activity.

DR. ALPERT: That part I think --

MR. ZATKIN: He wants to be clear at the beginning.

DR. ALPERT: I liked the -- you know, Rebecca and Brad saying "I'm worried about the language that Ron has.

1 MS. FARBER: I think the key is Ron's word said
2 "for collected procedures" and you want to flip it and
3 say for all procedures except up to a threshold and do
4 it the other way. You want to say you're authorized up
5 to here and here's the limits.
6 DR. ALPERT: Let me put it in contrast to the
7 next one. When we dealt with the catastrophic ones, the
8 irreversibility, as I referred to before, and the
9 compelling nature of this patient population was such
10 that if you pre-credentialed somebody you never get
11 another chance. Let them go there, but has to be -- a
12 pre-credentialed provider has to have all these
13 qualifications that you talked about for that, if you're
14 going to do it right now and release it for that. We
15 matched the more restrictive overview for you folks with
16 the compelling patie nt population.
17 For the other we said look at the doctor in two
18 years, and that's where Brad came in, and that was to
19 give that wiggle room that you're talking about.
20 DR. ALPERT: If we put -- would this meet you
21 both partway if -- after automatic approval if we said
22 "for a defined scope of practice?"
23 MS. FARBER: Yeah.
24 DR. ALPERT: Sure.
25 MS. BOWNE: From a continuation of my hand raise
26 before, I'm -- I'm concerned on E. I know that we want
27 to put dates in so tha t things get done. But I mean
28 we're now starting '98. These practice protocols and

1 the whole system of it I'm very concerned about having
2 the heavy hand of government coming in quite that
3 quickly.
4 DR. ALPERT: These are things that already exist.
5 I don't think this is going to be a good -- I think it's
6 going to save the plans money because I think --
7 MS. BOWNE: I know you think that. You're not
8 running the plan .
9 DR. ALPERT: That's true.
10 MS. BOWNE: And I would suggest to you that
11 people who are running a plan might not want to give
12 this ticket away quite so quickly.
13 DR. ALPERT: I think it's the biggest issue
14 that's produced all of the brouhaha and -- and it's why
15 we're here and I -- I don't want to leave 2000.
16 It's the year 2000.
17 MS. FARBER: Mr. Chairman.
18 CHAIRMAN ENTHOVEN: Yes.
19 MS. FARBER: One of the things --
20 CHAIRMAN ENTHOVEN: Jeanne Finberg is next.
21 Sorry.
22 MS. FARBER: I just wanted to comment on --
23 CHAIRMAN ENTHOVEN: Hold it, start over. Excuse
24 me.
25 MS. BOWNE: How about in the year 2000 they
26 consider the cost of making this happen?
27 CHAIRMAN ENTHOVEN: Got to get back to my list
28 here. Finberg and Hiepler.

1 MS. FINBERG: My concern is if you're saying it
2 has to be objectively verifiable and it's a
3 doctor-patient relationship to begin with, you're
4 questioning the judgment that you supposedly already
5 approved in your two-year time frame. Whether you
6 hospitalize someone at this time or not again, you can
7 second guess everything and it brings us back to make
8 the initial part irrelevant, which I think was a great
9 stride.
10 CHAIRMAN ENTHOVEN: But if we say "for defined
11 scope of practice," that backs down from that.
12 MS. SINGH: Is there any objection to that, "for
13 defined scope of practice," so we can move on?
14 Okay, thank you.
15 CHAIRMAN ENTHOVEN: Spurlock.
16 DR. SPURLOCK: I just wanted to comment on Ron
17 Williams' statement about his second line, "Plans to
18 require providers to obtain verification of eligibility
19 and coverage and approval for the procedure." I'd like
20 to put a period after that, where it says "obtain
21 verification of eligibility and coverage," period,
22 because the approval part is the whole thing we're
23 dealing with. Why even do it if you have to get
24 approval?
25 MR. WILLIAMS: The issue is a very important
26 consumer issue, because if the consumer ends up going
27 to, for example, an out-of-network facility, that
28 consumer can end up with very substantial additional

payments. And as the health plan, it's important that we be certain that the consumer is aware of the obligation that they're taking on. They may choose to and that's okay.

DR. SPURLOCK: Ron, I don't -- you would be getting involved with doing this problem with out of network physicians, I don't see that happening.

MR. WILLIAMS: Not out of network physicians, the member may end up at a facility that is not in the network. So, let me -- the issue about ending the period of coverage is fine. I think I'm comfortable with that, Bruce. My comment is really the second issue isn't just an issue about the health plan, it's a consumer issue about the consumer understanding they may be in an out-of-network amb ulatory surgery center, outpatient facility, some other provider where the physicians themselves are in the network but that provider -- and again we're talking about this not just for HMO plans, this is being talked about in the context of PPOs. So, it's a consumer issue in that regard.

DR. ALPERT: I can validate -- I didn't comment on the eligibility and coverage thing that exists. There's no question about that, the place where it is, and -- and I think the checking about coverage, I never had any questions about coverage.

Coverage is coverage, it's whether your policy has this in it or not. It's not making a decision whether you need it and so forth and so on. Is there --

1 I just -- this is a point of information, what is
2 eligibility maybe as opposed to coverage. Well,
3 eligibility says that, for example, if you have an
4 employer health plan, that you are still employed there
5 and that employer covers you, you are actively somebody
6 for that benefit. Or if it's an individual policy that
7 you may pay the premium for the month and the card, you
8 show up three months and, yeah, you are still eligible
9 for that package.
10 CHAIRMAN ENTHOVEN: Let's see, we need to deal
11 with this -- no, we still have this by the year 2000
12 issue we didn't resolve.
13 MS. FARBER: I want to speak to that.
14 MS. FINBERG: Actually, I want to speak to B.
15 CHAIRMAN ENTHOVEN: Okay. Sorry. Okay, Jeanne,
16 you're on the list. Okay.
17 MS. FINBERG: This is a generalized concern and
18 although I am definitely in favor of B and developing
19 statistically valid data, the concern that I have is the
20 lag time between when it's available, given how long
21 these studies take and how certain populations tend to
22 be under-studied, children, women of child-bearing age,
23 children with disabilities.
24 I'm concerned about the negative application.
25 The fact that there might not yet be statistically valid
26 studies approving a particular treatment. But I don't
27 want to be encouraging that side, and I'm wondering if
28 there's some qualifying language we could put in here

1 that would not encourage that.

2 CHAIRMAN ENTHOVEN: You want to speak to that,

3 Michael?

4 DR. KARPF: Yes. I agree with that. I think

5 when we take a look at how individuals ratify practice

6 patterns or approaches to care, some of it i s actually

7 evidence based on the literature. Some of it is

8 consensus based. In much of medicine we'll never get a

9 truly evidence-based approach but we can get a

10 consensus-based approach. So, we need to have some

11 language that speaks to acceptance process and a

12 ratification process and not necessarily strictly a

13 statistical process.

14 MS. FINBERG: Clinical consensus.

15 DR. KARPF: What?

16 MS. FINBERG: Clinical consensus.

17 DR. SPURLOCK: I'm not sure this really needs

18 every time to have an outcome based component to it.

19 For example, I order a chest X ray. If I order so many

20 chest X rays per thousand patients and I'm in the area

21 and there's never been a quality of care issue about my

22 deferral in the use of lung disease or heart disease

23 that requires a chest X ray, I don't think you have to

24 have an evidence base to show that you've approved care

25 for lung disease or heart disease, just that you've had

26 the usual quality stuff.

27 So, that's a -- that's a pattern of care that if

28 we don't have to have outcome based, evidence-based

population controlled, you know, studies to be able to say, "Okay, Bruce, you're qualified now to order chest X rays without prior authorization on your patients when they come in with pneumonia.

I think that's a simple thing that doesn't require an evidence-based outcome study. I think that's Allan was getting at is defined scope of pr actice and you can adopt the parameters to define that scope of practice, one of which is outcome-based data.

DR. ALPERT: With regard to Jeanne's objection -- question, it's not an objection, B was -- first of all, it wasn't -- wasn't offered specifically by me or Bruce, I think it was an -- sort of a consensus thing in terms of how to get to the path -- how to get from here to there.

CHAIRMAN ENTHOVEN: Okay, this --

MS. SINGH: Okay.

CHAIRMAN ENTHOVEN: Here's wor ding. "Task Force recommends to the health plans, medical group IPAs and their designees that they develop processes based on statistically valid data on patterns of care and patient outcomes or professional consensus. Does that --

DR. ALPERT: That's fine with me.

CHAIRMAN ENTHOVEN: Does that say what you're trying to say?

DR. KARPF: Say that again.

CHAIRMAN ENTHOVEN: In other words, it's got an either/or -- statistically valid patterns of care, you

1 know, the evidence-based side, or professional
2 consensus.
3 MS. SINGH: May have them, and/or.
4 DR. KARPF: In terms of what Bruce is bringing
5 up, it's really sort of the issue of protocol versus
6 medical management in the individual practices. I was
7 involved in a five-year five million dollar study of
8 pneumonia that gave broad guidelines, but that's it. It
9 didn't tell you anything on the individual basis.
10 MS. DECKER: We've now spent 32 minutes.
11 MS. SINGH: without objection, we'll take that
12 amendment.
13 MS. FARBER: Can I go back to the issue of the
14 year 2000?
15 CHAIRMAN ENTHOVEN: Nancy.
16 MS. FARBER: Can we go back to that issue that
17 Rebecca raised?
18 CHAIRMAN ENTHOVEN: Yes.
19 MS. FARBER: I think one of the things that the
20 Task Force is at risk of doing is setting not only in
21 this setting, this particular subject, but in many other
22 venues totally unrealistic expectations. The data
23 systems you think you're going to use and turn on in the
24 year 2000 do not exist today.
25 CHAIRMAN ENTHOVEN: Right.
26 MS. FARBER: And rather than have the product of
27 this Task Force be laughable, I think that all of this
28 has to be tempered by the rule of reason and what state

1 of the art is and information system. And it just quite
2 frankly doesn't exist.
3 And I don't want to put my name on something that
4 asserts w e're going to do something by the year 2004
5 that has -- has not yet happened, the technology doesn't
6 exist to make happen and big research institutions and
7 large health plans like Kaiser are working and
8 struggling hard to make these things happen now but to
9 this very point can't say that they're here.
10 And I think that's the same issue I want this --
11 CHAIRMAN ENTHOVEN: Good point.
12 MS. FARBER: -- as much as anybody else does, but
13 I think it is nonsense to mandate it in speci fic year
14 terms. As soon as possible and consider something
15 urgent is sufficient.
16 CHAIRMAN ENTHOVEN: Right.
17 MR. LEE: Can I make a suggestion for wording?
18 I think we really need to -- the last line there, "The
19 State agency for regulated managed care should consider
20 making the necessary changes." But then it's not an
21 issue of putting in place a law in two years, it's
22 consider making them -- I mean, I -- I know we all want
23 to say a lot of things. We have three other paper s
24 besides this one and maybe four hours, if people are
25 leaving at 4:00. So, I'd like to encourage us to be
26 specific to language and votes.
27 I don't know. I mean, Nancy, I agree with you,
28 you know, given the glacial pace with which polls are

1 possible even in the hands of the best people in the
2 best financial -- whatever you say, whether you would
3 like to just take out 2000 and substitute wording.
4 MS. FARBER: I think one of these problematic
5 kind of things it's over-arching all that we've done.
6 This isn't the only place where we may be committing
7 folly, and I think that we have to be very careful that
8 what we recommend is reasonable and doable, and where it
9 is, you know, a goal that we're reaching for, we should
10 say that we know the estimates don't exist now, and
11 we're urging all due dispatch in developing this system.
12 It's not just in this paper, we discussed a bunch of
13 them yesterday and this m orning that are like this.
14 MS. O'SULLIVAN: Except that doesn't require that
15 any new data be in place, it requires that prior
16 authorization process.
17 MS. BOWNE: But you have to have the data base in
18 order to be able to assess.
19 MS. SINGH: Members, one at a time, please.
20 Alpert.
21 DR. ALPERT: I'd like to respond to Nancy's
22 comment. Did somebody -- I think it was Maryann, I
23 don't think you necessarily need complicated data bases
24 to implement what this is trying to do.
25 To me, I'm -- I'm not -- you can eliminate B
26 totally and it wouldn't bother me. I'm happy to have it
27 in there and it gives a little guidance and a pathway,
28 but I'm not trying to make plans to spend a lot of money

1 getting data and so forth and so on. I think they have
2 the knowledge based on the way they credential people
3 and they're watching -- that's what managed care is,
4 they're watching how people are being treated. They
5 have the knowledge to do this now without getting any
6 more data.
7 Now, it would be nice if they do and that can all
8 be phased in once those outcomes and things are done,
9 but I wouldn't want to lose the immediacy of taking care
10 of this problem because it can't be taken care of until
11 we have some huge data set that costs a lot of money.
12 MS. SINGH: Is there objection to just adding --
13 instead of "should make" to say "should consider
14 making"? Without objection.
15 CHAIRMAN ENTHOVEN: What about this wording,
16 though. Okay. Okay, then also Task Force -- how about
17 this?
18 MR. LEE: What letters are we on, Alain?
19 CHAIRMAN ENTHOVEN: E. Beginning of E. Task
20 Force recommends to the Governor and Legislature that if
21 the private sector is not making significant progress to
22 modify the prior authorization/concurrent review process
23 to recommend -- or equipment modification -- the State's
24 regulation for modification -- that managed care should
25 consider making the necessary requirements of health
26 plan licensure or accreditation.
27 MS. FARBER: So, you take out the date?
28 DR. ALPERT: Does not make significant progress

by the year 2005.

MR. LEE: Plans may be worried that the Legislature may see that that's for next year instead of 2000. 2000 says there's some time before it even looks at that.

CHAIRMAN ENTHOVEN: They're just -- it's just saying start w atching. I mean, be watching it and --

DR. ALPERT: Everywhere else we've made some date for that documentation. And if you put 2000 it just means that they have to see if they're making progress by 2000.

CHAIRMAN ENTHOVEN: I want to respond to Nancy's point, which is kind of an amorphous thing and it's so complex and difficult. And the best people are there or there would be a debate about whether they're there or not, or when they're going to get there.

DR. NORTHWAY : It's not very amorphous if you get turned down. It's very non-amorphous at that point in time.

MS. SINGH: People would --

MR. KERR: I'm very concerned that so many times all these things really turn into nothing because we're getting rid of dates when they might not have it -- might not really think we're aware. At least the public has an idea what the thing --

DR. ALPERT: It would be a review at that time.

MS. SINGH: Let's have a straw poll vote on it.

CHAIRMAN ENTHOVEN: Let's just say that there

1 will be a review by the year 2000.

2 MS. SINGH: Okay.

3 CHAIRMAN ENTHOVEN: Dr. Karpf.

4 DR. KARPF: I just wanted to remind people we

5 heard testimony from the HMO that is already doing this.

6 So, it's being done right now.

7 MS. BOWNE: Yes, it is, but not by everyone.

8 MR. LEE: Can we please clarify the language on C

9 because I think that's the one place where there was

10 some unclarity, so we can try to vote on the whole and

11 move on to other areas.

12 CHAIRMAN ENTHOVEN: As I understand where C is

13 now, the Task Force recommends to the health plans and

14 their designee that they develop and implement strategy

15 that allow providers an exemplary practice profile to

16 practice medicine with automatic approval for a defined

17 scope of practice, grant a probationary period of up to

18 two --

19 CHAIRMAN ENTHOVEN: It's all the same. E is all

20 the same until we get to the end. "Plans may continue

21 to require providers to obtain verification of

22 eligibility and coverage and approval of the setting in

23 which the procedure is to be performed."

24 DR. SPURLOCK: I move to strike that.

25 DR. ALPERT: The period was after "coverage"?

26 MR. LEE: Period after "coverage."

27 CHAIRMAN ENTHOVEN: Ron spoke to this question of

28 it's a consumer issue.

1 MS. FARBER: We didn't agree to it.
2 MR. WILLIAMS: I'd like to say yes or no. I
3 think it's important. I think without that again it
4 follows you have a physician who's approved for a scope
5 of service but it's done in an institution that has poor
6 outcomes, then --
7 DR. ALPERT: I'm sorry, I -- the setting part is
8 fine with me. I think Bruce --
9 CHAIRMAN ENTHOVEN: Bud accepts the setting.
10 DR. SPURLOCK: Doesn't the scope of practice
11 include where the procedure or process or diagnostic --
12 MR. LEE: Cove rage should be the whole range.
13 MS. SINGH: Coverage is entirely different.
14 CHAIRMAN ENTHOVEN: It's not obvious that it
15 does.
16 DR. KARPF: We have Stanford doctors from
17 Southern California to do stuff; you can't tell them
18 it's going to be the same procedure.
19 CHAIRMAN ENTHOVEN: Okay.
20 MS. SINGH: They've all been amended. I think we
21 make sure we need to have the accurate word and
22 everybody knows.
23 CHAIRMAN ENTHOVEN: Let's --
24 MS. GRIFFITHS: I have a friend ly amendment that
25 I've been discussing with these guys and they're both
26 okay on it. I think part of the confusion and
27 hesitancy --
28 COMMISSIONER: Speak up.

1 MS. GRIFFITHS: Part of the confusion and
2 hesitancy is the lack of clarity of some of us about
3 what terms -- I know what "coverage" means, I was not as
4 clear about what "eligibility" meant. Ron defined it
5 and if we could draw up a footnote to add those
6 definitional matters.
7 CHAIRMAN ENTHOVEN: Okay. Footnotes.
8 DR. ALPERT: Yeah, that's friendly.
9 CHAIRMAN ENTHOVEN: To define --
10 MS. SINGH: Without objection.
11 CHAIRMAN ENTHOVEN: And the staff is authorized
12 to confer with the experts.
13 MS. SINGH: Get the correct terminology.
14 CHAIRMAN ENTHOVEN: So, now we're going to try to
15 take these one at a time.
16 MS. FINBERG: Why don't we take all of
17 recommendation 1 as amended.
18 MS. SINGH: Everybody is clear on all the
19 amendments?
20 MR. LEE: Except Jeanne has one last one.
21 MS. FINBERG: I just want to add something to the
22 sentence that we developed that ended with "outcome." I
23 wanted to add "that are sensitive to various --
24 different needs of various populations."
25 MS. SINGH: Yeah, particularly vulnerable
26 population.
27 MR. PEREZ: Move all of 1 as amended.
28 MS. BOWNE: Second.

1 MR. ZATKIN: Would you repeat E?
2 MS. FINBERG: I can't repeat it because I don't
3 have all the language.
4 CHAIRMAN ENTHOVEN: Ms. Vorhaus. Or professional
5 consensus.
6 MS. FINBERG: After the word "outcome," I'm
7 adding "that are sensitive to the needs of various
8 populations, particularly vulnerable populations."
9 MS. SINGH: Is there objection? Seeing none.
10 MS. BELSHE: I have a question. I think I know
11 the answer, but I'd like to hear it. If we approved C,
12 why do we need D?
13 MS. FINBERG: Because - -
14 DR. ALPERT: One is a two-year probationary and
15 one is an immediate elimination for catastrophic
16 condition.
17 MS. FINBERG: Event.
18 MR. HARTSHORN: In catastrophic conditions,
19 patients -- I'm not a doctor, but I have heard that
20 their systems, internal systems, are breaking down, so
21 they can be very complex and you have to have case
22 management and ongoing -- you have to have teams of
23 people working on individuals. So, is -- that's not
24 being eliminated, is it?
25 DR. ALPERT: No, that's what doctors do, that's
26 what taking care of people is all about. No, that's not
27 being eliminated at all. It's actually allowing that to
28 proceed without a big delay, denial or obstruction

1 before that starts -- it actually facilitates that
2 progress. That is the intent.
3 DR. GILBERT: The only thing --
4 MS. FARBER: I think the only thing Terry is
5 getting at, Bud, is the issue of the health plan may
6 have a very important role in terms of case management
7 and other issues in terms of getting all the other care
8 needed for the member. We need to make sure when we
9 decouple authorization processes we don't decouple that.
10 DR. ALPERT: Communication.
11 MS. FARBER: Can I call the question?
12 MS. SINGH: We have a motion on the floor.
13 DR. GILBERT: The difference between C and D is C
14 is referring to primary care physicians who are getting
15 automatic approval for referrals wi thin their scope of
16 practice, whereas D -- and, Bud, help me if I'm wrong --
17 that this is a specialist that has been pre-credentialed
18 for that particular specialty, for example pediatric
19 oncology, who then is able to provide treatment that are
20 medically accepted standards without additional prior
21 authorization and concurrent review.
22 So, there are two different things.
23 DR. ALPERT: I think it's broader than that. The
24 basic differences to me is between who is primary care
25 and specialist.
26 DR. SPURLOCK: There are national guidelines.
27 MS. SINGH: We have a motion on the floor. Can
28 we have a second?

1 MR. PEREZ: There was a second.
2 MS. SINGH: I didn't hear the second. Thank you
3 very much.
4 MR. ZATKIN: Would someone read E.
5 CHAIRMAN ENTHOVEN: Okay. The Task Force
6 recommends to the Governor and Legislature that there be
7 a review by the year 2000. If the private sector is no t
8 making significant progress to modify the prior
9 authorization/concurrent review process to recognize
10 exemplary care or equivalent modification," and it
11 states the reports should consider making the necessary
12 changes a requirement of health plan licensure or
13 accreditation.
14 DR. ARMSTEAD: No, that's no good. What it says,
15 Alain, I thought when you said review, that in fact
16 there's a time in which it would be reviewed and done.
17 And then that would in itself trigger -- there's still
18 not enough time.
19 CHAIRMAN ENTHOVEN: This is one on -- right,
20 not enough time to review it by 2000?
21 DR. ARMSTEAD: Exactly, we're getting to, really,
22 into '98. I mean, let's just look at the realities.
23 I'm just trying to lay out -- I'm not saying this is
24 rocket science, all I'm suggesting there are a number of
25 different plans that this is going to apply to. So, we
26 just have to look at the landscape. It's not all the
27 Nebraska cornfield, we got different types of l andscape.
28 We really need to look at the terrain and flush that

1 out. That's all I'm suggesting, is that it's just not
2 that simple from looking at it, and evaluating it first
3 and then go forward.
4 CHAIRMAN ENTHOVEN: Okay. I appreciate -- and I
5 also appreciate that the impact can be very different on
6 some health plans than others, and that it might be
7 quite devastating if we really enforce this on health
8 plans that are sensitive to the needs of various
9 populations, particularly vulnerable populations.
10 MR. LEE: Exactly. The very ones that Jeanne is
11 trying to get, you know, plugged in might be the ones
12 that are most vulnerable.
13 What I propose is that we vote on A through D,
14 then we'll deal with E.
15 MS. FARBER: You've forgotten F.
16 MR. LEE: There is other language that we
17 include. A through D and F.
18 MS. SINGH: Mr. Zatkin, will you amend your
19 motion to adopt A?
20 MR. ZATKIN: I didn't make the motion.
21 MR. PEREZ: It's my motion.
22 CHAIRMAN ENTHOVEN: Perez' motion.
23 MS. BOWNE: Second to adopt recommendation A, B1,
24 C, D and F.
25 MS. SINGH: Those in favor, please raise your
26 right hand.
27 Please keep your hands up.
28 Those opposed?

1 28 to zero. The recommendation is adopted except
2 for E.
3 CHAIRMAN ENTHOVEN: 28-0?
4 MS. SINGH: 28-0.
5 MR. LEE: Can I suggest --
6 CHAIRMAN ENTHOVEN: Now we're going to deal with
7 E.
8 MR. LEE: I got a simple amendment I think would
9 make it clear. I move this with the following
10 amendment: "The Task Force recommends to the Governor
11 and the Legislature that it review and report by 2000
12 how the private sector has modified the prior
13 authorization/concurrent review process to recognize
14 exemplar care or equivalent modification." Then a
15 parenthetical, "The reports should include making
16 changes a -- making neces sary changes a requirement of
17 health plan licensure." It's all then part of the
18 report that's two years down the path.
19 MR. PEREZ: Second.
20 MS. SINGH: Any discussion?
21 COMMISSIONER: Would you read it once again.
22 CHAIRMAN ENTHOVEN: Peter, would you please just
23 read it --
24 MR. LEE: Yes.
25 CHAIRMAN ENTHOVEN: -- and then.
26 MR. LEE: "The Task Force recommended to the
27 Governor and the Legislature that it review -- that they
28 review and report by the year 2000 the progress the

1 private sector has made to modify the prior
2 authorization/concurrent review process to recognize
3 exemplary or equivalent modification," open paren, "the
4 report should include consideration of requiring
5 necessary changes" -- or "making necessary changes a
6 requirement of health plan licensure."
7 DR. ARMSTEAD: Peter, I see how you word it the
8 same. The one thing I just want to capture is not just
9 to recogn ize the progress, it needs to in its report
10 recognize those challenges that may have been
11 problematic for those. So, you know --
12 MR. LEE: Review and report on the progress and
13 challenges in the private sector.
14 CHAIRMAN ENTHOVEN: You know, we're an hour
15 behind schedule. Let's just have a show of hands on
16 accepting that modification and then we will vote on
17 whether to adopt it.
18 MS. SINGH: The majority obviously is in favor.
19 MR. LEE: Move to adopt.
20 MS. SINGH: It's been moved. Is there a second?
21 MR. PEREZ: Second.
22 MS. SINGH: Those in favor to adopt E as amended,
23 please raise your right hand.
24 Those opposed.
25 27 to zero. It's adopted.
26 CHAIRMAN ENTHOVEN: Peter, would you be sure that
27 my troops have the language.
28 MR. LEE: I'd be happy to talk to them later.

1 CHAIRMAN ENTHOVEN: We'll move to recommendation
2 2.
3 CHAIRMAN ENTHOVEN: Could I request that I b roker
4 this since I'm the one that proposed formulary, please?
5 I'll try to be very quick.
6 A couple technical amendments, then get to a
7 vote, hopefully. First in the introductory paragraph,
8 this is all new language.
9 MS. BOWNE: 6?
10 MR. LEE: Page 6B. "Pharmaceuticals are rising
11 rapidly; formularies are" -- delete "necessary" and put
12 "one tool to manage these costs."
13 DR. SPURLOCK: Where are we now?
14 MR. LEE: Top of page 6. Approximately six lines
15 down.
16 MR. ROMERO: Five lines.
17 MR. LEE: "Formularies are one tool to manage
18 these costs."
19 The other technical amendment down below --
20 CHAIRMAN ENTHOVEN: What's the difference? I
21 mean --
22 MS. FARBER: Don't debate it, just accept it.
23 MR. LEE: It was requested by some folks, Alain.
24 A lot of amendments got made without us even talking in
25 the background, so -- down below --
26 MR. WILLIAMS: Wait a minute. Wait, you just
27 changed "formularies are necessary" to "formularies ar e
28 one tool"?

1 MR. LEE: -- "one tool to manage these costs."
2 MR. WILLIAMS: They are necessary.
3 CHAIRMAN ENTHOVEN: One necessary tool.
4 MR. WILLIAMS: They are one necessary tool.
5 CHAIRMAN ENTHOVEN: They are necessary.
6 MR. WILLIAMS: If you want a discussion, we can
7 have a discussion.
8 CHAIRMAN ENTHOVEN: They are necessary.
9 MR. LEE: Okay. Let me do the other technical
10 ones we will vote on -- lot s of things got through
11 before coming before us.
12 MR. WILLIAMS: Peter, these aren't technical,
13 these are substantive and you keep using the word
14 "technical," and there are numerous items that turn out
15 to be non-technical.
16 If they're substantive, let's talk about them.
17 MR. LEE: Can we do a straw poll on one necessary
18 or twice necessary?
19 MR. PEREZ: We're really -- we're getting into
20 such minutia --
21 CHAIRMAN ENTHOVEN: Yes, we are.
22 MR. PEREZ: -- that it's real ly insane. And --
23 while we can sit here and debate whether it's one tool
24 or a necessary tool, one tool seems to include that it's
25 necessary -- you know, necessary.
26 CHAIRMAN ENTHOVEN: It's necessary.
27 MR. PEREZ: I mean, I really --
28 MR. LEE: One necessary.

CHAIRMAN ENTHOVEN: Leave it alone, let's just get to the recommendation.

MR. LEE: I mean, the thing I would have to say is that there's a lot of ba ckground in here that has lots of perspectives, that I think that some perspectives are in here more than others. And I've felt a need on a number of points to make comments in background because perspectives are represented, rather than get things thrown at me for doing that.

It's purely technical. A lot of amendments I made before are not purely technical. Moving on.

In recommendation 2 --

CHAIRMAN ENTHOVEN: Yeah.

MR. LEE: Italics under A2, I would recommend be pulled down as recommendation 5. They're separate issues. This got -- was an amendment to my suggestion. I just want to sort of -- they're separate issues so I'd suggest that italics being considered as number 5. So, number 6 -- number old 5 would now be 6.

MR. PEREZ: You make it recommendation 2 sub 5?

MR. LEE: Yes, 2A5. 2A5 would be the italics language. And --

CHAIRMAN ENTHOVEN: Right.

MR. LEE: -- 5 would become 6.

MS. SINGH: Without objection.

CHAIRMAN ENTHOVEN: Well, there's still a question.

MR. LEE: We're going on -- we're going to talk

1 on this. This is just a placement issue. This really
2 is technical. The other under B is the "no practicing
3 plan physician with relevant expertise."
4 MR. ROMERO: So I'll insert, right, "relevant
5 expertise."
6 MR. LEE: With; with relevant expertise.
7 With that, open for comments and hopefully quick
8 action, move ment.
9 MR. ZATKIN: Peter, what does "make available"
10 mean in that context?
11 MR. LEE: Make available upon request.
12 MR. ZATKIN: What is availability.
13 MR. LEE: It would --
14 MR. ZATKIN: Does that mean you have an 800-page
15 book, you're supposed to mail it out or does it mean
16 people can come and look?
17 MR. LEE: I think it -- it could mean people
18 could come and look or if it's an 800-page book they
19 could pay for reasonable costs to get a copy of it. But
20 it does n ot mean -- the intent is not to have plans
21 incur --
22 MR. PEREZ: Publishing.
23 MR. LEE: -- publishing costs, for publishing and
24 distributing. If there's language you would like to
25 clarify that, I would welcome that.
26 MR. ZATKIN: I think you should indicate that the
27 plan -- I think it should indicate that the plan may
28 impose reasonable fees and that availability may be made

1 on a reasonable basis.

2 MR. LEE: I think that's --

3 MR. SHAPIRO: Could you speak up?

4 MR. ZATKIN: That reasonable fees and

5 availability on a reasonable basis.

6 MR. SHAPIRO: For what?

7 MR. LEE: This is -- there's a proposed amendment

8 which I would suggest as an amendment, would be a

9 parenthetical after "request plans may charge

10 reasonable" --

11 MR. SHAPIRO: Are we on number 1?

12 MR. LEE: Yes, we're on A1.

13 CHAIRMAN ENTHOVEN: A1. The point is these

14 things are subject to ongoing change and we don 't want

15 to say that they have to have an up-to-the-minute

16 publishing company. So, they could say we update it

17 quarterly or something like that.

18 MR. SHAPIRO: Can I make a point that Maureen

19 just pointed out to me, that the pending legislation on

20 this issue, which is non-controversial, only requires a

21 list of the drugs. A formulary is a huge book, okay.

22 So, I think we want to make sure that we're just talking

23 about the list of the drugs here, which is not a very

24 burdensome item. And we allow the public to get access

25 to that. I just want to preserve that concept and not

26 have Steve worry that we're trying to get the whole

27 formulary.

28 MR. LEE: I think that's a friendly amendment.

1 MS. FARBER: Plans may charge reasonable costs
2 and make available on reasonable terms. I mean, I'm a
3 reasonable person.
4 MR. SHAPIRO: I'm not sure that's a friendly
5 because right now the bill before the Legislatur e says
6 any member of the public who's thinking about choosing a
7 health plan can request a formulary list from the plan.
8 MR. PEREZ: Wait a minute, we have specifically
9 tried to stay away from discussing specific legislation.
10 Anything we do here is in recommendation form. It does
11 not in any way preclude the Legislature from doing
12 something that's much more stringent or less stringent
13 than what we're talking about.
14 And for us to debate the merits of the
15 recommendations base d on what may or may not get through
16 the Legislature and what may or may not get either
17 signed into law or vetoed really seems to drag this
18 debate on as opposed to having a reasonable agreement on
19 making reasonable access at reasonable fees.
20 CHAIRMAN ENTHOVEN: Right.
21 MR. ZATKIN: I'm assuming that "formulary lists"
22 means "drug lists," am I wrong?
23 MR. LEE: No, you're absolutely right.
24 DR. GILBERT: Good luck everybody. 17th wedding
25 anniversary today.
26 MR. PEREZ: And you want to have a next year.
27 MR. HARTSHORN: I got his proxy and everything.
28 MR. PEREZ: Don't make me go to the bylaws.

1 CHAIRMAN ENTHOVEN: Okay. And 1 is now revised
2 to say "All health plans that offer prescription drug
3 benefits and use the formulary," and their designation.
4 MR. LEE: Just a new paragraph -- "must
5 periodically publish their formulary list of drugs and
6 make them available to any member of t he public upon
7 request subject to reasonable costs."
8 MR. ZATKIN: Drug costs.
9 CHAIRMAN ENTHOVEN: Formulary -- you want to say
10 "formulary drug lists"?
11 MR. ZATKIN: List of drugs. I put "list of
12 drugs."
13 MS. BOWNE: Yes, list of drugs.
14 CHAIRMAN ENTHOVEN: Now, that's 1. Take on more,
15 on 2?
16 MS. FARBER: We're going to --
17 MR. LEE: Let's vote on them all together. I
18 think they should be non-controversial.
19 MS. SINGH: I hope members won't go back to this
20 and change, as the last time.
21 CHAIRMAN ENTHOVEN: Are you --
22 DR. KARPF: I'm on 2. The -- the item was pulled
23 out of italics, "All health plans must also disclose to
24 medical groups whether any discounts were taken up
25 front." I'm not sure what the intent of that is. Are
26 you concerned --
27 MR. LEE: I'm not going to speak to that one.
28 DR. KARPF: Are you concerned that some groups

1 are purchasing second rate drugs because of costs?
2 Because most homes and many groups will buy
3 through large purchasing operations and part of that
4 purchasing process is rebates given on how much you --
5 how much you participate in the process. It becomes a
6 very complex issue.
7 I think if you want to say all formulas should be
8 based on medical appropriateness first and foremost, I
9 don't have any problem with that.
10 MR. LEE: That one which is number 5, as I noted,
11 was not part of the recommendation I made and I don't
12 know --
13 MS. FARBER: It's part of the recommendation I
14 made. I don't have any trouble with it.
15 MR. LEE: Exactly.
16 CHAIRMAN ENTHOVEN: We'll discuss it when we get
17 to 5.
18 MR. LEE: That's new number 5.
19 CHAIRMAN ENTHOVEN: Any changes to number 2?
20 MS. SINGH: Let's move to number 3.
21 CHAIRMAN ENTHOVEN: Any discussion?
22 MR. HAUCK: I'm referring to the physicians and
23 consumer groups. But, you know, this is directed
24 towards the consumer , and my perception is in some cases
25 that it's the physician's office that doesn't know the
26 procedure for each and every plan that they deal with
27 and it -- it very well may be why in our survey that
28 Kaiser polled better than some non-medical staffed HMOs,

1 where there's a professional support staff that knows
2 their system, knows how to navigate it, and know how to
3 provide information to the consumer when they call the
4 physician's office and want to know how to get through
5 the system -- I think to some extent misses the point.
6 And we provide a lot of information to the consumer and
7 they're going to turn to their physician's office. I
8 just -- I make that comment, I don't know if there's a
9 way to solve it. But I'll --
10 MS. FINBERG: Why don't you have it known to the
11 physicians, too, then.
12 MR. LEE: Must have in place and make known to
13 consumers and providers, timely processes -- I think
14 that's a very good point because that is often the point
15 of contact.
16 CHAIRMAN ENTHOVEN: Okay, Nancy.
17 MS. FARBER: I just wanted, apropos to what you
18 just said -- I just wanted to remind you of the
19 testimony of a senior in El Sedungo whose physician's
20 office well understands the appeals process. He also
21 understood it well as a consumer, and we ended up being
22 his legislative representative who prepared the health
23 plan to provide the appropriate pharmaceutical.
24 MR. LEE: We ha ve no objection to adding "make
25 known to consumers and providers."
26 CHAIRMAN ENTHOVEN: That takes care of 3. 4.
27 MS. DECKER: We've now taken an hour.
28 CHAIRMAN ENTHOVEN: We are way behind.

1 DR. ARMSTEAD: There are sometimes circumstances
2 that it's just a matter of how we word this, where
3 there's a drug and it's not available, a drug will be
4 removed from the formulary which has no relationship at
5 all to cost.
6 So, either there has been a -- a change by the
7 FDA and some reclassification of the drug's application
8 or there have been several studies that have pushed and
9 come back -- for example, the really second generation
10 oral contraceptives, you know, better used, you know,
11 disciplinary data shows a higher incidence of DVT, as an
12 example.
13 So, there just needs to be some flexibility in
14 that where we just have to be able to -- and we do that
15 through a mechanism.
16 CHAIRMAN ENTHOVE N: What -- what if the Phen-Fen
17 comes down and the treating physician is on vacation?
18 MS. FINBERG: That is appropriate.
19 MR. ZATKIN: What if we say "where the drug is
20 considered no longer safe or effective for the
21 enrollee's medication"?
22 MR. LEE: Fine, that's great language. Can you
23 state that at the very end.
24 MS. FARBER: Unless the treating physician
25 prescribes a new agent.
26 MR. ZATKIN: Or the drug is no longer considered
27 safe and effective for the enrollee' s medical condition.
28 MS. FINBERG: Can we say by the FDA or something

1 outside of the health plan?
2 DR. SPURLOCK: If it's removed from the FDA, you
3 know, you can't get to it, anyway.
4 CHAIRMAN ENTHOVEN: Safe and effective for the
5 patient's condition.
6 MR. LEE: I think that's fine.
7 CHAIRMAN ENTHOVEN: New 5.
8 MR. WILLIAMS: Delete it. It's a contractual
9 issue. This gets to the contractual issues between
10 medical groups.
11 COMMISSIONER: Speak up, Ron.
12 MS. FARBER: Can I talk about it?
13 CHAIRMAN ENTHOVEN: You'll have your chance.
14 MR. WILLIAMS: My point in the new number 5, this
15 is essentially a contractual issue. It has to do with
16 contract materials between medical groups and health
17 plans, and I just don't think it's something that this
18 group ought to be getting into from a -- a contract
19 negotiation point of view.
20 CHAIRMAN ENTHOVEN: May I just add to that. From
21 my experience in the PBM business is discounts is kind
22 of a meaningless term because there's no such thing as
23 par for the course. You're talking about average
24 wholesale price.
25 Well, there are several of those and it's pretty
26 unclear and unmeaningful as to -- I just don't know -- I
27 mean, this sounds like this is a departure from a gold
28 standard price. There is no gold standard. It is a

very confusing and complex situa tion.

Barbara -- I'm sorry, Nancy.

MR. PEREZ: I just had a recommendation. My suggestion is that we go through everything including the new number 6, absent the new number 5.

CHAIRMAN ENTHOVEN: Yeah.

MR. PEREZ: See if we can come to consensus and then come back and discuss --

CHAIRMAN ENTHOVEN: Thank you. Okay.

Including B?

MR. LEE: I would--

MR. PEREZ: Everything.

MR. LEE: Yeah, 6.

CHAIRMAN ENTHOVEN: I'll accept that. Okay.

MR. LEE: I do not accept the italics, so I suggest we're considering this with that stricken.

MS. SINGH: Mr. Perez, is that your motion?

MR. PEREZ: No, that was --

CHAIRMAN ENTHOVEN: Just a recommendation.

MR. PEREZ: Just a recommendation to the chair.

CHAIRMAN ENTHOVEN: The Chair has cheerfully accepted. Look at the new 6.

MS. FARBER: We're going to vote one way or the other.

DR. NORTHWAY: Just a clarification.

MR. LEE: We're going to quickly finish 6B a nd then vote on that block and then come back to 5.

Well, because if it's going --

1 CHAIRMAN ENTHOVEN: Let me just clarify, we've
2 changed the nomenclature so that the italicized part at
3 the end of 2 has been pulled out of there and made a 5.
4 Then old 5 has been called renumbered 6. Then the Chair
5 has cheerfully accepted the recommendation of member
6 Perez that we forge ahead and achieve consensus on
7 everything bu t 5; vote for everything but 5. Then
8 separately we will vote on 5.
9 MR. LEE: Are there any other changes suggested
10 to 6 or B?
11 MR. RODGERS: Did we remove "or compliance"?
12 MR. LEE: Yes, we did. I would like to move
13 adoption on all but 5 at this moment.
14 HON. GALLEGOS: Mr. Chairman, just a clarifying
15 point, Steve, can you repeat for me on 4, what was the
16 language that had asked?
17 CHAIRMAN ENTHOVEN: Let me read it just so I make
18 sure that I've got it, too, while h e corrects me. "When
19 a health plan removes a drug from its formulary, it must
20 allow the patient to continue receiving the removed drug
21 for an ongoing condition unless the treating physician
22 prescribes a new agent, or the drug is no longer
23 considered safe and effective for the patient's
24 condition.
25 HON. GALLEGOS: That would be by whom?
26 CHAIRMAN ENTHOVEN: Well --
27 MR. LEE: To the undefined at this point.
28 CHAIRMAN ENTHOVEN: It could be --

1 MR. LEE: Undefined by this.
2 CHAIRMAN ENTHOVEN: If the Medical Director sees
3 an article in the New England Journal of Medicine that
4 Phen-Fen is causing heart valve problems --
5 MR. LEE: He would remove it, otherwise, if he
6 would care to.
7 HON. GALLEGOS: But the determination has to be
8 based on findings in the literature or the FDA, you
9 know. The plan can't just say, you know, we're
10 arbitrarily going to say --
11 MS. BOWNE: Right. Ri ght.
12 MR. LEE: Yes.
13 HON. GALLEGOS: Can we get they say it based on
14 something in the medical literature, something the
15 FDA --
16 MR. PEREZ: Based on medical evidence.
17 MS. BOWNE: Based on medical evidence.
18 MR. LEE: Based on medical evidence.
19 MR. ZATKIN: Appropriate medical evidence.
20 MR. LEE: Appropriate medical evidence that the
21 drug is no longer considered safe.
22 MR. PEREZ: No, just taking it out to the end.
23 MS. SINGH: Without objection.
24 CHAIRM AN ENTHOVEN: Presumably it will be the
25 Medical Director. You have to allow appropriate
26 response, you know, for calling the Medical Director and
27 say, "Hi, we're finding this thing is causing damage."
28 You know, my Medical Director will say, "Fine."

1 MR. LEE: We have a vote on it?
2 MS. SINGH: We have a motion and a second. Those
3 in favor -- those in favor, please raise your right
4 hand. All but five.
5 Those oppo sed?
6 I have 30 to zero.
7 COMMISSIONER: You can't.
8 MR. LEE: How did you get 30 with Brad gone?
9 MS. SINGH: I have a very difficult -- I have a
10 difficult time sometimes counting down here. So, it's
11 29 to zero.
12 MR. LEE: So, Terry, you are using that proxy?
13 CHAIRMAN ENTHOVEN: Alice is using San Francisco
14 methodology. 38.
15 MS. SINGH: Then it's 28.
16 CHAIRMAN ENTHOVEN: Now we're to going to just --
17 the vote on number 5, Rebecca has called for the
18 questio n. Is there a motion on 5?
19 MS. FARBER: Make a motion that 5 be adopted.
20 CHAIRMAN ENTHOVEN: Is there a second?
21 DR. SPURLOCK: Yes.
22 CHAIRMAN ENTHOVEN: Now number 5 has been
23 seconded by Dr. Spurlock.
24 DR. SPURLOCK: As it reads, correct.
25 CHAIRMAN ENTHOVEN: Nancy and then Terry.
26 MS. FARBER: Health plan pharmaceutical premiums
27 it charges to the employers range from roughly $15 to
28 $20 per member per month for the commercial enrollees,

1 while the funding of the health plan/health provider
2 pharmaceutical budgets range approximately from about $8
3 to $15 per member per month for the same commercial
4 enrollees.
5 The health plans are receiving 15 to 30 percent
6 estimated returns on purchased pharmaceuticals from the
7 pharmaceutical manufacturer rebates and discounts,
8 and rarely if ever generally, under the assertion that
9 it would be a kickback, passes discounts through to the
10 health care providers and/or their employees.
11 Providers are obligated to comply with multiple
12 and different pharmaceutical formularies based upon the
13 number of health plans they contract with. And this
14 creates a very difficult health care delivery problem
15 for the health care provider, namely the medical group,
16 and the patients.
17 These formularies are frequently charged --
18 changed by the health plans, and routinely add high cost
19 pharmaceuticals and formulary, experimental
20 pharmaceuticals for the lists of covered pharmaceuticals
21 and may be in direct relationship to the agreements or
22 discounts struck.
23 I feel very strongly that when you're asking
24 physicians not in a closed group model like Kaiser to
25 use plan formulary pills, which are the single runaway
26 cost in all of these HMOs and are causing such
27 substantial unhappiness with the public at large -- you
28 certainly heard the horror stories you didn't want to

1 hear, the public testimony -- that when and if a health
2 plan takes such a discount and does not pass it on to
3 the medical group and yet requires the medical group to
4 use the stipulated drug, that that information has to be
5 disclosed, at least -- at least the physician groups can
6 take it or leave it.
7 CHAIRMAN ENTHOVEN: Okay. Hartshorn.
8 MR. HARTSHORN: I'm not sure of all the figures
9 that were just read off. But to me it's -- I have a
10 concern that drug costs will go up even more if we start
11 disclosing all the discounts, because a number of the
12 health plans have their contracts with pharmaceutical
13 companies. These discounts won't be disclosed, it's
14 written right into the contracts, because they don't
15 want their competitors, other pharmaceutical companies,
16 to know. And, plus, it's a private contractual matter
17 and I don't believe it should be disclosed.
18 MS. FARBER: It's an effective medical practice,
19 though.
20 CHAIRMAN ENTHOVEN: Actually , the records here
21 don't show the amount of the discounts, just whether or
22 not they were taken.
23 MS. FARBER: If you call for the question, then I
24 will --
25 CHAIRMAN ENTHOVEN: So, this wording responds to
26 the question you just raised, Terry, I think. It's
27 still problematic.
28 MR. HARTSHORN: Not the amount.

1 CHAIRMAN ENTHOVEN: Well, as I say --
2 MS. FARBER: I didn't ask --
3 CHAIRMAN ENTHOVEN: A is not at issue.
4 MS. RODRIQUEZ-TRIAS: Health plans offer
5 discounts to have that.
6 CHAIRMAN ENTHOVEN: I don't know.
7 DR. ARMSTEAD: I think, Alain, the intent and I
8 think -- I mean, I hear Nancy's concern is this -- you
9 know, I would venture to say that there are some
10 problems although the majority of the time that they are
11 working. But I would really like to push in the context
12 of the process of the development of what is on the
13 formulary, those that deprive the selections of
14 medication that appear.
15 So, if in fact we're actually encouraging
16 involved -- plan involvement for input from practicing
17 physicians' specialty, the relevant data -- the
18 specialty being part of what is going to be the
19 cardiovascular drugs, what is going to be the G.I.
20 drugs, et cetera -- I think you begin to derive it based
21 upon the relevant clinical data, and I think that's
22 really where it should be, and not getting into trying
23 to dissect that. The intent is to really try to ge t in
24 and improve and fix it with item B that we have
25 approved.
26 DR. SPURLOCK: Mr. Chairman.
27 CHAIRMAN ENTHOVEN: Bruce.
28 DR. SPURLOCK: There's a fair amount of

1 misinformation about the process of what happens, and I
2 think what Nancy is trying to get at, this is really an
3 issue about truth in advertising, and what -- what
4 really happens in a negotiation between the health plan
5 and the medical group over this. T here's a price
6 that -- a PMPM price which is an aggregated price of all
7 of the pharmaceuticals that -- that a health plan says
8 to a medical group, "this is our price or cost of
9 pharmaceuticals." What's not disclosed in that, and
10 here's the truth in advertising part, is whether that
11 price includes discount or not. Most of the time it
12 doesn't include whether discounts are included in that
13 price.
14 So what ends up happening is that -- that medical
15 groups are expected to work u nder one business
16 environment, the price that is sold to them in the
17 negotiation process, and health plans are allowed to
18 work under different business environments with the
19 discount.
20 And I think what Nancy is trying to get at is to
21 say is this the discounted price in an aggregate, not on
22 individual aspect, so it wouldn't raise the individual
23 aspect and not be proprietary type information, but on
24 an aggregate basis are they included in the PMPM price
25 that we're talking abou t or are they not? Because I
26 think it allows for better negotiation to have an
27 accurate description of the true price or cost to the
28 health plan so that medical groups can actually manage

1 that risk, as well.

2 So, what I'd really like to get away from is

3 saying that he who takes a discount is responsible for

4 managing the formulary risk, but I don't think anybody

5 in this room would buy that.

6 MR. ZATKIN: Doesn't this get yo u down the road

7 of essentially regulating the health plans-medical group

8 negotiation? I mean, this is one area, that

9 relationship.

10 Conceptually, is it different from any of the

11 other areas?

12 MR. WILLIAMS: How big a discount you get on some

13 other item or some other--

14 MS. FARBER: Because this is a runaway area of

15 cost and it's a major patient-decision satisfier, and

16 you don't suffer the same thing in your closed system in

17 which everybody has aligned incentives, and th at's not a

18 problem in the Kaiser setting, I've worked there, I know

19 that.

20 CHAIRMAN ENTHOVEN: All right.

21 MS. FARBER: But in the outside commercial sector

22 it's a huge problem, and the people that have lined up

23 to complain about their pharmaceutical benefits in front

24 of this committee and have sent in their literature

25 should have made it abundantly clear at this point in

26 time that it's a big fat issue.

27 And when you look at the survivability of

28 independent IPAs and you want managed care to flourish

1 and work, then you've got to level this out just a
2 little bit so that the doctors' groups have a prayer of
3 understanding what they've agreed to.
4 CHAIRMAN ENTHOVEN: Right. I think we must get
5 to a vote.
6 MS. FARBER: I would like to call for a roll call
7 vote on this.
8 CHAIRMAN ENTHOVEN: You can.
9 MS. SINGH: You can ask for that after the vote's
10 been taken.
11 MS. FARBER: Okay.
12 MR. ZATKIN: What are we voting on?
13 CHAIRMAN ENTHOVEN: Why don't we do --
14 MS. SINGH: Wait a minute. All right.
15 MS. FARBER: Has the item been changed?
16 CHAIRMAN ENTHOVEN: No.
17 MR. ROMERO: I'll just read it again. Number 5.
18 "All health plans must also disclose to medical groups
19 whether any discounts were taken up front."
20 MR. HAUCK: The word "amount" is not -- Mr.
21 Hartshorn's still concerned about that.
22 MS. SINGH: By stating "yes," you will be
23 agreeing to adopt recommendation number 5.
24 Alpert.
25 DR. ALPERT: Yes.
26 MS. SINGH: Armstead.
27 DR. ARMSTEAD: No.
28 MS. SINGH: Bowne.

MS. BOWNE: No.

MS. SINGH: Conom.

MS. CONOM: Yes.

MS. SINGH: Decker.

MS. DECKER: No.

MS. SINGH: Enthoven.

CHAIRMAN ENTHOVEN: No.

MS. SINGH: Farber.

MS. FARBER: Yes.

MS. SINGH: Finberg.

MS. FINBERG: Yes.

MS. SINGH: Gallegos.

HON. GALLE GOS: Yes.

MS. SINGH: Gilbert.

COMMISSIONER: He's gone.

COMMISIONER: Yes.

MS. SINGH: Hartshorn.

MR. HARTSHORN: No.

MS. SINGH: Hauck.

MR. HAUCK: No.

MS. SINGH: Hiepler.

MR. HIEPLER: Yes.

MS. SINGH: Karpf.

DR. KARPF: No.

MS. SINGH: Kerr.

MR. KERR: Abstain.

MS. SINGH: Lee. Excuse me, Lee.

MR. LEE: Yes.

MS. SINGH: Northway.

DR. NORTHWAY: Yes.

MS. SINGH: O'Sul livan.

MS. O'SULLIVAN: Yes.

MS. SINGH: Perez.

MR. PEREZ: Abstain.

MS. SINGH: Ramey. Rodgers.

MR. RODGERS: No.

MS. SINGH: Rodriguez-Trias.

DR. RODRIGUEZ-TRIAS: Yes.

MS. SINGH: Schlaegel.

MR. SCHLAEGEL: No.

MS. SINGH: Severoni.

MS. SEVERONI: No.

MS. SINGH: Spurlock.

DR. SPURLOCK: Yes.

MS. SINGH: Tirapelle.

MR. TIRAPELLE: No.

MS. SINGH: Williams.

MR. WILLIAMS: No.

MS. SINGH: Zaremberg.

MR. ZAREMBERG: No.

MS. SINGH: Zatkin.

MR. ZATKIN: Abstain.

CHAIRMAN ENTHOVEN: Okay.

MR. KERR: Cowards.

MR. ZATKIN: Two words; Kaiser Permanente.

MS. SINGH: The vote was 10 to 13. The motion

1 fails.

2 CHAIRMAN ENTHOVEN: Okay.

3 MR. ROMERO: 10-13.

4 CHAIRMAN ENTHOVEN: Now we get on to this little

5 non-controversial question of accountability for medical

6 decisions. Two minutes on this one. Look --

7 MS. BOWNE: Can we eat ?

8 COMMISSIONER: I don't know if it's here yet.

9 COMMISSIONER: It's here.

10 CHAIRMAN ENTHOVEN: Let's just try to see if we

11 can get through this one thing -- I would hope we don't

12 need to have a lot of protracted speeches on -- on this.

13 MR. PEREZ: In the interest of full disclosure, I

14 think I've got a long protracted speech on this one.

15 CHAIRMAN ENTHOVEN: You do?

16 MR. PEREZ: Probably.

17 MR. KERR: We eat; you talk.

18 MR. LEE: Very briefly, how can we avoid it?

19 MR. KERR: Can we vote on that?

20 CHAIRMAN ENTHOVEN: John, are you trying to tell

21 me that we have to eat now? Is that the food out there?

22 MS. SINGH: The food is ready to be distributed,

23 I believe.

24 MR. KERR: I think we should work and eat unless

25 the court reporter can't do that.

26 DR. KARPF: We'll give her an I.V.

27 CHAIRMAN ENTHOVEN: We'll -- all right.

28 DR. NORTHWAY: Take her off the formulary.

1 DR. KARPF: I'm taking a discount on it.
2 CHAIRMAN ENTHOVEN: We'll go ahead and break for
3 lunch, and try to get here quickly and start John's long
4 speech.
5 MS. FINBERG: Can you tell us what the names are
6 for the new agency?
7 MS. FARBER: Dr. Alpert had the right one. What
8 was your agency?
9 DR. ALPERT: Chaos.
10 (Whereupon the luncheon break was taken.)
11 CHAIRMAN ENTHOVEN: All right, the Task Force is
12 back in order. I apologize for all the many bad things
13 I've done, including eating with my -- speaking with my
14 mouth full.
15 We're on to recommendation 3. So, first issue.
16 CHAIRMAN ENTHOVEN: I think, Tony, that would
17 come up -- there is obvious controversy about whether
18 the recommendation to say "e.g. micra," that is make a
19 reference to micra, and I think it would be a good idea
20 to just have -- so we don't waste time discussing where
21 people's minds are apparently made up, is just to have a
22 straw vote on the proposition, does a majority of the
23 Task Force want to remove the reference to micra or not.
24 So, --
25 MR. ROMERO: And to be clear, you're talking
26 exclusively of the parenthetical reference "e.g. micra"?
27 MR. LEE: No, the whole line.
28 MR. PEREZ: The whole reference micra.

MR. LEE: There's two places -- I think the question is a straw poll on the first sentence of limits before recommendation 3. And the second limits --

DR. SPURLOCK: Le t's take the recommendation if it's comes out there.

MR. LEE: Yeah, it's on both places, but it's the full sentence, it's not just the reference to micra.

MR. RODGERS: The whole sentence.

MS. SINGH: Those in favor that there should be a straw poll vote?

DR. KARPF: The issue is limits, whether there are limits or no limits?

MS. SINGH: I haven't said yet.

MR. PEREZ: Do we remove micra or not?

MS. SINGH: Those in favor of removing "micra."

DR. KARPF: If it doesn't remove micra, it doesn't mean you're removing the issue of limits.

MR. LEE: It's does remove that.

MS. SINGH: Those in favor of -- those in favor of deleting the following sentence --

CHAIRMAN ENTHOVEN: No, no, sorry. First just "micra" because some people say they don't like micra but they do like limits. First straw poll vote. Those in favor of just deleting micra, please raise your hand.

MS. GRIFFITHS: We will go on to the whole sentence later.

MR. LEE: Then we're going to go on to the whole sentence next.

MS. SINGH: 8. Or 9, I'm sorry.

Those opposed.

MR. RODGERS: Eliminating micra?

MR. ROMERO: Right.

MS. SINGH: It is majority.

CHAIRMAN ENTHOVEN: Keeping micra.

MS. SINGH: Yeah, keeping micra. Although you don't have the 16 votes either way.

MR. LEE: What --

MR. HIEPLER: This way there's a debate.

MR. PEREZ: You w ant to give us the counts just so we have a sense.

MS. SINGH: I didn't write it down. It was like --

MR. HIEPLER: Call us to vote gain.

CHAIRMAN ENTHOVEN: Okay, next.

MS. SINGH: Those in favor of striking --

CHAIRMAN ENTHOVEN: The whole last sentence.

MS. SINGH: -- the whole last sentence that begins with "this liability should", please raise your right hand.

Okay, those opposed to removing that.

11 to 11.

DR. KARPF: Does that mean it stays o r it doesn't stay?

MR. LEE: It means there's a controversy.

DR. KARPF: What?

MR. LEE: It means there's a controversy, it

1 would be hard to get 16 either way.

2 MR. ROMERO: Exactly.

3 DR. SPURLOCK: Has there been a move to adopt it?

4 MS. SINGH: No, it does not.

5 MR. LEE: We never voted to adopt this, Bruce.

6 MS. SINGH: There is no motion on the table to

7 adopt or not to adopt at this point in time. If we do

8 make a motion, members, realize you're going to vote

9 Robert's rules. Every time you make a little amendment

10 we're going to have to go through that whole process. I

11 just wanted everyone to know that. So you don't get mad

12 at me.

13 CHAIRMAN ENTHOVEN: Okay, Bud.

14 DR. ALPERT: I'd like to make one introductory

15 comment on page 7, I think and Carol Vorhaus, I believe,

16 is the author. Carol Vorhaus and I think the Chairman.

17 I think Carol specifically wrote at the bottom of page 7

18 the second to last paragraph.

19 If you look at -- starting with the second

20 sentence, and the reason I'm referring to this is --

21 because I think this encapsulates the entire issue this

22 recommendation deals with. In the spirit of equal

23 justice, consumers should have the same civil liability

24 protections whether they work for Employer A or Employer

25 B, and providers' remedies contributing to medical

26 decisions should have the same accountability and legal

27 responsibilities .

28 ERISA has created symmetry that has the

1 unintended effect of providing greater protection for
2 consumers who happen to work for an employer that offers
3 health insurance that is not subject to ERISA
4 perceptions. This encapsulates the whole thing.
5 And the unequal justice isn't the way things
6 exist now. And that's what our snapshot of the
7 statement of care deals with.
8 And the primary intent of bringing this
9 recommendation to this paper was to deal with that and
10 make the accountability equal. Having said that, move
11 for the recommendation.
12 There are a couple of word things. There's
13 line-in/line-out speaks for itself in paragraph 1. In
14 paragraph 2, on the second line, it says "be passed that
15 provides," and I put in the word "all entities which
16 contribute to medical decisions affecting health care,
17 including," and then I want to insert "but not limited
18 to." And then the rest reads as i t reads.
19 My position on the last sentence, which as I -- I
20 believe and hope the -- the only area of significant
21 controversy, is that there has been a lot of -- taking
22 the issue of micra first, that word, as the Chairman I
23 think appropriately took a vote on, the criticism that
24 has come in regarding this paper has been to the extent
25 that I've been actually branded an industry supporting
26 fanatic. And -- and I think that probably allows you
27 to -- you know, it shows you how much -- how much
28 confusion there's been.

1 The use of the word "micra," whether it's
2 intended here or not, connotes a very specific set of --
3 of regulations that exists now. And so I am -- I would
4 hope that we would remove that word. With the concept
5 of limits together, we have not really talked about that
6 at all. It's a much larger issue with regard to all of
7 these other entities, plans and so forth and so on, and
8 so I'm not -- I 've not invested -- although it may be
9 valid, I've not invested in the concept of keeping it
10 here because we simply haven't discussed that. It's
11 going to be dealt with by lots of entities in a
12 different level.
13 CHAIRMAN ENTHOVEN: Mark.
14 MR. HIEPLER: Just to give some practical basis
15 for what Dr. Alpert said-- Alpert said, and to read,
16 that the American College of Cardiology supports
17 allowing some type of accountability for HMOs because if
18 I don't, who does. It falls ba ck on the hospitals and
19 the doctors one way or another.
20 The AMA has also taken a position on this, that
21 they need to be accountable in some manner. And here's
22 how it plays out in real life. Phil Romero, who's a
23 government employee, is denied some type of crucial
24 procedure. We find out maybe there's a bonus involved,
25 there's all kind of terrible reasons why he's denied
26 that aren't appropriate.
27 He -- his family, because he's dead, has the
28 ability to sue, has the ability to recover his lost

1 earnings.

2 If we go to Bill Hauck and the same thing happens

3 to Bill Hauck, who is a private -- gets his insurance

4 through his private employer, same contract, same

5 everything, and it's a $200 procedure that he's denied

6 that is proven by all -- the highest standards of

7 medical evidence to have caused his death, Bill Hauck's

8 family gets $200.

9 Now, industry-wide, if you don't want to be held

10 accountable, I can understand why. It's a -- it's a

11 loophole that has unintended consequences that were

12 never specifically provided for health plans but that

13 they snuck under, and of course it's a nice place to

14 hide.

15 Now, when I get on the phone and I call on behalf

16 of -- this happens every day, we did one this morning, I

17 call on behalf of Phil Romero, that all his doctors are

18 in line and they want to do -- maybe just the wrong

19 person at the health plan was making a decision, they

20 asked the first question, "Is this an ERISA covered plan

21 or is this a non-ERISA plan?" They don't ask if it's

22 medically necessary. They do that later, hopefully, if

23 it's an ethical company. But that's -- that's what

24 we're talking about, is that they should be held to the

25 same standard.

26 It's a very -- and that's how it's breaks down in

27 reality and that's how we see it every day. And every

28 legitimate health plan shouldn't have any argument with

1 that.

2 We don't ask a billion dollar corporation like

3 the auto industry, they don't ask to be immune from

4 liability; if your car blows up they'll replace the car

5 and not the contents of the car.

6 I mean, it's absurd that anybody could really

7 truthfully be against this the way that it plays out

8 because it's existing in a very unfair manner.

9 The whole issue of limits and everything, we've

10 heard lots of discussions from the industry people. We

11 have a study that we haven't looked at, and to say what

12 might arguably apply to a single practice doctor in some

13 small town, 250 cap, should apply to a billion dollar

14 corporation is absurd.

15 So, micra -- and I understood the intent the

16 day -- I didn't happen to be here, you know, that it was

17 put in there as some idea. I think that, as Dr. Alpert

18 has -- has recommended, is something that needs further

19 study, that needs to be looked at.

20 But to -- to deny that and I think you' re already

21 to this point where there should be equal

22 accountability. That's exactly how it breaks down.

23 I think Bill Hauck should have the same remedies

24 as Bill Romero's family should that tragedy happen, and

25 they do happen -- we hope they never do, but they do.

26 And when they do, you need some accountability and the

27 fact that there is some accountability is probably the

28 best sort of tort reform that you ever get. And I hate

1 to be a little impassioned on that, but I am.
2 I didn't start in this whole business for any
3 legal purpose other than I got involved in it in our own
4 family. And from the industry standpoint, you want to
5 ferret out those people in your own industry that are
6 cheating. And -- the day after my sister's verdict came
7 in, I got condolences, I got congratulations and I had a
8 significant industry competitor call me who said, "You
9 know? What we felt that in this area, in several areas
10 this company had been cheating, they'd been doing all
11 kinds of illegal practices, and I'm an industry person
12 and I thank you for what happened in this case and what
13 got some public light," and what's changed in many of
14 these initiatives has come about from those changes.
15 Now, that's the reality of it. And, you know, if
16 you want people to be able to hide somewhere else or
17 under a 250 cap or whatever, that's something for
18 someone else to discuss. But do we want it to be
19 accountable? Do we want Bill Hauck's and the Romero
20 family to have the same possible remedies should a
21 tragedy occur, with the hope that will prevent tragedies
22 from occurring? That's what we're talking about. In
23 reality, that's how it plays off.
24 And if we don't, then the doctor and the hospital
25 and everybody else becomes the only other target and is
26 probably a target for a frivolous lawsuit in those
27 contexts because you can't get at the person who really
28 caused the problem if you can prove it. That's where it

1 breaks down into real life.

2 CHAIRMAN ENTHOVEN: Thank you. Spurlock.

3 DR. SPURLOCK: Thank you, Mr. Chairman. I think

4 there's been a lot of discussion in this area that's

5 used incorrect nomenclature. And if you go to the top,

6 the title of the paper, we've actually changed it to

7 "Improving the delivery of care and the accountability

8 in the practice of medicine."

9 Bud, Lee and I p roposed a principle back on

10 August 7th about extending accountability for those

11 decision-making -- decision makers in the health care

12 system, and it was a principle that we felt very, very

13 strongly about.

14 The notion is that whenever you make a decision

15 you should be accountable for those decision-makings,

16 and our premise is that in some situations health plans

17 participate in using their expertise, judgment and

18 knowledge to be able to make medical decisions, and that

19 is the p remises that it's the practice of medicine.

20 But the problem I have is that the practice of

21 medicine is inextricably linked with the limits and

22 liabilities that we have in California that we call

23 micra. And wherever you make that decision-making

24 process, the system of micra is in there to protect the

25 malpractice insurance system that had gone awry, that

26 was in crisis in 1975 where doctors weren't fair, where

27 patients didn't get service, where money was drained out

28 of the syst em and put not into better health care but

1 into a malpractice insurance system that was lost, that
2 was -- that was going nowhere, and patients weren't
3 getting served. So, I don't -- can't see where the two
4 are inextricably linked.
5 When you make a medical decision, you should be
6 held accountable in the same system and in the same way
7 that anywhere along the decision process is, and you
8 should be provided the protections a nd the same
9 malpractice insurance system that the other people are.
10 So, I think they're linked. I don't think you can wring
11 them apart.
12 We heard yesterday how it's not been tested, how
13 Texas has a law that has been put forward down there,
14 and I simply don't want to go back to the crisis
15 situation in 1975 with health plans -- I don't want to
16 get there before we find that we actually have to do
17 this.
18 But the most important reason why I support the
19 recommendation as is, is because I'm opposed to
20 enterprise liability. And if you don't have a micra
21 limitation on there, you develop what I call pseudo
22 enterprise liability. What ends up happening when you
23 have no limitations on one aspect of the tort system,
24 the movement and the activity will go to that direction.
25 It will move from the decision-makers early on and focus
26 on the deep pockets, the big awards, the big amounts on
27 the other side of the system.
28 And what ends up happening is that health plans

1 who were now accountable at a higher standard without
2 the malpractice insurance protections that everybody
3 else has, will then start to micra-managing the
4 decisions at the lower levels, and that's the danger
5 from enterprise liability, is that in fact the
6 recommendation one tried to remove, which is prior
7 authorization and micra management in the individual
8 patient-physician interaction will become greater with
9 pseudo enterprise liability. And without limitations
10 that's what you get. And I don't think that's what
11 serves consumers well, serves the doctor-patient
12 relationship well, in the long run costs the health care
13 system, not in approved quality of care, in overall
14 costs.
15 CHAIRMAN ENTHOVEN: I thought the most
16 interesting thing in the Hearst article that I
17 circulated was that 500,000 doctors decided or their
18 organizations decided to oppose enterprise liability.
19 It's kind of a 18 0 degree turn when they realized the
20 implications that you are describing now.
21 Ron, please.
22 MR. WILLIAMS: Yes, a couple of comments.
23 MS. SINGH: The mike doesn't work.
24 MR. WILLIAMS: Yeah, a couple of comments.
25 I'll speak to Mark's words, he used the term "in the
26 real world," and with all due respect, Mark, I think the
27 best analogy I can use is maybe a little bit like a vice
28 cop, somebody who spends their time seeing a particular

1 segment of the world, I'll use the world of vice; that's
2 real, but it doesn't mean that that's the whole world.
3 And I think there are circumstances and
4 situations where things don't work out and unfortunately
5 they end up in -- in your practice. I think that
6 increasing the whole exposure to larger settlement will
7 end up with a substantial increase in premiums, health
8 plans when they have done nothing wrong, often
9 physicians when they've done nothing wrong, an d you have
10 a tragic set of circumstances. You have a family, you
11 have a -- a wife, three small children, and someone who
12 had a very tragic illness, and people want to make it
13 better. They want to try and put that family back
14 together again. And you can't. And the only thing you
15 can do is award money.
16 And health plans represent a very sympathetic
17 target. Unfortunately, we don't make money, we just
18 charge customers for it. So that any increase in the
19 underlying cost is going to end up resulting in higher
20 premiums, which are going to end up making health care
21 more unaffordable for more and more people.
22 I think that Bruce has spoken very eloquently
23 about the link between micra and the health plans, and I
24 won't repeat his comments, but I think in general I
25 would speak in support of the recommendation as it
26 stands.
27 CHAIRMAN ENTHOVEN: Okay. Mark, I'll come back
28 to you but I think I need to -- Shapiro and then

1 Barbara.

2 MR. SHAPIRO: I think it's obvious that the micra

3 reference is an explosive recommendation within this

4 group and in the Legislature where we're trying to

5 repeal micra or limit its application. The costs

6 perceived in justice.

7 The only thing I would say in terms of the

8 foundation of this recommendation that the paper,

9 itself, indicates on page 7, first paragraph, C, the

10 bottom line, that limits that apply to individual

11 physicians may not be appropriate for large

12 corporations.

13 And that if you try and take Bruce's analogy,

14 $250,000 to an individual physician has a very chilling

15 effect on how they're going to practice. $250,000 in a

16 multi-billion dollar corporation may not have the same

17 context.

18 So, if you're going to try and apply the basis

19 for that limit when it was imposed on physicians and say

20 therefore we can extrapolate and impose that on a

21 billion dollar corporation, I think that does an

22 injustice for the rationale for that limit in the first

23 place having a disciplining impact on a major

24 corporation.

25 The second thing is Phil commissioned a study on

26 this issue which we received.

27 CHAIRMAN ENTHOVEN: Who?

28 MR. SHAPIRO: Phil Romero commissioned a paper on

1 this issue, that dealt on this issue that we should not
2 have enterprise liability. What that paper suggested,
3 among other things, is that you let actor s who make
4 medical decisions that cause injury because of
5 negligence should be held accountable to the extent that
6 they act and are the cause of that. And that makes the
7 market work. That's how the market should work, by
8 holding them accountable.
9 That means you're capping it artificially.
10 Someone else is absorbing that cost because it's not
11 being attributed to the market through the liability
12 system. And what we have in this country now or in this
13 state is the patient w ho is injured, who died, is the
14 one who is absorbing that cost.
15 CHAIRMAN ENTHOVEN: Okay. Thank you, Michael.
16 MR. ROMERO: Just to clarify -- just to clarify,
17 Michael, so in those comments do I hear that you are
18 endorsing the recommendation accepting a micra
19 reference?
20 MR. SHAPIRO: No, I'm saying it's so
21 controversial it should come out, be studied; that micra
22 has a logical extension to corporate liability.
23 CHAIRMAN ENTHOVEN: Nancy.
24 MS. FARBER: I want to quest ion what Rodney said.
25 I'm not sure I understood what you said.
26 MS. GRIFFITHS: Ron.
27 MS. FARBER: I'm sorry. Ron. You don't make
28 money so you're just going to pass it on to the consumer

1 in higher premium.

2 MR. WILLIAMS: That's where the money comes from

3 to operate the health plan.

4 MS. FARBER: But you have reserves, right?

5 MR. WILLIAMS: To pay claims.

6 MS. FARBER: Are you for profit or nonprofit?

7 MR. WILLIAMS: We're both -- we're for profit.

8 MS. FARBER: I would suggest you have money other

9 than what you get from patients' premiums to pay these

10 claims.

11 MR. WILLIAMS: We're operating a business, ma'am.

12 CHAIRMAN ENTHOVEN: Let's see, Peter Lee.

13 MR. LEE: A couple of things. First, I think

14 it's true that money that goes to pay claims comes out

15 of in some way the health care dollar, but the question

16 is at the same time, right, that it should. I mean,

17 however you cut it.

18 The issue -- I think Mark's point about treating

19 Bill Hauck versus Phil Romero differently is the

20 problem. Is that people, when those wrongs happen, and

21 the very small percentage of times that they happen, how

22 do you compensate people in terms of the harm suffered?

23 And there would be some cost increases. You know, the

24 Kaiser study that we all got recently said point 1 to

25 point 4 percent. I've not reviewed that particular

26 upside down and inside-side and sideways; in t erms of

27 fairness it's a huge problem. I think it would be

28 really terrible for the Task Force to not make a

1 statement of a position on this in terms of the way
2 Californians are treated very, very differently. In
3 some ways it's saying --
4 MS. BOWNE: Not just Californians.
5 MR. LEE: Not just Californians. But we're
6 making a recommendation -- which is why we're making a
7 recommendation both to California and the Pre sident and
8 Congress, because as the managed health care Task Force
9 we're in California. But this is a national issue, as
10 well, and I think that it is -- we talked lots in the
11 conflict of dispute regulation about what are the
12 essential elements of a fair and effective process and
13 one of the elements that we agreed on is that like
14 people should be treated like. That doesn't happen now
15 and by some way by standards -- maybe you didn't read
16 it, but the standards we all agree on, what are the
17 elements to resolve disputes in fairness. The system
18 isn't fair. The issue around limitations -- I mean,
19 everyone knows there's two sides to this argument.
20 There's one side which is damage cap. And limit
21 inappropriate lawsuits. I hope we haven't said limits
22 should be frozen so they aren't compensated.
23 The other side is they may restrain what people
24 should be fairly be compensated for.
25 Those are two sides right now. This paper only
26 has one, it says the only t hing that damage caps do is a
27 positive thing, which is stop costly lawsuits.
28 I think the way to address this is pulling it and

1 say that caps can have two effects. They could limit
2 costly lawsuits and they could limit the extent to which
3 the individuals get fairly compensated. I mean, that's
4 a bad way to deal with it. I think it would be a
5 tragedy if we, as a Task Force, didn't address the issue
6 about people in Califor nia being treated very
7 differently depending upon where they sit.
8 CHAIRMAN ENTHOVEN: What happened, Carol?
9 We had some balancing language at one point,
10 balancing --
11 MS. VORHAUS: We can put it back in.
12 CHAIRMAN ENTHOVEN: At that point we had some --
13 MS. GRIFFITHS: I don't know what happened.
14 CHAIRMAN ENTHOVEN: -- we had some words
15 balancing the need for compensation with the need to
16 avoid creating incentives for costly lawsuits. I
17 mean -- I mean that would b e a non controversial.
18 MR. LEE: To see whether it's in the
19 recommendations, say that liability -- the extent of
20 liability should consider both how limits may impact the
21 incentives for costly lawsuits or impact the extent to
22 which individuals are fairly and fully compensated --
23 something like that I'd be fine with.
24 CHAIRMAN ENTHOVEN: Did you say -- let me just
25 deal with your point because it -- at one time. Words
26 like this, after "micra" it would say "to balance the
27 need for fair compensation with the need to avoid
28 creating incentives for costly lawsuits"?

MS. FINBERG: No.

MR. LEE: What I was saying, this liability could be subject to limits, but it would need to consider the extent to which limits either -- either reduce incentives for costly lawsuits or lead to harms not being fairly compensated.

I mean, those are the two sides, as I -- as I understand it, of the debate. And it's f raming it that there's two sides.

CHAIRMAN ENTHOVEN: I don't understand where we're differing her. I'm proposing to put language to do that, to say balance --

DR. ALPERT: He's not putting in the recommendation. I think you're putting in the recommendation.

CHAIRMAN ENTHOVEN: You want to put it up above?

MS. BOWNE: You've spoken; there's other people who haven't spoken.

DR. SPURLOCK: That's what -- that's what I'm saying. After everybody else. I don't wa nt to speak yet.

MR. LEE: I mean other -- where that could go is either the last line of the recommendation or it's probably better to put pull it out of the recommendation and to be the last line leading up to the recommendation, which is currently where we are, there should be one lawsuit to -- the language say something along the lines of liability could be subject to limits,

1 you know, however such limitations on damages may either
2 reduce incentives for costly lawsuits or lead to harms
3 not being fairly compensated."
4 All right.
5 MR. LEE: I mean, that's sort of the -- it's
6 trying to show there's balance to the discussion of
7 damage caps.
8 CHAIRMAN ENTHOVEN: All right.
9 MS. SINGH: Is there objection to Mr. Lee's
10 suggestion?
11 CHAIRMAN ENTHOVEN: Yes.
12 MR. PEREZ: It's too conceptual.
13 MS. BOWNE: It's too conceptual.
14 CHAIRMAN ENTHOVEN: Okay. Well, Peter, I thought
15 I was just suggesting a -- a simple way to achieve your
16 point here by putting in the recommendation after micra
17 to balance the -- balance the need for fair compensation
18 with the need to -- but you say that just --
19 MR. LEE: I'm not quite clear what you're saying,
20 Alain.
21 CHAIRMAN ENTHOVEN: This is just words to try to
22 deal with your concern, is to say in the last line of
23 the recommendation, to put in --
24 MR. LEE: No, I was saying -- I was saying
25 could --
26 MS. SINGH : Liability could be subject to limits,
27 however such limitations -- and that's what I was going
28 off of -- such limitations on damages may --

1 MS. GRIFFITHS: Or should balance.
2 DR. ALPERT: Put that in the body of the paper.
3 MR. HIEPLER: Revise the body or the
4 recommendation?
5 DR. ALPERT: I would say in the recommendation,
6 put "this liability may be subject to limits," period,
7 is the recommendation. And then in the body of the
8 paper actually add some language. I had the Task
9 Force -- again not the recommendation, the Task Force
10 did not have an opportunity to fully look into the
11 extent to which limitations on damages may either reduce
12 incentive for costly lawsuits or lead to harms not being
13 fully or fairly compensated. It says those are the two
14 sides, that we didn't have a chance to fully do it and
15 then in the recommendation it -- it takes the micra word
16 out and it says "this liabil ity may need to be subject
17 to limits," period.
18 DR. KARPF: Does not have the expertise or time
19 to do it.
20 CHAIRMAN ENTHOVEN: Read me that sentence.
21 DR. ALPERT: For the body, "The Task Force did
22 not have an opportunity" -- oh, here, it's printed.
23 CHAIRMAN ENTHOVEN: Awesome. Okay.
24 DR. KARPF: Why don't you read it out loud.
25 CHAIRMAN ENTHOVEN: The Task Force did not have
26 the opportunity to fully look into the extent to which
27 limitations on damages may either re duce incentives for
28 costly lawsuits or lead to harms not being fully or

fairly compensated.

DR. ALPERT: It's both sides.

CHAIRMAN ENTHOVEN: So that will go in.

DR. ALPERT: The debate -- it says we're aware of the debates and that it's a very complicated issue. It's much above the basic premise of what we're trying to do, which is to right the equity and accountability and that limits it, and then in the recommendation there we're acknowledging that limits may still be out there and we're saying liability may need to be subject -- one, the recommendation is consistent with the fact that it may need to be, because we don't know.

CHAIRMAN ENTHOVEN: Okay.

MS. SINGH: Is there objection to that amendment? There is objection?

MR. LEE: Did you get a straw poll on that amendment?

MR. PEREZ: We're still on discussion and is there a list?

CHAIRMAN ENTHOVEN: There is a list.

MS. SINGH: There is a list, and you're on it.

CHAIRMAN ENTHOVEN: Okay. Griffiths, then -- okay, Griffiths.

MS. GRIFFITHS: Thank you. I think most of the rhetoric of what I would have said or wanted to stay has been covered by Michael and Peter in combination, and now Bud's brought up the real substantive point I wanted to bring up.

1 COMMISSIONER: Can you speak louder.
2 MS. GRIFFITHS: The substantive point I wanted to
3 touch on is the same as has just been touched on, is
4 this micra insertion and I'm left with a feeling here
5 and I'm really deeply concerned that we go down that
6 road without having the adequate evidentiary bases here
7 to make that kind of a recommendation. I think the
8 suggestions that have been put out now are helpful.
9 CHAIRMAN ENTHOVEN: All right. Perez,
10 MR. PEREZ: A couple of things. First of all,
11 I've got problems with the use of the term "costly
12 lawsuits", because the fact that a lawsuit is costly
13 doesn't mean that it's problematic. I think that
14 there's some times when a costly lawsuit is an
15 appropriate thing.
16 And I think we -- and I think we can all think of
17 some costly lawsuit that we were interested in but we
18 thought that was just and appropriate.
19 I think that the problematic lawsuits that we
20 should refer to are frivolous lawsuits. There's a big
21 distinction between a frivolous lawsuit and a costly
22 lawsuit.
23 The other thing is that we seem very quick to
24 want to study everything else in the world except for
25 the issue of what limits could -- consumers should have
26 on their ability to recuperate from some sort of an
27 injury that they've received. So that if we're going to
28 make any to reference to limits, whatsoever, then I

1 think that we ought to learn from all the other
2 recommendations we made and suggest that the issue of
3 limits oug ht to be studied that so that you can figure
4 out the appropriate balance between protecting yourself
5 from frivolous lawsuits and protecting the interests of
6 injured parties.
7 CHAIRMAN ENTHOVEN: Okay. Hiepler.
8 MR. HIEPLER: Just to correct a few things or
9 shed some light on what Dr. Spurlock said.
10 First of all, we heard so much we don't want to
11 over-regulate a system. Let me just share with you some
12 real life reality that we work in every day about how
13 it's already regu lated. You read about a large verdict,
14 you read about something, and you may not ever hear the
15 facts of it.
16 But internal in California's judicial system is
17 numerous systems to either use additur to increase an
18 unfairly low damage or reduce the remitter of an
19 unreasonably high verdict. And the first step, this is
20 already in the system that no one ever hears, you have
21 judgments notwithstanding verdicts. In every case, you
22 know, there's a large verdict, you get a motion for
23 that. The judge has taken away complete verdicts
24 as you've really seen in the Hughes Aircraft case --
25 against Hughes Aircraft. And he could add to it. But
26 that's one step that is already in the system.
27 But you never read that someone's huge verdict
28 ever got changed to a low one industry people would

1 think that's appropriate. So, that's in the system.
2 Secondly there's appeals. Real life statistics
3 we want to hear, but on this one we don't want to study
4 it, we just want to assume things, that is that appeal
5 in California, there has never been a punitive damage
6 upheld on appeal that was greater than 5 percent of the
7 net worth of a company. And if you understand why
8 punitive damages do exist and must exist, that's the
9 whole purpose, it's brought about by that.
10 So, that's a -- a systemic thing that is already
11 happening, is already there. The next thing, you got to
12 show by clear and convincing ev idence in these cases.
13 That reduces probably 99 percent of all frivolous cases.
14 And clear and convincing is much higher than a
15 preponderance of evidence or 51 percent. That's what
16 you must show.
17 Thirdly, it's bifurcated. You can't go in and
18 just show the terrible damages and hope that you've
19 established liability. You got to establish liability
20 first before you even get to damages. Those are already
21 in the system.
22 But I venture that 90 percent of the people here
23 don't even know that that's in the system already
24 working and we never read about that part that is in
25 there that takes care of this issue of damages.
26 Now, by extending micra, we can't do anything,
27 it's really a Federal law. Texas has done something.
28 George Bush had the opportunity to veto to it; he

1 didn't. But there it's already an on appeal because
2 it's a Federal issue.
3 So, what we're just doing is recommending that it
4 should be fair. We've recommended so many things and
5 recommended so many studies, we can't even make this
6 happen, we can -- we can shed some light on the fact
7 that there is not accountability. And then we're using
8 a different analogy of what's costly.
9 I mean, it's costly to prosecute embezzlers,
10 okay. And in many contexts where someone takes away
11 something that's deserved, whether it's costly or not,
12 we still choose to prosecute embezzlers. Okay.
13 We're not saying th at we should do away with
14 criminal punishment and in many cases civil liability is
15 the only way to take on someone who has done a criminal
16 act. And it's very rare that happens.
17 So, sometimes -- and I think the word "costly"
18 needs to come out of there and we have not had any
19 discussion. We don't have any experts, we could have
20 brought a lot of them if I had known this was going to
21 be a huge issue before both sides to talk about the
22 limit issue. And I think that micra, becaus e we're
23 looking in this context who's the defendant, it's not
24 going to be a doctor who's practicing medicine -- the
25 defendant is going to be a health plan, an HMO or an
26 insurance company.
27 And so, all of the reasons that Bruce thinks
28 micra should apply to big corporations or to smaller

1 corporations don't -- don't -- don't fit.

2 And so, I think that to try to get this

3 somewhere, if we leave the proposal as it was, striking

4 out that last sentence, and I would -- you know, if you

5 need to recommend someone to look into the issue of

6 should limits apply or not, that's fine. But we haven't

7 had any study on it and you guys haven't passed one

8 thing before that -- you know, that -- that we had

9 anecdotal evidence for, and you got all kinds of

10 anecdotes and you got so much bias on this subject on

11 which many people have no real background, so I would

12 suggest, as Mr. Perez says, if you really want to do

13 something you say, well, someone study that.

14 But do we believe it should be accountable or

15 not, that's the real issue.

16 CHAIRMAN ENTHOVEN: Let's see, Zatkin.

17 MR. ZATKIN: I hear people talking, mixing up two

18 issues. One is should there be accountability. And the

19 second is if there is, what is the extent of the

20 potential damages at least with respect to the micra

21 type issue. Micra doesn't just apply to individual

22 doctors, as I understand. It applies to hospitals.

23 It applies to very large institutions. It applies to

24 big hospitals?

25 MR. HIEPLER: But micra is only applied to

26 benefit determination.

27 MR. ZATKIN: We're talking about issues in which

28 there is a contribution on a medical decision. That's

1 what the language is that I read. So, the limit issue
2 has to do with the question which I think the
3 Legislature has already dealt with, namely the extent to
4 which plaintiffs will be compe nsated for non-economic
5 loss because of medically-related decisions. And the
6 proposal is to extend liability for medically-related
7 decisions to another class of plaintiffs who are large
8 but -- there are defendants, I'm sorry, who are large --
9 but there are already large defendants who have micra
10 protections and that's because the Legislature made a
11 policy decision back in 1975, which they have
12 continually extended, that says when balancing these
13 issues, namely the right to rec over for non-economic
14 loss against the impact on health care system costs,
15 that's an appropriate limit.
16 And so, I think there is a lot of background on
17 it.
18 CHAIRMAN ENTHOVEN: Hartshorn.
19 MR. HARTSHORN: I think we might be running into
20 one of these unintended consequences, I guess, areas
21 like we talked about before. A lot of the Task Force
22 recommendations prior to this and some of them later
23 this afternoon, we've been pushing the decision of
24 patient care, you know, further away from the health
25 plan. We're taking away some of the -- I'll call tools
26 to the physician. And some good and some maybe I don't
27 agree with, but we voted on them.
28 If something that takes away limits or something

1 that exposes health plans in a -- I guess
2 disproportionate way, you're going to have the
3 unintended consequence of us health plans getting much
4 more involved in the patient care process. And
5 that's -- that will raise costs right there.
6 In other words, if the liability is extended
7 when -- we're trying to push it away so it can be made
8 at the physician-patient point, then you can't -- you
9 can't have it both ways. So, I think we need to think
10 about that if we take a vote on this issue because
11 it's -- they could have severe consequences over the
12 next couple of decades if we make decisions like that.
13 CHAIRMAN ENTHOVEN: We're running way over time.
14 I think it's time to vo te.
15 MS. GRIFFITHS: I'd like to move the first
16 paragraph alone.
17 MS. O'SULLIVAN: I have a question about it
18 before you do.
19 MS. FINBERG: You only want to move the first
20 paragraph alone?
21 MS. BOWNE: The first paragraph, the italicized
22 or --
23 MS. FINBERG: Anything that affects health care.
24 MS. SEVERONI: Can we modify the second
25 paragraph. The intent to apply malpractice -- I just
26 want to know what you mean by it. What are the
27 consequences of it?
28 MS. GRIFFITHS: The consequences are that the

Legislature should -- Legislature should adopt legislation with -- that would implement this goal. Hold them liable and in those ways accountable.

MR. ROMERO: Hold them accountable in those ways which the Legislature determines to be appropriate.

MR. HAUCK: I don't think you can do one -- you need to -- I mean, I want to know -- if you're voting for liability, I want to know what you r intent is. If it's liability, I want to know that.

MS. GRIFFITHS: I assume there would be subsequent motions afterwards. But my purpose is to determine accountability which is something which would then be, you know, determined what exactly that meant through legislation.

DR. KARPF: If you bring it down to this point, you're talking about the issue.

MS. GRIFFITHS: My motion is the first sentence, the first paragraph. It's been seconded?

CHAIRMAN ENTHOVEN: It 's been seconded.

DR. SPURLOCK: I want to speak to that. I think Alain said on something extremely acrimonious.

The notion that they're not linked is a mistake. Once they're linked you can actually talk about some similarities. And I think the proper way to sort of find out what this group feels on this issue is to vote on the micra issue first and then come back on the accountability issue second.

MR. ZAREMBERG: The accountability, quickly,

through the regulatory agency.

MS. GRIFFITHS: With all due respect, I disagree with Dr. Spurlock.

MS. SINGH: There's a motion and a second.

CHAIRMAN ENTHOVEN: There is a motion on the table.

MS. SINGH: And a second.

DR. ALPERT: I can clarify, the intent was not to speak to the regulatory part of it. Accountability in this state over a hundred years has had two forms, through regulation and through civil liability. That's existed in the State since 1849.

This addresses the civil liability. The intent of this was to address the civil liability piece, the regulatory part was addressed in regulatory paper.

MS. GRIFFITHS: As the maker of the motion, I'd like to respond. "Accountable" is not a legal term and if we use that term here it will fall to the Legislature and subsequently, I presume, to the courts to determine what that means.

CHAIRMAN ENTHOVEN: All right.

MS. O'SULLIVAN: I have a question.

CHAIRMAN ENTHOVEN: Yes.

MS. O'SULLIVAN: Is "entities" intended to include individuals or only corporations here?

DR. ALPERT: Yes, entity is defined in the dictionary as being -- that's the first definition, so it was defined as all existing --

1 MR. SCHLAEGEL: So if I choose Kaiser to be
2 offered to my employees, am I part of this liability?
3 DR. ALPERT: That's not saying the same thing.
4 MS. GRIFFITHS: That's not contributions to a
5 medical decision.
6 MR. SCHLAEGEL: That's what I wanted,
7 clarification.
8 DR. KARPF: You can't choose anybody else.
9 MR. ZATKIN: If you operated a self-funded
10 arrangement and you make a decision regarding medical
11 necessity and it turns out to be bad, you would be
12 subject to --
13 DR. ALPERT: It has to have an impact on patient
14 care.
15 MS. GRIFFITHS: Again, my purpose is --
16 CHAIRMAN ENTHOVEN: All right.
17 MS. GRIFFITHS: My purpose is to try to move a
18 general statement and then obviously there would have to
19 be details filled in later.
20 MR. KERR: I would like to offer maybe a friendly
21 amendment. You're talking about the first sentence. I
22 would like to offer a friendly amendment which would add
23 the following, "The Governor and Legislature should
24 initiate a study" -- this follows this, "The Governor
25 and Legislature should initiate a study on financial
26 liability issues related to this accountab ility that
27 takes into effect -- that takes into account the effect
28 on incentives for frivolous lawsuits or that lead to

harms not being fully or fairly compensated." That's not good English, but it's the idea.

MR. ZATKIN: Say it again.

MR. KERR: In addition to the first sentence it would say, "The Governor and Legislature should initiate a study on financial liability issues related to this accountability that takes into account the effect on incentives for frivolous lawsuits or that lead to harms not being fully or fairly compensated.

MS. SINGH: Given that this isn't really a technical amendment and given this is such a controversial issue and we've already had a motion on the floor, if Mr. Kerr has moved, is there a second?

MR. PEREZ: Second.

MR. HIEPLER: We still got the first one.

MS. GRIFFITHS: Motion is on the floor.

MS. SINGH: There is a motion to amend. We haven't voted on yours yet. Right now we're going -- we have a motion to amend your motion.

CHAIRMAN ENTHOVEN: We have to --

DR. KARPF: It was presented as a friendly amendment.

MS. O'SULLIVAN: Not so friendly.

MS. GRIFFITHS: The study again -- read it, just what the study would do.

MR. KERR: It would initiate a study on financial liability issues related to this accountability which is talking about frivolous -- that takes into account the

1 effect on incentives for frivolous lawsuits or that --
2 that leads to harms not being fully or fairly
3 compensated.
4 MR. ZAREMBERG: Can I ask a question of
5 clarification, because I know the medical association is
6 strongly opposed to limit increasing the malpractice
7 limits and has opposed the Legislature. Does that
8 account of -- that last few words there imply that
9 people weren't adequately compensated?
10 MR. KERR: It says the two si des you discussed,
11 either way, going to frivolous lawsuits, take away cost
12 or will harm families that weren't certainly
13 compensated. It leaves it neutral.
14 MR. ZAREMBERG: Does it imply they were not
15 fairly compensated?
16 CHAIRMAN ENTHOVEN: Do you accept that?
17 MS. GRIFFITHS: I accept that.
18 MS. SINGH: Is there a second?
19 CHAIRMAN ENTHOVEN: We now vote --
20 DR. SPURLOCK: I'd --
21 CHAIRMAN ENTHOVEN: There's a motion.
22 DR. SPURLOCK: I'd like higher order to mov e to
23 table this paragraph until after the vote on the second
24 paragraph. Move to table the higher order motion and
25 we -- we can debate and discuss on the move to table
26 until after the vote on the second paragraph.
27 MR. PEREZ: Motions to table are not debatable.
28 DR. SPURLOCK: Let's vote on whether we should

table it.

MS. SINGH: It needs to be seconded and requires a majority vote.

MR. HAUCK: Second.

MS. SINGH: But if you could bear with me for one second.

MS. GRIFFITHS: Is there a motion to table?

CHAIRMAN ENTHOVEN: There's a motion to table, to defer this item until we voted on the second paragraph.

DR. SPURLOCK: That's correct.

MS. GRIFFITHS: That's not a higher order to defer a motion, to table one.

DR. SPURLOCK: A motion to table, to defer it until after the vote --

MS. GRIFFITHS: A motion on the table --

CHAIRMAN ENTHOVEN: -- to lay on the table requires a second and majority vote.

MS. FARBER: He's got a second. Let's see if there's more than a majority -- a majority.

MR. PEREZ: He's tabling to a time specific.

MS. SINGH: I believe what Dr. Spurlock is attempting to do is postpone this definitely by indicating that he would like to -- to postpone the voting on the first paragraph until we've adopted or voted -- excuse me, until we voted on the second paragraph. That requires a majority vote and it requires a second. It's a higher ranking motion than amending. So, at this point, members, we have Spurlock

has moved to postpone definitely and, Mr. Perez, did you second it?

MR. PEREZ: No.

CHAIRMAN ENTHOVEN: Mr. Hauck.

MS. SINGH: Those in favor of postponing this definitely, please raise your right hand.

Those opposed?

It's 13 to 13. The motion fails.

The motion on the floor at this point in time is to adopt th e first paragraph. It's been seconded.

MR. LEE: As amended.

MS. SINGH: With amendments.

MS. SEVERONI: As friendly.

CHAIRMAN ENTHOVEN: With the current amendments. Is there further discussion?

MS. SINGH: Those in favor of adopting the first paragraph with the amendments proposed by Mr. Kerr, please raise your right hand.

Those opposed?

I'm sorry, 13 to 14. The motion fails.

MS. FARBER: Could I make a motion that the original paragraph be voted on, as is, without amendment.

CHAIRMAN ENTHOVEN: Is there a second?

MS. O'SULLIVAN: I second it.

MR. PEREZ: Point of order. We've voted now on the first paragraph, which would bring the second paragraph before us.

MS. FARBER: No, we voted on an amended first paragraph.

DR. SPURLOCK: It was a friendly amendment.

MR. PEREZ: It was the first paragraph.

CHAIRMAN ENTHOVEN: It was the first paragraph.

MR. PEREZ: It was the first paragraph.

MS. SINGH: But, see, members, that's why I had proposed we vote on the amendment first and then vote on the recommendation. But we did it the other way, so at this point it's failed.

MS. O'SULLIVAN: Is there a way -- is there a way for the -- for you parliamentarians to tell me how you can bring that first sentence back?

MR. PEREZ: After you vote on the second paragraph, then you can.

MS. FARBER: We did this yesterday.

MR. PEREZ: You have to be on the prevailing side to reconsider.

CHAIRMAN ENTHOVEN: So now we have before us the second paragraph with the author's addition in the third line "including but not limited to health plans, hospitals," and so forth. So, do we have a motion for the second paragraph?

DR. SPURLOCK: Moved.

CHAIRMAN ENTHOVEN: I'm sorry, Dr. Spurlock moved.

MR. KERR: Without the first paragraph.

MS. GRIFFITHS: Can we read it, please?

1 MS. FINBERG: This is really the second paragraph
2 without 1 and 1 together, it's just 2?
3 CHAIRMAN ENTHOVEN: We're just voting on the
4 second paragraph.
5 MS. SINGH: That's correct.
6 MR. PEREZ: 1 has been deleted.
7 CHAIRMAN ENTHOVEN: Right now, as it's printed,
8 with the exception of -- of the author's change in the
9 third line, "including but not limited to health plans."
10 MS. O'SULLIVAN: I have what I think is a
11 friendly amendment. The author said it was his
12 intention "including but not limited to individuals,
13 health plans" -- to insert "individuals."
14 MR. PEREZ: The question's already been called.
15 MR. ZAREMBERG: Did they take out medical groups,
16 IPAs?
17 MS. BOWNE: No, it's all in there.
18 CHAIRMAN ENTHOVEN: Okay. So, that's the motion.
19 DR. NORTHWAY: And the last sentence has not been
20 altered in any way?
21 CHAIRMAN ENTHOVEN: No.
22 DR. SPURLOCK: It says --
23 MS. O'SULLIV AN: Can I put that word in?
24 MR. PEREZ: The question has already been called,
25 let's just vote on it.
26 MS. SINGH: Who seconded the motion? I'm sorry.
27 Do we have a second?
28 DR. ALPERT: The last sentence read as originally

1 second ED.

2 DR. SPURLOCK: Who seconded the motion?

3 DR. RODRIGUEZ-TRIAS: I did.

4 DR. SPURLOCK: Thank you.

5 MS. SINGH: Thank you. Those in favor of

6 adopting the second paragraph a s amended, please raise

7 your right hand.

8 Those opposed?

9 5 to 17. The motion fails.

10 MS. FARBER: I would like to make a motion to

11 reconsider, if this is the right point in time, the

12 first paragraph, "all entities which contribute to

13 medical decisions affecting health care should be

14 accountable for their impact on medical decisions."

15 That and that alone.

16 MS. SINGH: Originally proposed?

17 MS. FARBER: As originally proposed, and that

18 alone, no amendments.

19 MR. PEREZ: Point of order.

20 CHAIRMAN ENTHOVEN: Yes.

21 MR. PEREZ: Just so we don't get into this debate

22 again later, because you didn't just reconsider, what

23 you did is you moved that paragraph. Because I don't

24 want us to then go back and try to reconsider stuff we

25 voted down. You did not move to reconsider, you just

26 moved.

27 MS. FARBER: Whatever the technical thing, John,

28 that's fine.

MS. SINGH: She's proposing -- let's just pretend she's proposing a brand new first paragraph.

MS. FARBER: If that makes you happy, John, that makes me happy.

CHAIRMAN ENTHOVEN: That's how we're treating this. Do I have a second?

MS. BOWNE: Yes.

MS. SINGH: Yes.

DR. NORTHWAY: What are we pretending now?

CHAIRMAN ENTHOVEN: That we all are going home.

DR. NORTHWAY: I vote yes.

CHAIRMAN ENTHOVEN: Those in favor of adopting paragraph 1 as originally proposed, please raise your right hand.

Those opposed?

15-11 -- 11 to 11. The motion fails.

CHAIRMAN ENTHOVEN: All right. We'll -- now we'll move on to D. I'd like to raise the question on D.

MS. SINGH: So, there's no recommendation. The recommendation has failed.

DR. ALPERT: I would like to -- I'd like to move -- well, I don't know if it's to reconsider the second paragraph with -- with an amendment.

MR. LEE: Just make it a new motion, Bud.

DR. ALPERT: All right. Then I'll m ove -- I'll move the first paragraph as stated, the second paragraph.

MR. LEE: Point of clarification, the first paragraph has failed.

DR. ALPERT: But I'm going to include -- all right, the language of the first paragraph connected without making a second paragraph to -- to the language that now is the second paragraph, and with the last sentence being deleted and -- and amending by substitution the language "this liability may need to be subject to limits." Period.

MR. LEE: The last sentence of the second paragraph.

DR. ALPERT: Yes.

MR. SCHLAEGEL: I second that.

MS. SINGH: Schlaegel seconds. At this point in time the motion on the table is to adopt the first paragraph as stated, but it's going to be included with the second paragraph.

MR. HAUCK: What are we voting on here?

MR. LEE: And the last sentence of paragraph 2 would read "this liability may need - - may need to be limited."

DR. ALPERT: No, wait.

MR. LEE: May --

DR. ALPERT: "This liability may need to be subject to limits." Period.

MS. SINGH: Yeah, and deleting "e.g. micra."

DR. ALPERT: Yes, I'm ducking -- the issue of accountability to me is embarrassing and we would be a

laughing stock, in my impression.

MS. O'SULLIVAN: Friendly amendment. Can I add --

MS. BOWNE: Please.

MS. O'SULLIVAN: Can I add "individuals"? I want to add "individuals" after "including."

DR. ALPERT: Fine. Accepted.

CHAIRMAN ENTHOVEN: All right. After "but not limited to" in the third line. So, do we have a motion?

MS. FARBER: Motion. I'll make the motion.

MS. SINGH: The motion has been made. It's been seconded.

MS. FARBER: I'll like to call for roll call votes when you get around to doing it.

MS. SINGH: That will just take one moment for me. I just need to get my roll call sheets.

MR. HAUCK: There's a reference to ERISA in that?

MS. SINGH: ERISA, yes, not micra.

MR. HIEPLER: Can we have the language?

MS. SINGH: Not micra.

DR. ALPERT: A "no" vote means that you support the continued inequity in the system where civil liability --

CHAIRMAN ENTHOVEN: That's what it means.

DR. SPURLOCK: However you want to spin it.

DR. ALPERT: My impression --

MR. ROMERO: -- means no clarification on the language.

CHAIRMAN ENTHOVEN: A "no" vote might reflect your benefits through the tort system here is dysfunctional.

MS. SINGH: Okay. Those -- those in favor of adopting the recommendation as proposed by Dr. Alpert, which is including the first paragraph with the second paragraph and then adding "may need to be subject to limits," period?

DR. ALPERT: There might be a limit.

MS. SINGH: Yes.

MR. KERR: Mi nus the last sentence.

DR. ALPERT: I said period, so deleting the remainder.

DR. NORTHWAY: Does it also include "including but not limited to"?

CHAIRMAN ENTHOVEN: Yes.

MS. SINGH: By indicating "yes" you will be stating that you are in favor of this recommendation.

Alpert.

DR. ALPERT: Yes.

MS. SINGH: Armstead.

DR. ARMSTEAD: No.

MS. SINGH: Bowne.

MS. BOWNE: No.

MS. SINGH: Conom.

MS. CONOM: Yes.

MS. SINGH: Decker.

MS. DECKER: No.

MS. SINGH: Enthoven.

CHAIRMAN ENTHOVEN: No.

MS. SINGH: Farber.

MS. FARBER: Yes.

MS. SINGH: Finberg.

MS. FINBERG: Yes.

MS. SINGH: Gallegos.

HON. GALLEGOS: Yes.

MS. SINGH: Gilbert.

DR. GILBERT: Yes.

MS. SINGH: Griffiths --

(Laughter)

COMMISSIONER: He throws his voice.

MS. SINGH: Clarification required. Griffiths?

MS. GRIFFITHS: Yes.

MS. SINGH: Hartshorn.

MR. HARTSHORN: No.

MS. SINGH: Hauck?

MR. HAUCK: No.

MS. SINGH: Hiepler.

MR. HIEPLER: Yes.

MS. SINGH: Karpf.

DR. KARPF: Yes.

MS. SINGH: Kerr.

MR. KERR: Yes.

MS. SINGH: Lee.

MR. LEE: Yes.

1 MS. SINGH: Northway.
2 DR. NORTHWAY: Yes.
3 MS. SINGH: O'Sullivan.
4 MS. O'SULLIVAN: Yes.
5 MS. SINGH: Perez.
6 MR. PEREZ: Can I take a pass and come back to
7 me.
8 MS. SINGH: Ramey. Rodgers.
9 MR. RODGERS: No.
10 MS. SINGH: Rodriguez-Trias.
11 DR. RODRIGUEZ-TRIAS: Yes.
12 MS. SINGH: Schlaegel.
13 MR. SCHLAEGEL: No.
14 MS. SINGH: Severoni.
15 MS. SEVERONI: Yes.
16 MS. SINGH: Spurlock.
17 DR. SPURLOCK: No.
18 MS. SINGH: Tirapelle?
19 MR. TIRAPELLE: No.
20 MS. SINGH: Williams.
21 MR. WILLIAMS: No.
22 MS. SINGH: Zaremberg.
23 MR. ZAREMBERG: No.
24 MS. SINGH: Zatkin.
25 MR. ZATKIN: No.
26 MS. SINGH: Perez.
27 MR. PEREZ: I vote "yes " even though it's not
28 going to make a difference.

1 MS. FINBERG: Thanks a lot.

2 DR. RODRIGUEZ-TRIAS: Oh, he was keeping count,

3 huh?

4 MS. SINGH: 15 to 13. The motion has failed.

5 CHAIRMAN ENTHOVEN: All right.

6 MS. SINGH: Mr. Chairman, I recommend that you

7 move to recommendation number 4.

8 CHAIRMAN ENTHOVEN: I would -- it's -- look,

9 we -- we're having a terrible problem of time. We're --

10 we've really got people with planes and so forth. I've

11 received strong statements of people wanting to be out

12 of here by 5:00. I of course would stay if necessary,

13 it's my duty, but it would hurt. So, I want to raise

14 the question whether we really want to take up

15 recommendation 4, which is --

16 MS. DECKER: Try a quick vote.

17 CHAIRMAN ENTHOVEN: -- which is a very complex

18 vote. So, could we just have a straw poll -- the

19 question is those in favor of dealing with

20 recommendation 4 as o pposed to just bypassing it.

21 MR. KERR: You got to read it.

22 CHAIRMAN ENTHOVEN: Okay. Take a look at it.

23 MR. HIEPLER: I have a one-line deal that would

24 end up a written proposal that would be recommending the

25 Congress and Federal government evaluate this. And I

26 would like to just put that on as a motion so that we

27 don't completely punt on all of the hard work that's

28 going in by Dr. Alpert on number 3. It's a one-line

proposal. I won't ask for a roll call vote.

MS. FINBERG: I second that motion.

MS. BOWNE: Can we hear what the --

CHAIRMAN ENTHOVEN: Can we agree this will be the end of 3 one way or another?

MS. SINGH: So, we're back on recommendation number 3?

MR. PEREZ: Yes.

MR. HIEPLER: Here it is. "The Task Force recommends that the Governor and Legislature of the State of California urge the President and Congress to evaluate the ERISA statute and ask that it be revised to allow the relevant providers to be responsible and liable for damages to the extent the providers contribute to adverse outcomes that can be proven by law." And all we're trying to do is make the example of Mr. Hauck and Mr. Romero the same.

Because even if we enact in California some law right now, it's going to be preempted by the Federal law, anyway, and we're just recommending this is an issue you should look at it and it's going to be the Federal government that's got to look at it, anyway.

MS. FINBERG: Read it again.

MS. VORHAUS: We don't have it.

MS. FINBERG: Could you read it again.

CHAIRMAN ENTHOVEN: Then give them a copy.

MR. HIEPLER: The Task Force recommends that the Governor and the Legislature of the State of California

1 urge the President and Congress of the United States to
2 evaluate the ERISA statute and recommend that the ERISA
3 statute be revise d so as to allow the relevant providers
4 to be responsible and held liable for damages to the
5 extent the parties contribute to an adverse health
6 outcome."
7 And all that is intended to do is to say we want
8 everybody to be accountable and you at the Federal
9 government got to start the ball rolling, why don't you
10 look into it.
11 MS. SINGH: Is there a second?
12 CHAIRMAN ENTHOVEN: Is there a second?
13 MS. O'SULLIVAN: I second it.
14 MS. BOWNE: I want to say something about it.
15 CHAIRMAN ENTHOVEN: Very briefly, and then let's
16 get to the vote.
17 MS. BOWNE: I feel that the statement here is a
18 judgment call and it would be indicating that this
19 commission is advocating change in this law.
20 CHAIRMAN ENTHOVEN: Right.
21 MR. HIEPLER: You already made it through a
22 committee that made these recommendations before.
23 MS. BOWNE: A committee of two people.
24 CHAIRMAN ENTHOVEN: All in favor of Mark
25 Hiepler's new motion?
26 MR. HIEPLER: You might wa nt to call it something
27 else, just so it has a chance.
28 MR. PEREZ: Allan Zaremberg's new motion.

MR. HIEPLER: I think I can get Allan to bill on this one.

MR. ZAREMBERG: I died.

CHAIRMAN ENTHOVEN: I understand.

All in favor of the motion on the floor, please raise your right hand.

MS. SINGH: Those opposed.

15 to 13. The motion fails.

CHAIRMAN ENTHOVEN: Now may we please move to --

MR. HIEPLER: Thank you for your consideration of that. Thank you.

CHAIRMAN ENTHOVEN: I would like to -- to just say, I'd ask for a show of hands, how many people favor taking up this question?

MR. ROMERO: Recommendation 4.

MR. LEE: Are you trying to not vote on it?

MR. ZATKIN: Ask how many people have a problem with it.

MS. BOWNE: How many people have a problem with -- how many people have a problem with the language, ask that question.

CHAIRMAN ENTHOVEN: How many people have a problem with the language?

MR. LEE: Approving this just like we always do?

CHAIRMAN ENTHOVEN: I just want to see whether we take it up or not.

MR. LEE: We go through it with every single --

MS. BOWNE: You need to ask it in the reverse,

being that it's already here.

MR. LEE: We had straw votes on this.

CHAIRMAN ENTHOVEN: How many have a problem with the language?

MS. SINGH: How many people don't have a problem?

CHAIRMAN ENTHOVEN: Where I want to go is just to find out do we need to deal with this issue.

MR. LEE: Yes.

CHAIRMAN ENTHOVEN: Okay. Will somebody move the -- John Perez has moved.

MR. PEREZ: Move number 4.

MR. LEE: Second.

MS. SINGH: As proposed?

MR. LEE: Yes.

CHAIRMAN ENTHOVEN: Discussion. Karpf.

DR. KARPF: You want to move both A and B, I have some questions about. That we've gone through days and days of deliberations, most of the intent of what we've tried to accomplish is develop some clarity in terms of some standardization of processes, develop some comparability.

The terms that are still hanging out there that haven't been standardized, haven't been clarified, happen to be the most important terms that we have to deal with down the road, and that's medical necessity, appropriateness of care, experimental care. And if those aren't defined, you really haven't a ccomplished much.

1 So, in part B I have put forth a motion that
2 would put together a panel reporting to ONO, SOLO or
3 CHAOS, as Dr. Alpert -- that would essentially try to
4 catalog and define those terms much more explicitly.
5 MR. LEE: That's exactly what A is supposed to
6 do. The introduction of this section, that's terms that
7 are unclear, like names, it's to -- it's to decree a
8 blue ribbon panel to do just that.
9 DR. KARPF: When you define medical necessity,
10 medical necessity gets down to two levels. One is a
11 procedure standard of care and it is generally, accepted
12 and it does get down to the patient level. So, I'm
13 talking about issues like -- and we talk about
14 evidence-based medicine. Are you talking about
15 accepting bypass surgery for left main coronary artery
16 disease, where there's clearly there a two-year
17 mortality of 33 percent; 4 percent mortality untreated?
18 Everybody says t hat's evidence-based.
19 That may not be such in a 90-year-old man that
20 has unstable renal disease that has an 80 percent
21 mortality going into surgery. But we need to start
22 cataloging and defining what in fact is accepted as
23 evidence-based medicine. What is in fact accepted on
24 the basis of consensus, what isn't accepted, what is
25 considered experimental, when does it become accepted.
26 DR. SPURLOCK: I'd accept that as a friendly
27 amendment.
28 CHAIRMAN ENTHOVEN: Michael, woul d you read me

1 words then, catalog of definition --

2 DR. KARPF: I have that in a letter that I -- the

3 new regulatory agencies established for a more

4 sophisticated regulation of health care should convene

5 an appropriate panel representing all stakeholders

6 having an appropriate clinical expertise to accept,

7 catalog and organize data concerning agreement as to the

8 standardization and medical appropriateness in reference

9 to treat ment issues. This panel can review data

10 presented as evidence-based -- on an evidence based or

11 consensus base pertaining to clinical modalities. By

12 defining standard of care in medical appropriateness,

13 this panel could also define experimental care since

14 such a standard of care or -- as considered

15 appropriate -- it's either experimental or in limbo and

16 can determine when sufficient data become available for

17 a new clinical approach. Transition for being

18 experimental to standar d of practice. They can further

19 catalog the clinical trials where appropriate data is

20 yet to be developed for making such determination.

21 MR. PEREZ: Mr. Chairman --

22 MS. SINGH: You do not accept that, Mr. Perez?

23 MR. LEE: I think this is to take the place of

24 the second two bullets.

25 DR. KARPF: It's to take the place of B.

26 CHAIRMAN ENTHOVEN: So, a substitute B.

27 MR. PEREZ: That's friendly.

28 MR. LEE: Friendly.

1 MS. SINGH: Without objection, we're going to
2 substitute the current B with the proposed B.
3 We have a motion on the table to adopt number 7.
4 We do not have a second.
5 MR. PEREZ: We do.
6 CHAIRMAN ENTHOVEN: Who's seconding it?
7 MR. PEREZ: Lee.
8 CHAIRMAN ENTHOVEN: Number 4. The
9 Parliamentarian wants to read this one just once more.
10 DR. KARPF: You want me to read it once more?
11 CHAIRMAN ENTHOVEN: I have it here, I just --
12 DR. KARPF: This is the -- this is the second and
13 third paragraph of my letter to the Task Force. I've
14 taken out one part. This should have been distributed
15 to all members.
16 CHAIRMAN ENTHOVEN: Yeah, it is.
17 Concerning agreement as standard of care --
18 Michael, are you implying a single standard of care
19 here? You know, I'm troubled with the term "standard of
20 care." Of course we know -- people talk about it as if
21 there was one gold standard, but in reality there's a
22 wide spectrum.
23 DR. KARPF: There -- there is a merging -- we've
24 talked a lot about evidence-based medicine, the
25 importance of that. There are a variety of data that
26 are being accumulated that say this is the standard of
27 care for this procedure. That doesn't mean that
28 everyone with that procedure gets that standard of care.

1 That's a yardstick. There are variances to standard --
2 to a given standard; variances may be bad or good. And
3 it depends -- it depends on the circumstances, but at
4 least it starts defining what is the standard of care
5 and then one can --
6 CHAIRMAN ENTHOVEN: I'm just worried, back to the
7 olden days.
8 DR. SPURLOCK: Alain, here's the issue, is that
9 there's no central group, no clearing house, of all
10 evidence-based medicine, so what happens when
11 evidence-based medicine becomes standard of care, it
12 diffuses very inaccurately because nobody in this part
13 of the country or in this part of the State knows this
14 has been the standard of care. When you have a central
15 clearing house like Michael has talked about, then you
16 have a mechanism that you can diffuse or anoint somebody
17 as a standard of care business, it has met certain
18 evidence-based criteria.
19 CHAIRMAN ENTHOVEN: I'm just a little worried
20 about the DOC decreeing this is the standard of care and
21 cutting out desirable or -- you know, I tell you,
22 frankly, I'm thinking back to the bad old days back in
23 the '70s when Permanente physicians were being defamed
24 and deprecated because they kept their patients in
25 hospitals 40 percent less. And I'm just worried about
26 not having some kind of body here that says, "That's not
27 standard of care, you got to keep them in the hospital
28 twice as much."

1 DR. SPURLOCK: I think we're talking about two
2 different things. The standard of care you're talking
3 about may come out of health services researc h. I think
4 what Michael is talking about is clinical research on
5 modalities and treatment that people would do.
6 So, I think those are two different kinds of
7 standards, health service's research, which is based on
8 length of stay, number of population and all that stuff;
9 and clinical research which Michael is talking about,
10 which gets -- that's what Permanente is saying, not only
11 is this not experimental, but this is the best practice
12 for this clinical procedure.
13 CHAIRMAN EN THOVEN: So, agreement as to clinical
14 standard of care?
15 DR. KARPF: Clinical modalities are ones, either
16 the bucket of evidence-based approach, consensus
17 approach, experimental or we just don't know. Okay.
18 And at the same time you have that, "we just don't know"
19 has to either be moved out to it doesn't work or it does
20 work, or there is a consensus on it.
21 Experimental ultimately has to be -- has to be
22 decided whether it works or it doesn't work. And you
23 need some place th at ultimately makes those kind of
24 decisions, if in fact we're going to have clarity as we
25 move ahead, and if in fact you start looking at outcomes
26 and start comparing data.
27 CHAIRMAN ENTHOVEN: Okay. I mean, I'm sure in
28 favor of that, I just want to be sure that -- all right.

1 All right. A vote and --

2 MS. BOWNE: I want to speak strongly against

3 recommendation, for I think if we look around the room

4 we have good ev idence of what happens in a blue ribbon.

5 I also feel that asking the blue ribbon panel to start

6 dealing with benefit language and health plan contracts

7 is extremely dangerous. I would caution you that even

8 using Dr. Karpf's example -- not in your part B, I'm not

9 objecting to that, but in part A, the whole notion of

10 this implies that you could have some expert group come

11 together and reach agreement and impose on every health

12 plan the same benefit language.

13 And what I would sug gest to you is Dr. Karpf gave

14 us the example of -- I think you said a 90-year-old, it

15 depends upon their condition. Even if you had identical

16 benefit language, the way that language is going to be

17 applied in different circumstances will promptly vary.

18 There is no cookie cutter. There will still be

19 differences of conditions and differences of

20 applicability.

21 And I would also contend that I don't care if it

22 was Stanford, itself, or UCLA, itself, different

23 geographic areas are going to have different

24 interpretations according to the way that those

25 physicians practice medicine; the art of medicine in

26 their community as to what is appropriate and what is

27 the standard. And while well intentioned, I feel that

28 this is far-reaching and will cause considerably more

damage than good. And, therefore, I do not agree with it.

CHAIRMAN ENTHOVEN: Okay Nancy.

MS. FARBER: I'd like to make a point of clarification, that the letter doesn't refer to benefits language.

MR. LEE: 4A does.

MS. BOWNE: I'm speaking of 4a.

DR. KARPF: My amendment was inserted just because this is where it seemed to fit at the time, because I missed the discussion where else it might fit.

MS. BOWNE: I think that 4A is trying to solve a problem that is to create more problems.

MS. O'SULLIVAN: I have another amendment that I would like to propose.

CHAIRMAN ENTHOVEN: All right.

MS. O'SULLIVAN: The second bullet, this is language from folks in the disability committee.

MR. ROMERO: A or B?

MS. O'SULLIVAN: A, second bullet, I'm sorry.

So, it would end up we should consider the objective of maximizing financial capacity and inclusion of benefits to maintain function, and to slow or prevent deterioration of function.

CHAIRMAN ENTHOVEN: Does anyone object?

MS. BOWNE: Yes, I do.

MS. O'SULLIVAN: That what the bullet is about?

MS. SINGH: There's an objection.

1 CHAIRMAN ENTHOVEN: There is an objection.
2 MS. BOWNE: Again, while well-intentioned, this
3 is another attempt to greatly expand the scope of
4 benefits that are covered by the health plan.
5 DR. KARPF: Could we vote A and B separate?
6 MR. LEE: We need to take a straw vote of those
7 objecting to Ms. O'Sullivan's amendment.
8 MS. SINGH: Those in favor of Ms. O'Sullivan's
9 amendment, please rai se your right hand. It's a straw
10 vote only.
11 Those opposed. You did not secure the majority.
12 Therefore --
13 MS. O'SULLIVAN: What did I have, 14?
14 MS. SINGH: Less. 14 to 2.
15 CHAIRMAN ENTHOVEN: That's a straw poll vote for
16 Ms. O'Sullivan's amendment.
17 MR. LEE: I think it might have been misled.
18 This is would say what benefit definitions are, it's not
19 saying what the benefits offered are. This entire Blue
20 Ribbon task force is not saying what's mandated to be
21 included by nine. And I'm a little -- Rebecca, you've
22 spoken a bit on the concerns about this, you've got a
23 number of discussions about the need for consumers to
24 get clear and consistent information.
25 And what this is talking about is benefit
26 definitions, to consider how to communicate these
27 issues. This is talking about communication.
28 MS. BOWNE: I think what it is doing is saying

1 that it was included in the benefit d efinition.

2 MS. O'SULLIVAN: What's considered by the Blue

3 Ribbon committee?

4 MS. BOWNE: The inclusion of these different

5 kinds of benefits,

6 MS. DECKER: It lost, so can we move on?

7 CHAIRMAN ENTHOVEN: Well, you know --

8 MS. SINGH: It didn't -- it didn't secure

9 sufficient votes.

10 CHAIRMAN ENTHOVEN: You just explained to this

11 confused old Committee Chairman -- I thought the straw

12 votes we went by the majority and the real votes we went

13 by the Rule of 16.

14 MS. BOWNE: We do. So, that's correct.

15 CHAIRMAN ENTHOVEN: What I just said is correct?

16 MR. LEE: Correct. It still can't have 16.

17 CHAIRMAN ENTHOVEN: So, Maryann O'Sullivan had

18 the majority.

19 MS. SPURLOCK: So, I move to vote immediately.

20 CHAIRMAN ENTHOVEN: We're going to vote on the

21 whole thing.

22 DR. SPURLOCK: For A and B.

23 CHAIRMAN ENTHOVEN: All in favor of 4A and B.

24 MS. SINGH: With the O'Sullivan amendment.

25 CHAIRMAN ENTHOVEN: And Dr. Karpf amendmen t.

26 We just brought your amendment back from death.

27 MS. SINGH: The Parliamentarian stands corrected,

28 she's getting tired.

1 MS. O'SULLIVAN: Thank you.
2 DR. KARPF: Two paragraphs of it.
3 MS. SINGH: The vote before you members --
4 CHAIRMAN ENTHOVEN: Okay.
5 MS. SINGH: -- is recommendation 4 with Dr.
6 Karpf's language substituting the previous one and the
7 O'Sullivan amendment regarding the inclusion.
8 CHAIRMAN ENTHOVEN: A bullet 2.
9 MS. SINGH: A bullet 2. Those in favor, please
10 raise your right hand.
11 Those opposed?
12 The vote is 20 to 1. The motion passes.
13 Recommendation 4 is adopted.
14 MS. SINGH: Mr. Chair, we need to have about a
15 20-minute break for the Court Reporter. She is out of
16 paper.
17 (Whereupon a short recess was taken.)
18 CHAIRMAN ENTHOVEN: I'm going to feel
19 handicapped when I have to give up this gavel.
20 Alice -- I'm calling upon Alice to speak .
21 MS. SINGH: Okay. Next we have the findings
22 before us at this point in time. There is a question,
23 however. John Perez.
24 MR. PEREZ: Given recommendation number 3 has
25 failed in its entirety, do the members want to consider
26 deleting C, "extend the accountability of medical
27 decisions" from the findings?
28 MR. HIEPLER: I'm moving that everything with

regard to C be deleted, since the findings were not passed.

MR. PEREZ: Yes.

MS. SINGH: So, Mr. Hiepler, what we'll say is you're moving the adoption of the findings minus Subsection C. Is there a second?

MR. PEREZ: Second.

MS. SINGH: Anything else dealing with recommendation number 3? Language associated with --

DR. NORTHWAY: Recommendation number 3 doesn't deal with C.

MR. PEREZ: Yeah.

MR. SHAPIRO: Liability.

MS. SINGH: So, we'll delete C.

MR. PEREZ: The motion that Mark made and I seconded was t o --

MS. SINGH: Delete all language.

MR. PEREZ: That was related to recommendation 3.

MS. SINGH: Yes. All right. Those in favor --

DR. NORTHWAY: Hang on a second. What does that mean?

MS. SINGH: I don't know where --

CHAIRMAN ENTHOVEN: There's an E in the first part of the paper, a C in the latter part, and it's all revolving around 3. So, anything relating 3, which is E first and C second.

MR. PEREZ: That's what we said. Is that clear?

CHAIRMAN ENTHOVEN: We're adopting the findings,

MR. PEREZ: And directing staff to delete any reference to substantive matters related to time.

MS. SINGH: There's a motion and a second. Those in favor of adopting the findings minus C and E and any other language pertaining to recommendation 3, please raise your right hand.

MS. O'SULLIVAN: Discussion -- nobody said discussion.

CHAIRMAN ENTHOVEN: We did kind of ta lk about it, but discussion, yes.

MS. O'SULLIVAN: There's a couple of things I'd like just taken out that are just purely editorial. On page 2C, line one, two, three, four, five -- the particular line down, "However Congress" -- "However, Congress and the California Legislature should not be medical practice team members." Kind of sarcastic. Politics should not determine medical practice. I recommend that come out.

MS. SINGH: Politics shall not determine medical practice has already been deleted.

MS. O'SULLIVAN: The sentence before that can come out, also. The same one, page 5, the last sentence in the findings.

MS. FINBERG: The whole paragraph?

MR. PEREZ: Yes.

MR. LEE: The whole paragraph C is out?

CHAIRMAN ENTHOVEN: No, no.

MS. FARBER: We're voting on that now.

CHAIRMAN ENTHOVEN: Maryann is proposing taking one line out.

MS. FINBERG: I would like to propose we take the whole paragraph C out.

MR. PEREZ: That was the motion.

COMMISSIONER: That is the motion.

MS. SINGH: There is -- members, there appears to be some confusion, which I see can be can legitimized. You have recommendation -- you have -- there's a C on page 2.

MR. LEE: Yeah.

MS. SINGH: -- that talks about in the face of limited industry action legislators respond. Miss O'Sullivan is recommending that we delete, "However, Congress and th e California Legislature should not be medical practice team members." Is there any objection to deleting that sentence?

CHAIRMAN ENTHOVEN: I can do that.

MS. SINGH: There's a second.

MS. O'SULLIVAN: It's a sarcastic offhand remark.

CHAIRMAN ENTHOVEN: I'm horrified that the President of the United States discusses the length of stay for mastectomy in the State of the Union address.

MS. O'SULLIVAN: I'm horrified we're getting thrown out.

MS. GRIFFITHS: It' s in the Governor's state of the State address coming up then, Alain.

CHAIRMAN ENTHOVEN: I just don't think.

MS. O'SULLIVAN: If we want to discuss --

MS. SINGH: Members, can we have a straw vote, please?

Those in favor of deleting the sentence at hand, please raise your right hand.

MS. FINBERG: I want to take out that whole paragraph.

MS. SINGH: You do not have a majority of those present.

DR. ARMSTEAD: There is a tremendous amount of noise; I don't know what the hell we're voting on. Let's get this under control so we get through.

MS. SINGH: Please, members, don't talk when I have the floor.

MS. O'SULLIVAN: Do you know what we just voted on? No? Well, maybe we need to vote again. These people --

MS. SINGH: This is a straw vote.

MR. PEREZ: Point of order.

CHAIRMAN ENTHOVEN: Is this going to go to the straw vote?

MR. PEREZ: What is the main motion before us?

MS. SINGH: Mr. Perez, the main motion on this table today is to adopt the findings minus C -- minus number E, on page 3, accountability and practicing medicine; and minus deleting C, on page 7, extend accountability for medical decisions, and any language in the findings that may relate to recommendation 3

which was defeated earlier this afternoon. That is the motion currently on the floor. Tha t's been seconded. Ms. O'Sullivan.

MS. O'SULLIVAN: I had something else I asked.

CHAIRMAN ENTHOVEN: Ms. O'Sullivan -- just a moment, please.

Mrs. O'Sullivan has proposed that we delete the sentence on page 2 under Subsection C from -- it's one, two, three, four -- the fifth line from the bottom, that says, "However, Congress and the California legislature should not be medical practice team members."

MS. FINBERG: I'd like -- can I broaden that?

MS. SINGH: I be lieve -- I believe Ms. Finberg's question should take -- one at a time at this point because it's getting to be too confusing.

MS. FINBERG: I could amend something for a friendly amendment. I'd like to delete that whole paragraph. I find it objectionable.

MS. SINGH: At this point, members, I'm going to ask that we have a formal motion and a second so that everything is clear, and there's not any of this majority of who's here and who's not.

Ms. Finberg has made the m otion to delete Subsection C on page 2. Do we have a second?

MR. LEE: Second.

CHAIRMAN ENTHOVEN: Lee seconding.

CHAIRMAN ENTHOVEN: I'm sorry, we're not taking straw votes.

MS. O'SULLIVAN: That's my concern. By switching the procedure now we need 16. We've had people leaving, we're trying to get language clear quickly.

MS. SINGH: The reason wore doing this is because it's getting to be out of hand and very confusing, and we need to have order to get through this as quickly as possible, and I have indicated this is the procedure that we should follow and the Chairman supports that. Correct?

DR. KARPF: Go, Alice.

COMMISSIONER: Standing over you, who's got the hammer?

MS. SINGH: Those in favor of deleting Subsection C on page 2, please raise your right hand.

Those opposed?

The motion fails, 13 to 10.

Next, the motion on the floor is to adopt the findings ag ain minus Subsection D.

CHAIRMAN ENTHOVEN: No, C.

MS. SINGH: Subsection E on page 3, and Subsection C on Page 7.

MR. PEREZ: Point of order.

CHAIRMAN ENTHOVEN: Yes, Mr. Perez.

MR. PEREZ: Ms. O'Sullivan had already had a motion to amend that we didn't vote on.

MS. SINGH: We just voted on that.

MR. PEREZ: No, we voted on Ms. Finberg.

MS. O'SULLIVAN: No, I had another one.

MS. SINGH: We'l l do it again.

CHAIRMAN ENTHOVEN: I understand there was a combined effort. Ms. O'Sullivan has a motion on the floor.

MR. PEREZ: They seconded each other's motions.

MS. O'SULLIVAN: Right.

CHAIRMAN ENTHOVEN: This has to do with the one sentence.

MS. SINGH: Ms. O'Sullivan is moving that we delete on page 2 the sentence under Subsection C, "However, Congress and the California Legislature should not be medical practice team members." Is there a second?

MS. GRIFFITHS: Second.

MS. SINGH: Griffiths seconds. Okay, members, those in favor of deleting that sentence, please raise your right hand.

Mr. Perez, is your hand raised?

MR. PEREZ: Yes, it is.

MS. SINGH: Mr. Hiepler, is your hand raised?

MR. HIEPLER: Yeah.

MS. SINGH: Those opposed?

MR. HIEPLER: Not a toast to anyone.

MS. SINGH: The motion fails. 14 to 10. The sentence remains.

MR. ZATKIN: Can I suggest a change to the language because I do think it is a little patronizing.

MS. SINGH: So, you're going to move to amend?

MR. ZATKIN: Yes. If we say, "However, Congress and the California Legislature should not -- should avoid enacting legislation that will dictate medical practice."

COMMISSIONER: Worse.

DR. RODRIGUEZ-TRIAS: That's dangerous.

MR. ZATKIN: Dictating medical practice?

MR. SHAPIRO: Leave it alone.

MR. HIEPLER: God fo rbid anybody be accountable.

CHAIRMAN ENTHOVEN: Okay.

MS. SINGH: Without further discussion.

MS. GRIFFITHS: I have another motion. I'd like to move to amend the sentence to read, "However, neither Congress nor the California Legislature nor health plan executives should be medical practice team members."

MS. O'SULLIVAN: Yea, Diane.

DR. KARPF: What happens if health care executives are M.D.s that take care of patients?

MS. GRIFFITHS: That's fine.

MS. SING H: Non-M.D.s, okay. Did everybody hear Ms. Griffith's motion?

COMMISSIONER: Say it again.

MS. GRIFFITHS: However, neither the Governor nor the California Legislature nor health plan executives who are not physicians licensed to practice in California shall be -- should be medical --

DR. KARPF: Health care providers.

COMMISSIONER: Gold star.

MS. GRIFFITHS: -- health care providers.

MS. SINGH: Is t here a second to the motion?

MR. LEE: Second.

MS. SINGH: Those in favor of Ms. Griffiths' amended version of that sentence, please raise your right hand.

Those opposed?

The motion is adopted with 16 to 2.

Ms. Griffiths, if you would be so kind to give Ms. Vorhaus your exact language so that it's --

MS. O'SULLIVAN: Did you vote for it, Alain?

CHAIRMAN ENTHOVEN: No, I voted against it.

MS. SINGH: Members, the findings on this paper -- could we please have a vote -- there's a motion on the table, it's been seconded. Those in favor of the findings as -- as amended, deleting the C and the E and changing that sentence of -- as recommended by Mrs. Griffiths, please raise your right hand.

Those opposed?

Okay, the findings are adopted 23 to 1. Thank you.

CHAIRMAN ENTHOVEN: All right. Okay. Now we're going to move to Consumer Information and Involvement. Ellen Severoni, Lee, Finberg --

MS. SINGH: That's 6G, membe rs.

MS. FINBERG: Can we return to the recommendations on page 3.

CHAIRMAN ENTHOVEN: All right. May I suggest

that --

MS. FINBERG: 6G.

MS. SINGH: Yeah, 6G.

CHAIRMAN ENTHOVEN: What's 6G?

MS. SINGH: That's Consumer Involvement.

CHAIRMAN ENTHOVEN: Okay. Let's see, Jeanne, may I suggest we go right to page 3, recommendations under C, recommendations for consumer information.

MS. FINBERG: Y es.

CHAIRMAN ENTHOVEN: You just march right through that.

MS. DECKER: How long have we got allocated?

CHAIRMAN ENTHOVEN: That's a good question, madam timekeeper. And the answer is --

MS. SINGH: Do you have it?

DR. KARPF: 20 minutes.

CHAIRMAN ENTHOVEN: It's just -- let's try -- I think we ought to do it in 30 minutes.

MS. FINBERG: I think we can probably go through very quickly. There haven't been any --

CHAIRMAN ENTHOVEN: Let's try 30 minutes.

Please be quiet everybody so I can hear Jeanne.

MS. FINBERG: 6G.

MS. SINGH: Just one point of order, members who have not paid for their lunch, please do so. Please pay Lawrence. I have a list of names. I want to get reimbursed.

CHAIRMAN ENTHOVEN: All right. Damn helicopter

1 is out there making noises.

2 MS. FINBERG: The troops are coming.

3 CHAIRMAN ENTHOVEN: Okay, Jeanne.

4 MS. FINBERG: I thin k we can go through them

5 fairly quickly. There are no independent changes to

6 this and have been submitted either by Ellen or by me or

7 other members of the Task Force. There are some changes

8 to the paper that were put into the version that was

9 sent out. Each of those changes are things that

10 reflected to the best of our ability the conversation

11 that we had before.

12 There was at least one thing that failed in our

13 straw poll voting -- poll, and we deleted that. And --

14 and the rest we just accommodated suggestions.

15 So, going to the first recommendation that --

16 page 3, number 1, it relates to the publication about

17 the health care system that we're asking the State

18 agency now, the new agency, to prepare. And there were

19 some additions put in at the end of this suggestion to

20 make it as cost effective as possible. To give the

21 plans the discretion to give it out with enrollment

22 materials for -- to disseminate it as part of things

23 they're already doing.

24 DR. KARPF: Jeanne, do you have to have annual or

25 could it be periodically? Things don't change that fast

26 and it would just be a cost issue.

27 CHAIRMAN ENTHOVEN: Where is "annual," Michael?

28 DR. KARPF: Second line.

MR. LEE: Second line.

MS. FINBERG: Well, I guess we wanted it to be up to date. And the number and style of plans seems to be changing a lot every year. So, that's why we put "annual" in. P robably at some point it would need to be done annually.

DR. KARPF: "Periodically" just gives you flexibility as to whether you do it annually, every two years, every three years.

MR. LEE: Periodic production, booklet on -- you said currency anywhere, something about current? Current information.

MS. FINBERG: Okay.

CHAIRMAN ENTHOVEN: A current consumer focus is --

MS. FINBERG: Periodic production of a consumer --

MR. RODGERS: Up to date.

MS. FINBERG: Okay.

MR. LEE: Up to date.

MS. SINGH: Without objection.

CHAIRMAN ENTHOVEN: All right. Okay. Is there a motion?

MR. ROMERO: I'd just like to over a minor technical amendment, as I did in the Governor organization. We replaced "Request For Proposals" with competitive procurement, in essence.

MS. DECKER: What line is that on?

MR. ROMERO: That is the second line under C1. And that, again, is just because there -- there are multiple ways in State procurement to do things competitively. RFP is just one way to form.

CHAIRMAN ENTHOVEN: So conduct a competitive procurement.

MS. FINBERG: Or contract, actually.

MS. BOHME: They could do it themselves.

MR. ROMERO: Or competitively.

CHAIRMAN ENTHOVEN: Yeah.

MS. FINBERG: So, should produce or conduct competitive procurement for --

MR. ROMERO: Right.

CHAIRMAN ENTHOVEN: Should produce --

MR. ROMERO: Thank you.

MS. FINBERG: Or procure, thank you.

CHAIRMAN ENTHOVEN: All right. Let's see, do we have a motion for this recommendation?

MR. LEE: Move.

DR. KARPF: Second.

MS. SINGH: As amended.

CHAIRMAN ENTHOVEN: All in favor?

MS. SINGH: There's a question.

CHAIRMAN ENTHOVEN: Yes.

MR. WILLIAMS: The -- there's no discussion of the cost of this or the -- who pays for it, and I just AM trying to understand what the intent was. I don't know what the estimated production would be, but if you

1 would imagine you produce ten million of these a year,
2 it would be ten million dollars. Very easily.
3 So, I just would like to understand what the
4 intent was in terms of who paid for it.
5 MS. DECKER: I don't think she can hear you. Can
6 you hear him?
7 MS. FARBER: No, over the helicopter.
8 MS. DECKER: I speak louder. He's concerned
9 about the cost and what's the in tent of who would pay
10 for it.
11 MS. FINBERG: Well, the obligation is put on the
12 agency, so presumably the agency would pay for it.
13 MR. ZATKIN: The agency gets its money from us.
14 So, the health plan --
15 COMMISSIONER: Right.
16 MR. ZATKIN: -- which means that the employer
17 will pay for it.
18 MR. HIEPLER: Health plans pay for it, the
19 purchasers pay for it.
20 DR. KARPF: The period is longer.
21 MS. FARBER: You guys complained about hospital
22 costs shifting; look at t his.
23 MR. WILLIAMS: My interest is if you produce ten
24 million of these, it's going to cost ten million
25 dollars, period.
26 MR. HIEPLER: How about to the extent these
27 resources are available, Leonard Tambrock (phonetic)
28 make financial contributions.

1 MS. BELSHE: I think the Task Force indicated we
2 think that consumers should be informed and be able to
3 participate in this process. This is just one very
4 modest way to help educate consumers.
5 MR. WILLIAMS: I guess the point I'm trying to
6 raise is we had trouble getting consumers to read their
7 current health plan literature which we spend lots of
8 money on. It's a challenge to get people to read their
9 own current material that they receive from the health
10 plan, and if we're proposing to spend ten million
11 dollars or whatever the number turns out to be, we ought
12 to address how it's going to be paid for in the
13 recommendation in some way.
14 MR. KERR: I have a concern, also, and it's about
15 two things. One, about whether people are going to read
16 this thing and, secondly, whether we can combine some
17 things.
18 I'm wondering about the idea of BCCHI (phonetic)
19 sends out their list of evaluation of the health plans,
20 plus now the medical groups, too. I'm wondering if we
21 could maybe just sort of save money and ask that as part
22 of that that comes out automatically that there be a
23 section in there that describes the healt h care system
24 and differences between HMOs and PPOs; sort of instead
25 of sending out one document that maybe could go to
26 everyone, but it would have medical group information,
27 health care comparisons, just all this information
28 together. It would be a more valuable document.

1 You probably say -- instead of doing this three
2 times, you can do this once, get the information out.
3 You might even get people to read it more becau se you
4 have more information in there and the comparisons and
5 so on.
6 MS. SINGH: I think the mikes are working now,
7 members. At least for five minutes.
8 CHAIRMAN ENTHOVEN: We have received a lot of
9 evidence that huge numbers of consumers just don't have
10 a clue as what the system is all about. We get these
11 letters about people falling between the cracks and --
12 and will this all --
13 MS. SEVERONI: Mr. Chairman, I just wanted to
14 say, Ron, you raised this issue at our la st meeting and
15 as a result we did make some change in language.
16 Unfortunately, when this paper went out you didn't get
17 the copy with the line-in/line-out. Jeanne, there's --
18 MS. FINBERG: I do have one master copy that has
19 line-in/line out, and that's the bottom part. It says,
20 "in as cost effective a manner as possible," e.g. mailed
21 with plans, and Roman II, made available in providers'
22 offices, and support on the Internet.
23 MR. LEE: That's what's being proposed?
24 MS. FINBERG: That's what -- that was in the part
25 that was mailed out and it was intended to accommodate
26 the concerns about cost.
27 MR. ZATKIN: Jeanne, how would you feel about an
28 amendment that suggested that -- that the -- that the

publication be produced through any excess reserves available to the Department rather than increasing the assessment on the plans?

MS. FINBERG: I don't know what that means; what effect tha t would have. If it means that it -- we wouldn't get published, then I wouldn't be in favor of it.

MR. ZATKIN: The question -- the question with all of these items of this nature is whether -- I think there is some value here. I don't know how much, except the best way to spend the Knox-Keene million dollars, you know, that's a reasonable estimate -- it probably would cost a dollar per booklet. Is that the best way to spend the next ten million dollars we want to spend on -- on health care, and health-related items? Ten million dollars, we can do a lot of other things. So --

MS. DECKER: I was just going to say it's been ten minutes.

MS. SINGH: That is correct.

CHAIRMAN ENTHOVEN: Mr. Shapiro.

MR. SHAPIRO: I think the question raised on this issue is a fair question on every one of the recommendations, how were you going to pay for it? I think it's been left to this sort of grind at the end. A hundred recommendations are not like ly to be implemented because they're going to be ranked on a cost benefit analysis, on a political analysis. So, my only concern, this is a consumer information request. If you

1 want to say it has a low priority, I mean you can vote
2 on the merits, but I think that question is fairly posed
3 to almost all the recommendations, because cumulatively
4 we all know it's going to be an ambitious undertaking.
5 So, just to keep that in mind, but whether we
6 should single this one out for -- if there's some money
7 left after you spent everything else, seems to put it at
8 the very bottom of the pack.
9 MS. SINGH: Mr. Schlaegel.
10 MR. SCHLAEGEL: Jeanne, I support the idea and I
11 spend an incredible number of hours trying to edit my
12 employee communications to make sure they're
13 understandable and they look nice and they want to read
14 them. They just -- they just don't. And I just -- I
15 can't support that you sp end all this money and it's not
16 going to actual health care.
17 And I do have a question, maybe somebody knows,
18 there -- the new Federal Medicare risk program,
19 apparently there's a huge sum of money assigned to do --
20 MR. ROMERO: How much? 95 percent?
21 MR. SCHLAEGEL: So, that's one vulnerable
22 population that's going to be taken care of.
23 MR. LEE: I think we can assume, unfortunately,
24 that will take care of that, given the confusion around
25 Medicare choice.
26 MR. ZATKIN: That's a lot of money.
27 MR. KERR: My main concern is ten million is ten
28 million. I'm not sure people are going to read it.

CHAIRMAN ENTHOVEN: I was just joking, but I'm only half joking, we could pay Gary Larson a million instead of ten and he could have has standing cows expanding the health care system in cartoon columns or on the freeway; I think people would pay attention to it. And I'm not suggesting that's possible, Jim, I'm just describing there are ways that people would pay attention and read.

I suggested last time cartoons. I, too, have been in a situation that we try to make things readable in order to read them.

This is fairly difficult material. We would read it; not everybody is as interested in the subject as we. We could do many things; take advantage of cartoons, columns or whatever.

DR. RODRIGUEZ-TRIAS: Cartoons would be great.

MS. FINBERG: Our office gets dozens of calls every week asking for this information and they're out there. The consumer union has done evaluations, we don't cover all the California plans. Pacific Business Group and some of those other efforts are more California-oriented and do cover more, they don't cover all of them. I don't have all the necessary information or -- or apply to all the population, so I think it's important.

I mean, you know, obviously we need to vote.

DR. KARPF: It's this f undamental paradox to me, between yesterday and today we approved a zillion kinds

1 of reports. The consumer benefits, they're ten times
2 more sophisticated than this information. How can you
3 support that and not support this? I mean, there's --
4 there's a problem there.
5 MR. ZATKIN: This says to all managed care
6 consumers. All managed care consumers get material
7 that's supposed to explain how things work. And what
8 this suggests, and I don't mean to be -- sound
9 anti-consumer, I'm not, but what this says is, okay, we
10 gave them specific materials for the plan and a lot of
11 them don't read it, so we're going to send them a
12 generic piece that isn't related to the plan and that's
13 supposed to be more helpful to them.
14 I don't think -- is that going to help people
15 deal with Kaiser better than -- you know, it's not going
16 to be even written about Kaiser, it's going to be a
17 generic piece that says her e's a managed care
18 organization. It's going to millions. It's not going
19 to be --
20 MR. HAUCK: No one reads it.
21 MR. ZATKIN: -- not going to be enough focus to
22 really help a person dealing with their plan. That's --
23 that is my problem. I don't want to sound
24 anti-consumer, I just don't think this has sufficient
25 value. It has some value, but I wouldn't put much.
26 MS. FARBER: I want to agree with Steve. I am
27 about as pro-consumer as you possibly can get. And I
28 know I've talked in this forum before about our

1 insurance counseling service, and I'll just repeat very
2 briefly what I have to say about that.
3 People don't read this stuff until they have a
4 problem. When they have a problem, they go to an
5 advocacy place like an insurance counseling service or
6 to their consumer representative group, and that's when
7 they begin to read this material. It's of no interest
8 to them whatsoever at the time of purchase. Only
9 passing interest is shown. They collect it all up, they
10 stuff it in their purse or their briefcase and they move
11 on. It's only when there's a big fat problem that it
12 suddenly becomes of interest.
13 CHAIRMAN ENTHOVEN: All right, I think we have to
14 vote on it. All right.
15 MS. SINGH: It's been moved. Is there a second
16 to adopt recommendation 1 as amended?
17 CHAIRMAN ENTHOVEN: Do I hear a second? Peter
18 Lee moved.
19 MR. LEE: Thank you.
20 MS. O'SU LLIVAN: I second it.
21 MS. SINGH: O'Sullivan.
22 MR. KERR: Where's the amendment?
23 CHAIRMAN ENTHOVEN: Just up at the front. And
24 the second line, "should produce or conduct a
25 competitive procurement for periodic -- a periodic
26 production of an up-to-date consumer-focused educational
27 booklet on the health care system in California."
28 MS. SINGH: That's the only amendment. Those in

1 favor of adopting recommendation num ber 1 with
2 amendment, please raise your right hand.
3 Those opposed?
4 11 to 12. The -- the recommendation fails.
5 CHAIRMAN ENTHOVEN: Number 2.
6 MS. FINBERG: Number 2 is a working group on
7 standard definitions, and we're asking for there to be
8 a -- a standardized description that would facilitate
9 comparison of plans. And certain information is
10 specified of what would be included.
11 There are virtually no changes to this except at
12 the very end we had "free of charge" a nd it changed to
13 "at a nominal charge," so that the plans can recoup
14 their costs for copying.
15 MS. SINGH: Ms. Decker, I'm sorry.
16 MS. DECKER: Mr. Chairman, I have a minor
17 comment, it refers to the DOC in here and I think it
18 needs to be adjusted.
19 CHAIRMAN ENTHOVEN: Regulatory agency.
20 MS. SINGH: Without objection.
21 CHAIRMAN ENTHOVEN: Peter, did you have a --
22 MR. LEE: My only question, this -- we had a
23 helpful cross-grid passed out. I don't know -- I don't
24 think this -- in addition to the recommendation, this is
25 reinforcing the standardization recommendation which
26 gives a lot of detail about what would be in these
27 standard EOCs. We had extensive edit on it a while ago.
28 So, I don't know -- I think it's somewhat confusing to

1 make it sound this is different when I think it's the
2 same thing.
3 MR. ZATKIN: If it's cross-referenced, it should
4 be the same. They're not as they're currently drafted.
5 MR. LEE: They're not.
6 CHAIRMAN ENTHOVEN: What do we do about that?
7 Sara -- I'm not sure that it's exactly the same. Do you
8 know?
9 MS. FINBERG: There's some specific information
10 that would be in addition. You know, it is possible
11 that the details could be part of the standard benefit
12 packages, but --
13 CHAIRMAN ENTHOVEN: Well, no, it's -- the
14 standardization recommendation was not in the benefit
15 packages, but next there was a standard outline f or the
16 EOCs.
17 MR. LEE: Right.
18 CHAIRMAN ENTHOVEN: You mean -- I think you mean
19 there, don't you, Jeanne?
20 MR. LEE: That's correct. I'm trying to find the
21 cross-reference.
22 MS. FINBERG: I'm confused.
23 MR. LEE: I retract -- it's going to be confusing
24 when we can't cross-reference ourselves and I am a
25 little worried about the cross-referencing, but I'm fine
26 with this.
27 CHAIRMAN ENTHOVEN: Okay. Is there further
28 discussion? All in favor --

1 MS. SINGH: I'm sorry, Mr. Chairman, we need a
2 motion to adopt recommendation 2.
3 MS. DECKER: So moved.
4 MR. RODGERS: Second.
5 MS. GRIFFITHS: That's in favor of adopting
6 recommendation number 2 with the technical amendments,
7 including State regulatory --
8 MS. SINGH: Okay. Those in favor, please raise
9 your right hand.
10 MR. WILLIAMS: Alain, what are we voting on?
11 CHAIRMAN ENTHOVEN: Recommendation 2.
12 MS. SINGH: Those opposed?
13 CHAIRMAN ENTHOVEN: Okay.
14 MS. SINGH: The recommendation is adopted, 20 to
15 zero.
16 CHAIRMAN ENTHOVEN: Recommendation 3.
17 MS. FINBERG: Okay. 3 has to do with reporting
18 on the ten major health conditions or illnesses that
19 refer to specialty centers. We had had "or centers of
20 excellence" that was removed because it was considered
21 to be somewhat controversial. And in addition we had a
22 request to add that "when risk adjusted outcomes become
23 available tha t that also be produced" -- the very last
24 couple of sentences are new. "Provision should be made
25 to ensure that data is presented in a way that patient
26 confidentiality is maintained. And it's available to
27 consumers and organizations upon request."
28 MS. BOWNE: Jeanne, I had a question of you. You

1 want the patient confidentiality maintained but you're
2 asking where and from which physicians the patient
3 received care?
4 MS. FINBERG: Right.
5 CHAIRMAN ENTHOVEN: Did we say physician or just
6 specialty centers?
7 MS. BOWNE: I'm wondering about the specificity
8 of that. Do you want to say Dr. Jones of our health
9 plan -- Dr. Jones had the most and this is what happened
10 to him?
11 MS. FINBERG: I think it would primarily be at
12 the medical group or IPA level rather than individual
13 physician.
14 MS. BOWNE: Then that's what it should say then.
15 MS. FINBERG: Well, it does, I think.
16 DR. RODRIGUEZ-TRIAS: No, it says "wherein such
17 physician."
18 MS. FINBERG: Okay. Okay. So, from which --
19 CHAIRMAN ENTHOVEN: Strike the physicians.
20 MS. FINBERG: Okay. Well, see, that's what we
21 got before. We're trying to clarify it, I think. Okay,
22 from --
23 MS. SINGH: So, we're deleting that.
24 MR. LEE: "Which entity the patient received
25 care."
26 MS. SINGH: From which entity.
27 MR. LEE: Is that --
28 DR. RODRIGUEZ-TRIAS: We're --

1 MS. FINBERG: Yeah, that's --
2 DR. RODRIGUEZ-TRIAS: We're deleting physician.
3 MS. FINBERG: We're deleting "from" and we added
4 "which physician" because they thought "where" was too
5 confusing.
6 MS. BOWNE: You're referring to care referred to
7 specialty centers, right? Let -- could you explain the
8 thrust of what you are trying to accomplish.
9 CHAIRMAN ENTHOVEN: Wasn't the idea if you need a
10 transplant, are they going to send you to Stanf ord or
11 Washington Hospital?
12 MS. FARBER: Are you making this personal? I
13 want to call your attention to a report that David
14 Werdegar has in his hands right now; two stars at
15 Washington. How many at Stanford? How many at
16 Stanford?
17 CHAIRMAN ENTHOVEN: Oh, I retreat.
18 MS. FARBER: Only one, okay.
19 CHAIRMAN ENTHOVEN: I apologize. I apologize.
20 MS. FARBER: You better. You win.
21 MR. RODGERS: Consumer information would have
22 helped in this issue.
23 CHAIRMAN E NTHOVEN: Could we -- isn't really what
24 we want, which medical center?
25 MS. FINBERG: Yeah.
26 MS. SEVERONI: Can we substitute "entity"?
27 MS. FINBERG: Medical -- from which medical
28 center.

1 CHAIRMAN ENTHOVEN: Medical Center.
2 MS. SINGH: So, delete "physicians" and
3 substitute it with "medical centers."
4 MS. FINBERG: Okay.
5 MS. SINGH: Is there any further discussion?
6 MR. LEE: Move to adopt.
7 CHAIRMAN ENTHOVEN: Lee moves we adopt as amended
8 Is there a second?
9 DR. RODRIGUEZ-TRIAS: Yes.
10 CHAIRMAN ENTHOVEN: Rodriguez-Trias.
11 MS. SINGH: Those in favor of adopting
12 recommendation number 3 as amended, please raise your
13 right hand.
14 Those opposed?
15 Recommendation is adopted. 22-0.
16 MR. HIEPLER: Would you --
17 CHAIRMAN ENTHOVEN: Recommendation 4. Jeanne.
18 MS. FINBERG: This is to make available written
19 treatment guidelines or authorization criteria. We
20 had -- at the request of an enrollee we were requested
21 to add "a member of the public," which we did. And to
22 specify for a given condition, so would limit
23 availability.
24 MR. RODGERS: Didn't we also include --
25 MS. FINBERG: We have in here "at a nominal
26 charge."
27 MR. HIEPLER: I move.
28 MS. FARBER: Second.

1 MS. SINGH: Discussion, members?
2 MS. FARBER: He's moved; I seconded.
3 MS. SINGH: Mr. Hiepler has moved; Farber
4 seconded. Those in favor of adopting recommendation
5 number 4 as proposed, please raise your right hand.
6 Those opposed?
7 The vote is 19 to 12. The recommendation is
8 adopted.
9 CHAIRMAN ENTHOVEN: Okay, number 5. Super
10 directory.
11 MS. FINBERG: Okay, the next one is a super
12 directory. And there were some minor language changes
13 here. Well, we changed "physician" to "providers." We
14 tried to specify that the primary care providers are
15 indicating wh ich medical groups are IPAs they belong to.
16 And we added language at the end to minimize paper flow
17 to help with the costs.
18 So, this paragraph at the end, "Every effort
19 shall be made to minimize paper flow," et cetera, was
20 added.
21 MR. LEE: Could I make what I think is a
22 clarifying amendment, which is to -- I really think
23 these are two separate proposals. And so, it might be
24 appropriate to call them A and B. And on the second
25 part, which is about what plans do, themselves , is on
26 page -- the next page, page 5, where it says in quotes,
27 "Super directory," I think the intent is not to have
28 plans provide information about the quote-unqoute super

1 side of everything, but provide information about their
2 participating physician provider. So, could we read
3 this, "Super directory to provide information for their
4 participating provider."
5 MS. FINBERG: I think it says that, to provide
6 super dire ctory information for their --
7 MR. LEE: I just think it's --
8 MS. FARBER: It says that.
9 MR. LEE: I think the word "super directory," I
10 think that's confusing due to the prior paragraph.
11 MS. FINBERG: Okay, yeah.
12 MR. LEE: Super objection.
13 MS. SINGH: Without objection, we'll delete
14 "super directory."
15 CHAIRMAN ENTHOVEN: And put in above there,
16 "providers."
17 MS. BOWNE: Excuse me, can you tell me what size
18 you expect this to be and how someone could possib ly
19 either download it or print it or carry it around?
20 I mean, if it contains every provider and every
21 hospital and who they refer to and whether they're
22 accepting new patients --
23 MS. FINBERG: Yes, I don't really expect you to
24 be downloading it. But the idea is that you keep this
25 information that you have to know what it is and so
26 there's a way for a consumer to find out.
27 I want -- don't want to ask for the whole
28 directory, I want to say what pediatricians or what

1 neurosurgeons would be available to me if I picked this
2 plan or this medical group. And so, with regard to one
3 discrete thing, you could print me out those two pages.
4 That's -- that's what we're looking for.
5 MS. BOWNE: But that -- I'd ask the plans, but
6 it boggles -- we -- we little -- the little thing that
7 we are, I mean, our provider directories are huge. I
8 mean being a PPO, and to go through there and for every
9 one say wh ere do they refer, and are they open or not.
10 And --
11 MS. FINBERG: Here's the problem --
12 DR. KARPF: Would it help any --
13 MR. HARTSHORN: These are phone books, they're
14 very thick documents.
15 MS. BOWNE: I respect your intent and purpose, I
16 absolutely do. But I just am not sure of the practical
17 implementation. That's what concerns me.
18 MR. KERR: Let's see, can somebody tell us how
19 they do it with HPC (phonetic), because the HPC has a
20 super directory, which seems li ke a great idea.
21 MS. BELSHE: We do have one, and I can't tell you
22 off the top of my head the degree of detail that it
23 provides, but it clearly provides the names of all of
24 the primary California providers of each of the
25 contracting members. It has not been unwieldy and
26 unworkable.
27 But it's printed by area. It's printed by what
28 area you're in, and you get the stuff for each region.

1 MS. BOWNE: But it's updated with w hether they're
2 accepting patients or not?
3 MS. BELSHE: I don't know if that -- if it has
4 that degree of detail. You might say "as feasible and
5 appropriate to get into that level of detail." But it
6 has been found to be very, very useful, if you will, in
7 an employee choice situation.
8 MS. BOWNE: I'm sure it would be. I'm not
9 arguing that point.
10 MS. FINBERG: Somewhere that information is
11 available in somebody's computer because you need to
12 know what the restrictions are, and this is just saying
13 that the consumer ought to be able to call and find out
14 other information, not the book that they get now that
15 is outdated and incomplete.
16 CHAIRMAN ENTHOVEN: Ms. Decker and then Mr.
17 Williams.
18 MS. DECKER: I think to clarify and to get to
19 Rebecca's concern, this first paragraph in 5, when you
20 say a super directory, at the -- I mean, in the -- on
21 page 4, the beginning of the recommendation, first
22 paragraph, the last sentence says, "this informa tion
23 should be made available to all consumers at the time of
24 enrollment." That sounds very plan specific.
25 So, is the super directory that you're talking
26 about in this paragraph cross -- cross matching every
27 plan in the State or is it -- are you saying each plan
28 has this and provides it on request for their

1 information?
2 MS. FINBERG: Well, we were not expecting plans
3 to give -- to be required to give any information that
4 goes beyond their plan. We were hoping that a consumer
5 when they're enrolling in a plan and then in a medical
6 group, that when they need to make that choice, which
7 they do at the time of enrollment, they should be able
8 to get the current information to know which groups are
9 part of the plan and then in turn which physicians are
10 part of the group and -- and if I'm interested in a
11 particular specialty or sub-specialty, I could also ask
12 that and get that information. We weren't ex pecting the
13 plan to be providing an entire super directory to an
14 individual.
15 MS. DECKER: So, it sounds to me like the plan's
16 responsibility is for their own contractor/providers.
17 MS. FINBERG: Correct. Correct.
18 MS. DECKER: And then somewhere there's this
19 huge database that people can go look at maybe only
20 on-line.
21 MS. FINBERG: The agency is charged with the
22 responsibility of getting this created and maintained.
23 The agency also presumably has this information
24 somewhere, because it's charged with monitoring the
25 plans and the adequacy of the networks, et ceteras. So,
26 it's not new information, it's just encouraging the
27 agency to set up a system so that consumers could access
28 current information.

1 You know, we don't know the exact details of how
2 it would work, and that's why we put in disqualifying
3 language of how we'll try and get the costs down.
4 MS. SINGH: We have quite a fe w recommendations
5 in this paper, alone. So, I would recommend we have a
6 motion to adopt recommendation number 5. It's been
7 moved by Mr. Kerr. Is there a second?
8 MS. DECKER: Second.
9 CHAIRMAN ENTHOVEN: By Ms. Decker.
10 MS. SINGH: Those in favor of adopting
11 recommendation 5, please raise your right hand.
12 Those opposed?
13 13 to 10. The motion fails.
14 MR. LEE: Could I make an amended motion, please,
15 which would be the first line of the first paragraph
16 read, "Th e agency's charge for oversized managed care,"
17 et cetera, should read "research and report on the
18 feasibility and cost of creating, A" -- and then it
19 reads as it does in the second paragraph, stays the
20 same.
21 MR. TIRAPELLE: I'll second that motion.
22 MR. LEE: Cost is a --
23 CHAIRMAN ENTHOVEN: A cost factor.
24 Can you read that?
25 MR. LEE: The agency's charge -- DOC and DOI
26 should research and report on the feasibility and cost
27 of creating, A, and then it comments exactl y as amended
28 prior, and the second paragraph stays as also amended.

MS. SINGH: Cost of creating --

MR. WILLIAMS: Customer value to the consumer.

MR. ROMERO: Utility.

MR. LEE: Feasibility, utility and cost.

MR. ZATKIN: No one accuses this Task Force of trying to create a consumer firm.

MR. LEE: I'm quitting my job, I know.

MS. SINGH: Members, we have a motion on the floor to adopt the first sentence as a mended -- excuse me, Mr. Lee, you're just amending the first sentence and leave the rest -- rest of the recommendation?

MR. LEE: Yeah. The recommendation is all as we previously voted on. There's a couple of other tiny wording changes.

CHAIRMAN ENTHOVEN: Okay. Members, is there a second?

MR. TIRAPELLE: I second. Call for the question.

MS. SINGH: Those in favor of the adopting the amended number 5, please raise your right hand.

I'm sorry, just get to --

Those opposed?

The motion is adopted. 23 to zero.

MS. O'SULLIVAN: Dr. Enthoven, can we take a minute to talk about process? It's 3:30. Could we just find out who's leaving for -- I'm curious in terms of votes and majority.

MR. LEE: Want to move some votes up now or hold them back later?

MS. O'SULLIVAN: Really, are we going to be acting after 4 o'clock? Are their going to be enough people here?

CHAIRMAN ENTHOVEN: I honestly don't know. I'm giving it my best shot.

MS. O'SULLIVAN: Can we ask who's leaving at 4 o'clock? Who's leaving before 5:00?

MR. PEREZ: I am leaving at 5:00.

MS. FARBER: I'm leaving at 5:00.

MS. O'SULLIVAN: Could I say where this stuff that people know they're not going to vote on and -- they just can't stand it, anyway, if they could not have a say about it?

MS. SINGH: Members, one thing we can do is limit debate to one minute p er speaker or you can limit debate only in support or opposition of a recommendation. I mean, there are several ways you can go to try expedite this process. I'm happy to just keep tabs and say two people in support; two people in opposition. Whatever is the pleasure of this Task Force.

MS. O'SULLIVAN: I would like to see us get through as many recommendations as we can before 5 o'clock. If there's something that makes the process move faster, maybe we have to leave some t hings behind.

If there are things you are positive that you absolutely don't want left behind, you should say that, too.

MR. PEREZ: I really think we ought to limit the

debate to two people in favor and opposed to each issue. By the end of the day today, that's it.

MS. SINGH: Okay, members, so you'll be responsible for paying attention as to how many people have spoken in support and opposition.

MS. FARBER: Can I ask a question? Sometimes the member might not want to ask -- to state in support or against, but they may have a simple request for information.

MS. SINGH: That can be a point of information.

MS. FARBER: A point of information.

MS. SINGH: That would not be included as a --

MS. FARBER: All right.

MS. SINGH: But please make -- please make that clear to me, that this is a point of information or a point of clarification.

MR. ROMERO: You really need to know it.

MS. FARBER: Not to be abused.

MS. SINGH: Okay. Recommendation number 6, members.

MS. FINBERG: Okay, this is --

MR. LEE: Are there any objections to it?

MS. SINGH: Is there any discussion on recommendation number 6?

MR. PEREZ: Call the question or move it.

MS. SINGH: Perez moved. Kerr seconded. Any discussion?

Those in favor of adopting recommendation 6,

please raise your right ha nd.

Those opposed?

Okay, 17 to 1. The recommendation is adopted.

MR. PEREZ: Move 7.

CHAIRMAN ENTHOVEN: Okay. Second? I'll second it.

MS. SINGH: Mr. Perez and Mr. Enthoven. Discussion?

Those in favor of adopting recommendation number 7, please raise --

DR. ARMSTEAD: Hold on one second. I'm trying to remember what it is.

CHAIRMAN ENTHOVEN: Page 5, down at the bottom.

MS. SINGH: Okay. Those members in favor of adopting recommendation 7, ple ase raise your right hand.

Those opposed?

Mr. Perez, are you opposed?

MR. PEREZ: No.

MS. SINGH: 22 to zero. The recommendation is adopted.

Recommendation number 8. Is there an 8?

MS. DECKER: Yes.

MS. SINGH: Is there a motion?

MR. LEE: Mr. Lee moves.

CHAIRMAN ENTHOVEN: Actually, Farber moved. Enthoven second. Discussion?

MS. SINGH: Those in favor of adopting recommendation 8, please raise your right hand.

Those opposed?

17 to 2. The recommendation is adopted.

Okay, now we move on to consumer involvement. Page 8.

DR. KARPF: This one's tough.

MS. SINGH: Okay, members, recommendation Number 1 is -- questions?

MR. LEE: I've got a proposal, I think it's a friendly amendment to number 1, is under B. I'd recommend we say, "In addition, the Task Force recommends" and then where the word starts "several," is that entire block going down to the proposed revision in Knox-Keene be moved over to right before "principles."

This is a -- a very long sort of discourse on what's currently in place and background that we generally try to have in findings. So, it's just on the prior page. Ellen finds that a friendly amendment.

MS. SINGH: So, Mr. Lee, your motion is currently --

MR. LEE: B would read, "The Task Force recommends the Knox -- that Knox-Keene be amended to include more extensive provisions," et cet era, structures, it then picks up at really -- it picks up at --

CHAIRMAN ENTHOVEN: Proposed revision.

MR. LEE: -- the first bullet. The first bullet at the top of page 9. And the bracketed section as well as proposed revision is deleted.

CHAIRMAN ENTHOVEN: Yeah.

MS. SINGH: So, deleting --

MR. LEE: The text from "several" through the bullet -- last bullet on page 8 is blocked and copied to page 7. Staff knows where I'm looking.

DR. RODRIGUEZ-TRIAS: Background. Background.

MS. SINGH: Ms. Vorhaus, are you clear on that?

MS. VORHAUS: I got it.

CHAIRMAN ENTHOVEN: What happened here is in the last meeting, the Task Force voted against requiring having board members and then some wording was changed that Ellen felt was kind of confusing and preferred to go back to a different formulation which was to "either/or" --

MS. SEVERONI: Right.

CHAIRMAN ENTHOVE N: -- instead of "and".

MS. SEVERONI: That's correct, that's right. So, essentially the significant change that you're seeing between bullet 1 and bullet 2 is "or" instead of "and."

CHAIRMAN ENTHOVEN: We might take that next bullet up because it's all one thing.

MR. LEE: Which next bullet were you talking about?

CHAIRMAN ENTHOVEN: On page 9, you killed the top paragraph because that's just explanatory stuff.

MR. LEE: That's deleted.

CHAIRMAN ENTHOVEN: Th e next two paragraphs should be under one bullet.

1 MR. LEE: You mean -- okay.
2 MS. FARBER: So, consolidate --
3 MR. LEE: Maybe we could have after it "A"
4 instead of a bullet, to be consistent.
5 MS. SINGH: So you're going to move those two
6 bullets on page nine?
7 CHAIRMAN ENTHOVEN: And we call that 1.
8 MS. SINGH: You're going to call that 1?
9 MR. LEE: No, this is 1 -- 1C, thank you. 1C.
10 MS. SINGH: Okay. So, that's going to be C.
11 CHAIRMAN ENTHOVEN: Okay.
12 MS. SINGH: So, those two bullets are C.
13 MR. LEE: Then could I suggest that we also in
14 what is currently the second bullet, where we say "HMO
15 plan," we aren't using HMO anywhere here, so we just say
16 "plan administrators."
17 We're talking about a whole range of health
18 plans.
19 MS. SEVERONI: We lifted it from the original
20 Knox-Keene language. I want to say -- I want to say
21 there's also one friendly amendment here from Mr. Zatkin
22 at Kaiser, and that is "establish a Member Advisory
23 Committee," you should make that also "committees" with
24 an "s" in parentheses, and would read throughout giving
25 organizations like Kaiser and other of our colleagues an
26 opportunity to decide whether or not they wanted one
27 committee or several regional committees.
28 MR. ZATKIN: Peter, the effect of your amendment

to create a 1D was previously that - - and that linked the second and third bullets on that page, it indicated to me that the third bullet applied to the second but not the first.

MR. LEE: My understanding was that the third bullet, Alain, is the one that merged the first two bullets together. So, my understanding, which is to clarify, is that the third bullet related to either whether people have a governing board with body -- with public members or advisory board urging the State agency to look at mechanis ms for accountability.

MR. ZATKIN: That may be. That's not the way it literally reads.

MR. LEE: May I suggest that we change "instead of," upon request, that it's in addition to C, if that's the current renumbering of the above bullets.

MS. SINGH: So, we're going to incorporate that last bullet right before the number 2 on page 9 into the new Subsection C, is that correct?

MR. ZATKIN: No.

MR. PEREZ: We're dropping the word "and."

DR. RODRIGUEZ-TRIAS: And c alling it D.

MR. PEREZ: We're dropping the word "and."

MS. SINGH: And calling it C.

MS. BOHME: Wait, wait, there's a difference of opinion.

MR. ZATKIN: I'm not sure I have a problem with that, I just wanted to get the sense -- I do have a

problem with -- in the new 1D, the notion that any interested party can come in and require basically a complete explanation about an activity, that is an obligation un der the Knox-Keene Act. I think that is an unusual precedent.

Typically, the obligation of the plan is to justify what it's doing to the regulating organization, not to any -- any member of the public. And I -- and I think this creates a very different kind of obligation

MS. SEVERONI: I would accept a friendly amendment to have that come out, Steve.

MS. SINGH: So we're deleting Mr. Zatkin?

MS. SEVERONI: No, we're not deleting Mr. Zatkin.

CHAIRMAN ENTHOVEN: Not u ntil 5 o'clock, anyway.

MS. FARBER: There goes the quorum. I'll get some revotes.

Since we deleted him, can we vote again?

CHAIRMAN ENTHOVEN: Where is this?

MS. SINGH: I'm sorry, Mr. Zatkin, what are we deleting?

MR. ZATKIN: It's really upon the request of the State -- of the regulatory agency.

MS. SINGH: We're deleting that?

CHAIRMAN ENTHOVEN: No, no, no, you retain that.

MS. DECKER: Use the microphone.

MS. SEVERONI: And you just remove, Alice, the words "or other interested parties."

MS. SINGH: Thank you.

1 MS. FINBERG: I wonder if you want to put in "a
2 member or an enrollee" because don't you want your
3 enrollees to understand how they could become involved
4 in the health plan and -- and use their opportunity for
5 feedback? So, I -- I think if you're going to take out
6 "interested parties" then you ought to figure out how
7 you can communicate it to your mem bers or your
8 enrollees.
9 MS. SEVERONI: Well, I think we might be able to
10 get to that through the Member Advisory Committee
11 activities, Jeanne --
12 MS. SINGH: Okay.
13 MS. SEVERONI: -- and deal with it.
14 CHAIRMAN ENTHOVEN: Okay.
15 MS. SINGH: Okay, members, are we ready to vote
16 on this?
17 MS. SEVERONI: May I just say that we have one
18 other friendly amendment that I wanted to include in
19 here, and that did come from Dr. Rodriguez-Trias, and
20 that is in the Member Ad visory Committee bullet these
21 words would follow on the third line after
22 "plan" -- "health plans." This statement would then
23 read, "This committee shall include representatives of
24 the vulnerable populations they serve."
25 MS. BOHME: They serve a --
26 CHAIRMAN ENTHOVEN: Where does that go?
27 MS. SINGH: I'm not clear, where does this go,
28 Ms. Severoni?

1 MS. SEVERONI: I'm on page 8 -- 9. We're looking
2 at the Member Advis ory Committee bullet --
3 MR. LEE: Second bullet.
4 MS. SEVERONI: -- "shall be responsible for
5 establishing a mechanism and process for enrollees to
6 express their views and concerns about the HMO plan.
7 This committee or committees shall include
8 representatives of the vulnerable populations they
9 serve."
10 That was an amendment that came up at our last --
11 MS. SINGH: Without objection. Is there an
12 objection?
13 MS. BOHME: Yes, I object.
14 MR. LEE: If I could suggest t o get around the
15 objection, this is talking about mechanisms, "including
16 mechanisms to get the views and concerns of enrollees
17 who are members of vulnerable populations." Is that
18 acceptable? It's not saying they're members.
19 MS. BOWNE: Yeah, to get the views. I think I'd
20 be fine with that.
21 MS. SINGH: So, this committee shall obtain the
22 viewpoints --
23 MR. LEE: Right.
24 MS. SINGH: Including the viewpoints of enrollees
25 who are members.
26 MR. LEE: Enrollees who are members of vulnerable
27 populations.
28 MS. SINGH: Enrollees who are members of

1 vulnerable populations.

2 MR. LEE: Yes.

3 MS. SINGH: Enrollees who are members --

4 MS. DECKER: I'd like to note we are 45 minutes

5 on our 30-minute allotment.

6 CHAIRMAN ENTHOVEN: Okay.

7 MS. SINGH: Is there a motion to adopt

8 recommendation --

9 CHAIRMAN ENTHOVEN: 1.

10 MS. SINGH: -- 1 --

11 MS. GRIFFITHS: So move.

12 MS. SINGH: -- which contains A and B and C and

13 D.

14 It's been moved by Ms. Griffiths as amended.

15 Seconded by Ms. Rodriguez-Trias.

16 Those in favor of recommendation 1, please raise

17 your right hand.

18 Those opposed?

19 The recommendation is adopted. 20 to 0.

20 MR. LEE: May I suggest that if there are any --

21 not any technical amendments, we take 2, 3, 4 and 5 as a

22 block.

23 MS. FINBERG: Did we already include that last

24 paragraph? There's some confusion on that; it was

25 already voted?

26 MR. LEE: Yes.

27 MR. ROMERO: As 1D.

28 MR. PEREZ: Second Mr. Lee's motion.

MS. SINGH: Okay, just a moment, please. I'm sorry. All right. Mr. Lee. And Mr. Perez has seconded the motion to adopt recommendations 2, 3, 4 and 5. Those in -- any discussion?

Those in favor, please raise your right hand.

Those opposed?

The recommendations are adopted. 22 to zero.

Members, we now have the findings. Can we have a motion to adopt the findings as proposed?

MR. LEE: Move adoption.

CHAIRMAN ENTHOVEN: Moved by Mr. Kerr.

Mr. Lee, do you second that?

MR. LEE: Yes, I do.

MS. SINGH: Discussion.

MR. LEE: It reflects the amendment that we talked about earlier. Move the recommendation to adopt the finding.

MS. SINGH: I would see that as a technical --

CHAIRMAN ENTHOVEN: Yes.

MS. SINGH: -- entity. Those in favor of adopting -- excuse me, the findings as amended, please raise your right hand.

Those opposed?

19 to zero. The findings have been adopted.

CHAIRMAN ENTHOVEN: The vulnerable populations is next.

MS. SINGH: Vulnerable populations is 6.

CHAIRMAN ENTHOVEN: Only recommendations start on

1 page 3.

2 MS. SINGH: Recommendations start on page 3.

3 Tony.

4 MR. RODGERS: Mr. Chair, we're going to recommend

5 a change in format, if tha t's okay with the -- the

6 committee.

7 What we did, we went back and forth on this issue

8 as we pulled forward into the vulnerable population

9 section a number of recommendations that are contained

10 in other papers and we tried to conform those. What

11 we're recommending for this committee's consideration is

12 to not include 1 through 14 as voted on recommendations,

13 but they would just be references to the matrix.

14 We just reference that we have actually dealt with those

15 in other secti ons, and those are for vulnerable

16 populations.

17 CHAIRMAN ENTHOVEN: So moved.

18 MS. SINGH: So, 1 through 14 are just

19 information, not recommendations?

20 DR. RODRIGUEZ-TRIAS: They're recommendations

21 that appear elsewhere.

22 MS. SINGH: So, we're not voting to adopt them?

23 MR. RODGERS: No.

24 MR. LEE: I've got one question on that, point of

25 information. I think I'm a little unclear what that

26 means with regard to number 11, because 11 relates to

27 standardizing health b enefits which, I mean, does --

28 what does it now include?

CHAIRMAN ENTHOVEN: When did that particular change happen? That's one of the notes I had, is when, on that first sentence.

MR. LEE: That's apparently --

CHAIRMAN ENTHOVEN: Was revised to include --

MR. RODGERS: I'd have to check with the staff.

STAFF: We're looking it up on line.

MR. LEE: All we're recommending there is that vulnerable populations - - instead of 305 we're just saying that all standard packages should include information for vulnerable populations. I mean, I just want to make sure that the recommendations that we have include that.

MS. SINGH: Okay.

CHAIRMAN ENTHOVEN: Dr. Northway.

DR. NORTHWAY: I would just like to encourage the Task Force, this is a very vulnerable population and I can't see anywhere why we can't have the recommendations that are listed in other places written again here in this population just -- in this chapter, just to make sure that people understand.

MS. SINGH: They will be written, Dr. Northway.

DR. NORTHWAY: You're talking about putting them in some kind of a matrix. I can't see any reason why they can't be reprinted just as they are here with the notation they are also found in another area. I'm just saying I think it's important for us to let people know that we spend a lot of time on vulnerable populations

and the recommendations are here as well as in other chapters.

MR. LEE: Well, I very strongly support J. D.'s motion or idea. It's one they brought up at the end of yesterday about, hopefully, other papers, as well, including recommendations where there's cross-reference. I do think it's particularly important in this section.

DR. KARPF: So, we won't have to vote on them again.

MR. LEE: We don't have to vote on them.

DR. NORTHWAY: This process is aging us and will make us a vulnerable population.

MS. SINGH: May I suggest a motion to be made by a member that recommendations 1 through 14 do not require additional adoption to be included.

MS. FARBER: So moved.

MS. BOWNE: To the extent that they have been --

MS. SINGH: To the extent that they have been adopted, they do not require additional adoption for inclusion in the recommendation.

MS. FARBER: Yes, yes.

MS. SINGH: It's been moved by Mrs . Farber.

MR. LEE: I want to come back to my point on number 11, which is it's one a number of meetings ago we sort of leap-frogged over and it wasn't dealt with, and we said we'd get back to it. We haven't. And either we have to amend recommendation 3B, standardization, which currently does not include vulnerable populations --

and I think we should do that.

I'd move we do that. I think that it's appropriate given it's noticed here as part of our vulnerable population discussion.

So, could I move that we amend.

CHAIRMAN ENTHOVEN: We have a motion on the floor. Let's remove 11 from that motion.

MS. SINGH: Yeah. May I recommend that we simply remove number 11 from the motion that's on the floor. Without objection.

Those in favor of -- I can't even remember the motion that I originally stated, minus 11, please raise your right hand. That is, that we don't have to adopt these over again for inclusion.

Those opposed?

21 to zero. It's been adopted.

MR. RODGERS: Can we talk about number 11 again.

STAFF: We have conflicting versions of the draft on 11-24 from the previous meeting on vulnerable populations. It was added to in discussion.

MR. LEE: Can I move we clarify --

MS. SINGH: Let's just do it.

MR. RODGERS: Let's just vote on that.

MR. LEE: The standardization in Section 2B and 3B, which are the two places where the re's, so to speak, laundry lists of groups, we add in "representatives of vulnerable populations."

MR. RODGERS: I move that.

1 MR. PEREZ: Second.
2 MS. SINGH: Okay, that's been moved by Mr.
3 Rodgers, seconded by Mr. Perez.
4 Any further discussion?
5 CHAIRMAN ENTHOVEN: I just want to see it for a
6 minute, please.
7 Okay, I've got "standardization." Where are you?
8 MR. ZAREMBERG: This is a brand new thing t hat
9 was brought up today, vulnerable populations here and
10 here (indicating).
11 CHAIRMAN ENTHOVEN: Oh, just of the groups that
12 are -- okay.
13 MS. SINGH: 2 what?
14 CHAIRMAN ENTHOVEN: 2B and 3B.
15 MS. SINGH: 2B and 3B. Any discussion?
16 Those in favor of moving 11 to the standardized
17 benefits papers -- 11 to 2B and 3B, please raise your
18 right hand.
19 Those opposed?
20 The motion is adopted. 20 to zero.
21 CHAIRMAN ENTHOVEN: Okay, number 15.
22 MR. RODGERS: A lit tle background on this one.
23 The intent actually was to resolve a problem that occurs
24 when you talk about doing everything else we want to do
25 for vulnerable populations, provide them with quality
26 information, do quality audits, et cetera.
27 If you can't track them, you can't do that. The
28 question for us as a committee is how do we get the

1 industry to move forward and assure that they are
2 monitoring the vulnerable populat ions within their
3 membership so that they can do the quality audits, the
4 satisfaction surveys, assure that there are not access
5 to care problems, or that there are other barriers to
6 these vulnerable populations? And we have listed the
7 types of vulnerable populations in our paper.
8 CHAIRMAN ENTHOVEN: I'm sorry?
9 MR. RODGERS: The point we're trying to make and
10 maybe we can make it better and I would be open for
11 amendment of language, was that the State does contract
12 and have both in its regular employee contract with PERS
13 as well as its contract through Medi-Cal, a number of
14 these vulnerable populations, and from time to time they
15 add to those populations, and that we were going to use
16 the State to move this issue forward by saying the State
17 would contract with only those plans that can
18 demonstrate they have that ability or could develop that
19 ability to keep track of these populations even within
20 their commercial base so that they're not losing these
21 populations.
22 That was our intent. It has been proposed since
23 the issue is not so much that SDHS does not already
24 require this -- SDHS does require us to be able to track
25 these populations -- but rather that there are a number
26 of vulnerable populations within the commercial market
27 where plans don't necessarily track them and do these
28 very things. We were going to use this as -- as

1 leverage, and I'm open for how we can write this
2 statement if we believe that this is important, and I
3 believe this is the only way we can accomplish the rest
4 of what we're trying to do with the population.
5 I'm open to changes in how we get this
6 accomplished.
7 CHAIRMAN ENTHOVEN: Could I ask Dave Tirapelle to
8 comment on this. I was originally thinking that State
9 you were talking about DHS and then I realized this was
10 ambiguous, what were talking about. It sounds like it
11 adds a significant cost element to Sta te employees
12 and -- and really has to be addressed as a separate
13 issue. Dave.
14 MR. TIRAPELLE: Again, like we used in some other
15 language, I think we ought to urge the State to explore
16 doing this rather than mandating. I don't know what the
17 cost implications are of doing this or if they can do
18 it.
19 MS. BELSHE: Point of clarification. DHS, as
20 Tony said, does impose this requirement on Medicare
21 plans. Tony and I have spoken. I take exception to the
22 term "State." The State is a very broad term.
23 DHS, as a purchaser, has entered into contractual
24 arrangements with our plan partners to meet the
25 particular needs and circumstances of the population we
26 are serving. I would also note, though, that as a
27 matter of policy as well as law, we have excluded many
28 if not most of the vulnerable populations identified in

this paper from Medi-Cal managed care. So, I think there is a need here to be a bit more precise in terms of who we mean by the State, if that is the focus of this Task Force.

But what I'm hearing from Tony, it's really more of a purchaser prospective, not just a State purchaser, but a broad purchaser perspective, and the question before the Task Force is, is it appropriate for there to be a uniform approach or should that be a decision left to purchasers given the needs and circumstances of the people they're purchasing the care for?

MR. RODGERS: Th e other way to do this is that the regulatory agency -- this would be a regulatory requirement on all Knox-Keene plans, that they be able to track various vulnerable populations. If you can't track them, you can't do the quality care, you can't do the other things. That's the issue.

MR. ZATKIN: My concern is the definition of "vulnerable population" is quite broad. For example --

MS. BOWNE: For example?

MR. ZATKIN: For example, and I'm looking on page 2, "socially a nd economically disadvantaged, culturally isolated."

MR. ROMERO: That's most State workers.

MR. ZATKIN: Well, I think this group, at least in the last clause, would probably qualify, right.

And so, we're saying basically if those people would have to be identified affirmatively, presumably --

MS. BOWNE: So would the chemically dependent.

MR. ZATKIN: -- then they would have to be specially tracked or the S tate employees would lose the opportunity to enroll in -- in the health plans.

MR. RODGERS: Well, the plan would have to demonstrate that it has processes in place. Once those populations were identified either through a contract where you are serving that population or by identification through your encounter processing, that you would maintain and be able to demonstrate you have processes to connect them to the appropriate educational programs, to connect them with the appr opriate or do the quail. audits, et cetera, do membership satisfactions for those populations that indeed are the most vulnerable.

Now, if I go back to the survey, those are the very populations that have the greatest concern about the effectiveness, if you will, of managed care or issues with managed care, and I think if we are going to address those issues, we have to know who they are in our membership base.

The systems are already there to do it. I mean, all the pl ans have systems to track members. Whether they're asthmatic and they do it through medical issues or through the demographics that you have when you're contracting for Medi-Cal, that's typically a -- a high risk or a disadvantaged group. So, you would have to be able to track for Medi-Cal. In Medicare you have frail

elderly, so you'd have to be able to track those within your Medicare group.

MR. ZATKIN: Well, is th at a term of art, "frail"?

MR. RODGERS: Frail.

MR. ZATKIN: Frail elderly. I know that there are -- there are categories that one can use in terms of daily living. But these are very broad terms and the penalty for not doing it, as I see it, would be the loss of all of the State employees. So, I'm not -- I'm not disagreeing with the value of -- of trying to move forward. I guess I would support David's suggestion about looking at the feasibility of this with respect t o the State employees.

MS. SINGH: Members, we need to move this along.

CHAIRMAN ENTHOVEN: Could we say DHS to contract and Cal-PERS to examine the feasibility of?

MR. ZATKIN: It's already a DHS requirement.

CHAIRMAN ENTHOVEN: Oh, it already is.

MR. ZATKIN: So, --

MR. RODGERS: I would go with --

MS. BELSHE: I also go back to my point, this is not just a State issue. And we encourage that the Task Force would encourage purchasers to look at the feasibi lity of tracking and -- identifying and tracking vulnerable populations that are within their membership.

MS. SINGH: You're proposing that as an amendment?

1 MS. BELSHE: Yes.
2 CHAIRMAN ENTHOVEN: Encourage purchasers to --
3 MS. BOWNE: All purchasers.
4 MS. BELSHE: That's right. If they have
5 employees who would fall in the vulnerable category,
6 that the plans then contract with -- for the best
7 feasibility of t racking those members.
8 MR. ZATKIN: If you're going to track it, it's as
9 easy to track it for everyone.
10 MS. SINGH: Mr. -- do you have that language?
11 DR. RODRIGUEZ-TRIAS: Encourage all purchasers,
12 that includes the State as purchasers.
13 MS. SINGH: Without objection.
14 MR. ZATKIN: To examine the feasibility, is that
15 it? Yes?
16 CHAIRMAN ENTHOVEN: Encourage purchasers to
17 explore the feasibility of identifying and tracking
18 their vulnerable populations. Now, what do we do about
19 these other --
20 MR. RODGERS: That is to monitor performance and
21 quality outcomes.
22 CHAIRMAN ENTHOVEN: Yeah, but I mean then we have
23 A, B, 16, 17, 18 -- can we just do -- explore the
24 feasibility in all those cases?
25 MS. BELSHE: Yes. That would define the rest of
26 15, yes.
27 MS. SINGH: Just on 15. The Chairman is also
28 wondering if that applies to 16, 17, 18, 19 and 20. Mr.

1 Chairman?

2 CHAIRMAN ENTHOVEN: Right.

3 MS. BELSHE: Okay. Now, 16 happens to be a

4 reference in the "out-of-network" section we talked

5 about earlier, under which -- under what conditions

6 out-of-network services would be provided. That's kind

7 of like the other recommendations. If you recall in the

8 dispute language issue we dealt with vulnerable

9 populations in terms of out-of-network services, I

10 believe, in that section. So, I wouldn't include 16.

11 Let's just do 15.

12 MS. SINGH: Okay. M embers --

13 DR. RODRIGUEZ-TRIAS: I have a question.

14 CHAIRMAN ENTHOVEN: Yes.

15 DR. RODRIGUEZ-TRIAS: Kim, this is a question for

16 you, in terms of the State role here. Since the State

17 currently requires the tracking, et cetera, with the

18 Medi-Cal population, can the State serve as a model or

19 monitor in terms of this feasibility for other

20 purchasers? In other words, would there be information

21 forthcoming a couple of years down the line as to the

22 cost effectiveness -- effecti veness and cost

23 effectiveness of --

24 MS. BELSHE: I think that's true, Helen. Maybe

25 if you want to be more explicit, you could include

26 something along the lines of -- the recommendation as I

27 heard it today is more along the Task Force is

28 encouraging purchasers to explore the feasibility,

itself.

DR. RODRIGUEZ-TRIAS: That's correct.

MS. BELSHE: Something like such examination can be or "purchasers should work with" - - God forbid we're including the public sector with the private -- work with the -- maybe we should encourage the private sector to work with the public sector here -- for us to provide information to form this technological feasibility basis. I mean, it really is the plan community that has that information. We as a purchaser can say, yes, it did or did not. It's really a question whether the plans have that capacity and our contracting plans are developing that.

MS. SINGH: Without objection.

CHAIRMAN ENTHOVEN: Are we still on 15?

Members, are we ready to vote on 15A and B? If so, can I have a motion?

MR. LEE: Move to adopt.

MS. SINGH: Moved.

Those in favor of recommendation 15A and B as amended, please raise your right hand.

STAFF: Does that include Kim's amendment?

MS. SINGH: We took that amendment without objection. There wasn't an objection.

Those opposed?

Recommendation is adopted. 21 to zero.

MR. RODGERS: Okay. Number 17. The purpose of this was to talk about or was to assure that

1 out-of-network providers would be available for
2 specialty care where such specialty was not provided in
3 network. I recall our conversation this morning, I
4 believe we addressed this issue, but -- Helen, I'd have
5 to ask you, do you feel it was adopted and that it's
6 really -- we had addressed it already this morning?
7 DR. RODRIGUEZ-TRIAS: I thought it was, yeah. I
8 thought it was.
9 DR. NORTHWAY: I'm not sure what this says.
10 DR. RODRIGUEZ-TRIAS: Addressed --
11 DR. NORTHWAY: The State to contract -- I mean,
12 if -- if a plan doesn't agree to treat somebody out of
13 plan then -- then the person goes to the State?
14 CHAIRMAN ENTHOVEN: No.
15 DR. NORTHWAY: I'm not sure what this sentence
16 says.
17 CHAIRMAN ENTHOVEN: Is it not a legal obligation
18 of a Knox-Keene plan?
19 MS. FARBER: It's already there.
20 CHAIRMAN ENTHOVEN: It's already there.
21 MR. ZATKIN: If it's covered but you don't have
22 a --
23 MS. SINGH: One at a time, please.
24 MR. ZATKIN: If it's a covered benefit and you do
25 not have a qualified network provider, you have to find
26 the service --
27 CHAIRMAN ENTHOVEN: Right.
28 MR. ZATKIN: -- wherever you can find it.

1 MR. LEE: I propose we delete this and make
2 appropriate cross-referencing to the doctor-p atient
3 specialty.
4 MR. RODGERS: Yeah, that's fine.
5 MS. SINGH: I'm sorry, we need to vote on it. Is
6 there a second?
7 MS. FARBER: Yes. All in favor.
8 MR. LEE: It's not -- is it moved already?
9 MS. SINGH: You moved it.
10 MR. LEE: I take my motion back. We'll just move
11 on to number 17 and no one move it at all.
12 CHAIRMAN ENTHOVEN: We'll just delete it.
13 MR. LEE: So, skip it.
14 MS. SINGH: So, we're just going to skip it.
15 MS. FARBER: Does that mean a s far as how the
16 final product looks --
17 MS. SINGH: That means that number 16 does not
18 exist, it has not been moved.
19 DR. KARPF: 15 to 17.
20 DR. NORTHWAY: There is some place --
21 CHAIRMAN ENTHOVEN: Cross-referencing.
22 MR. RODGERS: There will be a resolution --
23 MR. LEE: Not a resolution.
24 MR. RODGERS: I'd like to have then Ms.
25 Rodriguez-Trias talk about linkages and acute care.
26 DR. RODRIGUEZ-TRIAS: Yes.
27 MS. SINGH: Members, number 17.
28 CHAIRMAN ENT HOVEN: Dr. Rodriguez-Trias.

DR. RODRIGUEZ-TRIAS: Thank you. This came out of some of the interviews that we did with representative members of some vulnerable populations, particularly people with disabilities, and it's a major issue also for people who are vulnerable because of social or economically related health hazards, particularly violence and so on. That the ability to actually con -- connect the -- the pl an services with the long-term care services that may be available in the community and necessary to people with chronic illnesses, as well as with linkages to social services in the community is very crucial to continuity of care and to comprehensiveness of care.

CHAIRMAN ENTHOVEN: Kim.

MS. BELSHE: Mr. Chairman, I think as Helen indicated, I think this is an issue where I think the commission is a laudable one. Indeed, all of us, I think, are very supportive of promot ing integration of services along the nature that has been identified here.

Two observations, though, goes back to again we're talking about the State. What part of the State are we talking about? If we're talking about health services, we have not included long-term care in our Medi-Cal managed care package of benefits in large part because we're serving single women and children and, number two, just as a practical matter, we have a lot of unanswered questions at State level , at the plan level and the community level in terms of how the integration

of acute long-term care services can occur in practice. It's one of the reasons why the Governor and the Legislature began a process a couple years ago to implement pilot projects to see how we can do a better job in integrating these services.

So, I'm a little anxious, Helen, at the fairly straightforward nature of this recommendation, and I would encourage the Task Force to consider something that perhaps is a step-back system recognizing the value of the goal envisioned but acknowledging that a lot of work remains to be done. And perhaps to underscore support for the continued implementation of pilots that are being developed to determine what's the most appropriate means of integrating these important services.

DR. RODRIGUEZ-TRIAS: Well, I think in that case we would entertain an amendment similar to the prev ious language to say, I guess -- oh, XXX to explore or to study the -- the feasibility of integration of acute and long-term care services as well as linkages to social service in the community for all plans.

MS. BELSHE: That may, Helen, be one where I don't know if I would encourage the Task Force to specify the nameless entity. The pilots are currently under way under the leadership of the Department of Health, Department of Aging, Department of Social Services, et cete ra.

DR. KARPF: Can we just say "appropriate

agencies"?

MS. BELSHE: Appropriate State agencies.

CHAIRMAN ENTHOVEN: I don't think -- I don't think we want to include Cal-PERS in this.

MS. BELSHE: But, again, there are a lot of vulnerable populations, however you define "vulnerable," being served through the Cal-PERS system. But if you want the Task Force to be speaking to something that is real and tangible , you can speak to the effort that is currently under way by the Health department specific to the Medi-Cal population.

CHAIRMAN ENTHOVEN: Well, could we then just make it read "Department of Health Services to continue to explore the pilot -- the feasibility of integration of," et cetera?

MS. BELSHE: That would be -- we would welcome the support of this Task Force in its difficult efforts.

CHAIRMAN ENTHOVEN: Okay. There's a motion. Second?

MS. SINGH: I'm sorry, who moved?

DR. KARPF: I did.

MS. SINGH: Motion by Karpf.

CHAIRMAN ENTHOVEN: Comments?

DR. ARMSTEAD: I don't know this is significant, if we call it good or bad data available from the old HMOs, demonstrations from HCFA, as well as the new pieces that have been expanded through the DBA and what have you. And so, I would just suggest that we are able

1 to expand or look even a little bit further, behind wha t
2 is even beyond, what is available within the State
3 Department and the Department of Aging, as well.
4 MS. BELSHE: You might want to say DHS and
5 others. Certainly we're not the only one struggling
6 with this problem.
7 CHAIRMAN ENTHOVEN: Other departments.
8 MS. BOHME: Why don't you say "DHS and others,"
9 it leaves it open.
10 CHAIRMAN ENTHOVEN: "DHS and others," okay.
11 All right.
12 DR. NORTHWAY: Would you accept the idea that you
13 talk about acute and chronic care rath er than long term?
14 Long term sort of implies you're going to be in some
15 kind of residential care thing, and that's not part of
16 managed care, at least at this point in time. I'm not
17 saying it necessarily should be.
18 CHAIRMAN ENTHOVEN: Tony?
19 MR. RODGERS: Yes.
20 MS. SINGH: Without objection.
21 MS. BELSHE: Just be clear, though, what our
22 effort is -- it's dealing with primary, acute, chronic,
23 institutional, the whole continuum of services, social
24 and medical, that make up long-term care, broadly
25 defined.
26 MS. O'SULLIVAN: Do you want acute, chronic --
27 DR. RODRIGUEZ-TRIAS: Say acute, chronic and
28 long-term care services, then more of the continuum.

MR. LEE: Move for adoption.

MS. SINGH: It's already been moved and seconded.

MR. LEE: Sorry.

CHAIRMAN ENTHOVEN: All in favor, please raise your right hand.

MS. SINGH: Those opposed?

22 to 0. The recommendation is adopted.

CHAIRMAN ENTHOVEN: Number 18.

MR. RODGERS: On 18 --

DR. RODRIGUEZ-TRIAS: Go ahead, Tony.

MR. RODGERS: Well, actually I believe that the State does this already. And I wasn't sure why that was in there, unless there -- you're talking about PERS and others?

CHAIRMAN ENTHOVEN: No.

MS. SINGH: Okay.

CHAIRMAN ENTHOVEN: I'd like to suggest we delete it if we think the State does it already.

MS. SINGH: Why don't we just not make a motion, Mr. Chairman. That will eliminate it without the need for a vote.

MS. SINGH: So, we go to --

CHAIRMAN ENTHOVEN: 19.

MS. SINGH: -- recommendation number 19.

MR. RODGERS: This was about the importance of -- with many of the vulnerable populations, it goes back to tracking and identification. A physician, physician groups, et cetera, must be made aware of the populations

1 that are being assigned to them and you need to assure
2 that they are properly credentialed to serve these
3 populations. And so, what we are recommending here
4 and --
5 MS. BELSHE: Does this recommendation reflect a
6 concern on your part, Tony, that our plan partners are
7 not appropriately credentialing?
8 MR. RODGERS: There's no requirement to have
9 special credentialing based on the type of population
10 you're serving. Only that you are credentialed. You
11 have a link to practice A, et cetera. It's a very
12 generalize d credentialing.
13 What we were proposing here, and this is a
14 broader definition just focusing on DHS, is that as
15 people are placed in managed care, and especially if
16 they have limited choice, that if a plan is aware that
17 they have one of the many vulnerable members, they need
18 to make sure that the physician groups are properly
19 credentialed to serve that member.
20 MS. FARBER: What do you mean by "properly
21 credentialed"?
22 MR. RODGERS: Well, in the case --
23 MS. BOWNE: Ho w are you going to measure
24 sensitivity and cultural competence?
25 MR. RODGERS: The way that we do it now is if
26 they do not speak the language or have no one in the
27 office to speak the language that you're assigned to,
28 then they --

DR. RODRIGUEZ-TRIAS: May I say there are standards of cultural competency that have been integrated into the requirements that the State makes on the Medi-Cal programs.

MS. BOHME: Like wh at?

MS. BELSHE: Largely on the language side.

MS. BOWNE: Basic language.

MS. FARBER: When you say "credentialed," I keep thinking of medical credentials, in terms of academic and practice. And I think you should differentiate --

MS. BELSHE: Let me give -- if you have a population example -- if you have an AIDS population, for example, and you've just assigned them to a primary care provider, you may not -- that provider may not be prepared to serve that population . There is no requirement for us to look at that prior to making those assignments or for the medical group to identify, yes, we have verified that this person is properly credentialed.

MS. FARBER: Thank you. I understand better.

MS. SINGH: Ms. Decker.

MS. DECKER: That's a cue, it's now been 30 minutes on this paper. It means we have 53 minutes before 5 o'clock.

MS. SINGH: And we have many recommendations left in this paper. Members --

MR. RODGERS: May be I should change this, "The Task Force recommends that purchasers be encouraged to

1 work with their plans to assure that medical groups are
2 properly credentialed to serve the vulnerable
3 populations that are assigned or identified in their
4 membership."
5 Would that be acceptable?
6 CHAIRMAN ENTHOVEN: Ms. Inman, do you have that?
7 MS. INMAN: Purchasers being required --
8 encouraged to work into their plans.
9 MR. RODGERS: Yes, the Task Force recommends.
10 MS. INMAN: Similar to the same language how we
11 modified 15.
12 MR. RODGERS: Exactly. I move that.
13 CHAIRMAN ENTHOVEN: Got it.
14 MS. SINGH: It's been moved. Is there a second?
15 MS. FARBER: Second.
16 MS. SINGH: Those in favor of adopting
17 recommendation 19 as read, please raise their right
18 hand.
19 Those opposed?
20 The recommendation is adopted. 23 to 0.
21 DR. RODRIGUEZ-TRIAS: Number 20, and this was
22 included here bec ause, again, from the interviews we did
23 and what we've reviewed in the literature, too, it's a
24 very important issue for people with disabilities. Some
25 health plans have released disabled enrollees to
26 inappropriate rehabilitation facilities and/or nursing
27 homes when there were other options that would have met
28 their health care needs, while recognizing their desires

for maximum independence and autonomy.

So, our attempt to cover that, the State to require and monitor prohibiting discharge of enrollee or placement of enrollee in any institutional setting without informed consent. The comment appears, and this I guess was from existing staff, you did some research on this -- that statement conflicts with the law and would not be possible with individuals who are not competent. And the Task Force may wish to consider revising that language.

But I did get some comments again from people who represented people with disabilities and the comment was that there is no knowledge of any law. Usually when one person -- individuals who are not competent, the law allows for a designated representative to give informed consent, as it does in the case of other legal matters. So, they -- this may apply in this case, as well.

But we felt that was an important human rights issue for vulnerable populations.

MS. DECKER: Move the recommendation.

MS. SINGH: There's a motion. I s there a second?

DR. RODRIGUEZ-TRIAS: Second.

MR. ZATKIN: I have a question here, and I wasn't privy to the legislative debate around this issue. Is there anybody here in the audience who was?

COMMISSIONER: I'm sorry, I can't hear you.

MR. ZATKIN: I understand that this has been the subject of legislation.

MS. BELSHE: I am not mindful of that.

MR. ZATKIN: Maureen, can you comment briefly? Because it was a very complex issue. We went beyond disabled.

MS. O'HARE: I think Beth Ann Koepel (phonetic) could also say something. There was a bill -- I think it was derailed in --

CHAIRMAN ENTHOVEN: Maureen O'Hare with the California Association of Health Plans.

MS. O'HARE: Thank you, Mr. Chairman. Members, there was a bill that was, I believe, derailed in the Senate that would have prohibited a provider from discharging someone, including a provider who had a patient in his or her office, for example, a physician in an office from letting that person go home without providing training to their care-givers. And I guess some sort of consent -- I'm not sure that consent was a big issue as much as training the care-giver at home or making sure that the person had training. So, that was the closest thing to this issue.

MR. ZATKIN: So, this is narrower than that.

MS. O'HARE: Pardon?

MR. ZATKIN: This is a narrower provision than that because it's only institutional and it's just informed consent.

MS. O'HARE: Yeah.

CHAIRMAN ENTHOVEN: Helen?

DR. RODRIGUEZ-TRIAS: I vote against this.

1 I don't want to be found insensitive -- this is so far,
2 very far, from anything that I understand at all, that
3 it sounds like it's being dealt with in the legislative
4 process. I just don't see why this Task Force, which is
5 supposed to be straightening out managed ca re, needs to
6 reach into such a thing as that.
7 So, I'm just apologizing ahead of time why I need
8 to vote unfavorably.
9 CHAIRMAN ENTHOVEN: Any other comments?
10 MR. ZATKIN: How does it work in a hospital?
11 MS. FARBER: How does it work in a hospital now?
12 When -- when a patient is going to be discharged to an
13 extended care facility, you have to have the agreement
14 of the family and the patient to go there. The patient
15 is not competent to say "yes," the family can refuse it.
16 And what happens is that sometimes patients get stacked
17 up in hospitals because reasonable alternatives can't
18 be -- be found. Sometimes families just simply aren't
19 ready to accept that it's time to leave the general
20 acute setting and go to a lower standard of care because
21 of the implications that it has about the prognosis of a
22 loved one. It's a very difficult issue.
23 MR. ZATKIN: Is it an informed consent issue?
24 MS. FARBER: It's not now an informed consent
25 issue. What we do is we send all of our discharge
26 planners to do surveys on these facilities and we give
27 them quality ratings of our own.
28 DR. KARPF: I agree with -- with Dr. Enthoven,

1 this is not a managed care issue, this is a social
2 issue, and it's really beyond the purview of us to deal
3 with this today.
4 CHAIRMAN ENTHOVEN: Thank you.
5 MS. O'SULLIVAN: Beth, you work in the
6 legislation, also. Beth Koepel back there.
7 MS. KOEPEL: The legislation was introduced on
8 standard results of compression of hospital stays
9 arising from managed care. It is directly derived from
10 that issue, it is being held in the Senate Insurance
11 Committee for the reason many current bills are held in
12 the Senate House. It's directly a managed care issue.
13 Long-term care facilities are required to assure
14 that the family is capable of caring before someone is
15 sent home and there's additional support. There was an
16 attempt to look at this in the -- not only the acute
17 care setting, but in those settings in which outpatient
18 surgery is done since same day mastectomy is outpatient
19 surgery.
20 CHAIRMAN ENTHOVEN: I just think we really to
21 have to get to a vote on this. I just see the clock
22 running out.
23 MS. FARBER: I have just one thing. We seem to
24 be very concerned about cost. One of the things I don't
25 think we know very much about is that when premature
26 discharges occur, and the recidivism rate with patients
27 being admitted, it's somewhat tangential to this but
28 it's really at the heart of does managed care cause more

1 harm than good.
2 I don't know if we want to have any kind of a --
3 a focus on this. We certainly ordered up enough studies
4 to fund ten grand institutes but this may be something
5 worthwhile that touches on your concern, Doctor.
6 CHAIRMAN ENTHOVEN: All right. Do we have a
7 motion?
8 MS. SINGH: Mr. Chairman, we do have a motion and
9 a second to adopt recommendation number 20.
10 Those in favor of adopting recommendation 20,
11 please raise your right hand.
12 Those opposed?
13 9 to 13. The recommendation fails.
14 MS. FARBER: May I offer a substitute?
15 MS. BOWNE: Come on.
16 CHAIRMAN ENTHOVEN: Well, Nancy, if you
17 understand that -- that you're going to wipe out some
18 other considerations, some other people's work and
19 ideas.
20 MS. FARBER: Well, this is her work and her
21 ideas. And I think she's touched on something very
22 important.
23 CHAIRMAN ENTHOVEN: All right.
24 MR. LEE: Have your word and throw it out quick.
25 MS. FARBER: The State -- this would be another
26 one of these mandated studies, that you take a look at
27 the impact of early discharge and recidivism.
28 Readmission.

1 MS. SINGH: That's been done. You know the
2 studies, the John Hopkins -- I mean, there's--
3 MS. FARBER : Yes, but I want the State of
4 California through ONO or OSO, or whatever it is, to
5 look at it.
6 MS. SINGH: Is there a second?
7 CHAIRMAN ENTHOVEN: Can you give us the words,
8 Nancy?
9 MS. FARBER: I just did.
10 MR. ROMERO: Let me take a shot. The new
11 regulatory organization should commission a study of the
12 effects of early discharge on the health and -- on the
13 health status and premiums --
14 MS. O'SULLIVAN: And recidivism.
15 MS. FARBER: Early discharge and recidiv ism,
16 thank you. That the study should include both costs and
17 health status impacts.
18 DR. RODRIGUEZ-TRIAS: May I make a comment, and
19 this does -- the motion, however solid it is, it does
20 not address the particular issue to people with
21 disabilities of their informed consent, and I think you
22 know that, the issue of their -- their rights. Okay,
23 their individual rights.
24 CHAIRMAN ENTHOVEN: All right. Second?
25 MS. FINBERG: Second.
26 CHAIRMAN ENTHOVEN: Seconded. All in favor,
27 please raise your right hand.
28 MS. SINGH: Those opposed?

MS. FARBER: But not in California.

MS. SINGH: 10 to 8. It fails.

MS. DECKER: And we're now at 17 after 4:00 with 43 minutes left.

MR. RODGERS: I need time to solve the uninsured health care crisis.

CHAIRMAN ENTHOVEN: You got to do it in five minutes, Tony.

MR. LEE: If I could beg your indulgence for one moment. I would like to go bac k to 18 and make a motion on that. And the reason is I was dozing for a moment, I'm very sorry.

This issue was brought to our attention by a number of people representing vulnerable populations, both the M.S. Society and the group representing people with HIV and AIDS, and I feel it's important for the State to require compliance with these non-discrimination and accessibility standards as a condition of retaining State licensure because they're separate causes of action -- to say you want plans to be accessible to people with disabilities. I don't think it is currently.

The Department of Corporations does not as part of its licensure look at whether or not you got a wheelchair ramp, for instance, so they're separate tracks.

These people in the disabled community are saying that -- they're saying that should be considered as part

of the licensure for providing care because it is so important to the people who are disabled.

CHAIRMAN ENTHOVEN: Aren't you going to overburden DOC? Isn't somebody supposed to be measuring compliance with existing Federal and State laws?

MR. LEE: Generally, it's not monitored except by private causes of action, generally.

MR. ZATKIN: We don't want any costly lawsuits.

MR. LEE: Exactly.

DR. KARPF: It goes down --

MR. KERR: These type of access issues are dealt with in multiple ways. Most of them mostly Buildi ng Codes. When you make modifications to your building, you're required to make sure your facilities are up to ADA facilities. There are a whole host of things.

CHAIRMAN ENTHOVEN: We are getting far afield, Peter, I just feel I have to ask you not to do that. We just have to move forward here.

MR. LEE: Alain, I'm sorry, I'm making a motion that the State consider compliance.

MS. SINGH: Is there a second?

MR. LEE: I say consider compliance, not require and monitor. Consider compliance with Federal and State non-discrimination and accessibility standards in their licensure of health plans.

MS. SINGH: Okay. It's been moved.

MR. PEREZ: Cast the votes.

MS. SINGH: It's been moved and seconded. All in

1 favor, please raise your right hand.

2 Those opposed?

3 MS. DECKER: Can you skip the positions?

4 MS. SINGH: No, I can't.

5 I'm sorry. 12 to 6. It fails.

6 MS. DECKER: Failed, okay.

7 MR. RODGERS: I have a request that we go to C1

8 before Terry leaves. And you wanted to --

9 MR. HARTSHORN: I apologize, the plane is at

10 5:00, I'm trying to make it.

11 On C1, I would like to have the words taken out,

12 "managed care plans serving Medicare patients," because

13 right now, I mean, we're -- those plans are regulated by

14 HCFA and Knox-Keene. And this -- if it's taken away,

15 it's pretty sweeping language, it means we're now

16 subject to having DHS and, you know, it's another layer

17 of regulation. I think we have plenty of regulation

18 already.

19 MR. ZATKIN: If there's a conflict, HCFA --

20 MS. BOWNE: What are we on?

21 MR. HARTSHORN: C1.

22 MS. BELSHE: The point is the State doesn't have

23 the authority to impose all recommendations in all

24 sections of this paper.

25 MR. ZATKIN: Because HCFA has priority.

26 MS. O'SULLIVAN: That's fine.

27 MS. BELSHE: It does not have the authority.

28 MS. O'SULLIVAN: Tony, are you okay with that?

CHAIRMAN ENTHOVEN: To take out all reference to Medicare.

MS. O'SULLIVAN: That --

MR. HARTSHORN: Medicare managed care plans be governed by all recommendations in all sections of the Task Force. So, it's specific to our plan partner. So, it would rate the State.

MR. ZATKIN: There are some State Medicare plans that are not State licenses.

MS. BELSHE: That are not State licenses?

MR. ZATKIN: Some of the County plans used to come in and get special provisions.

MS. BELSHE: Well, I look at this Medi-Cal managed care plan, Steve, as all the folks we do business with independent of their licensure status. So, that would be kind of our organized health clinics and our local initiatives and our commercial plans, at least that's how I interpreted the intent of this recommendation.

MS. BOWNE: Again, I have a very big concern with the strength of this language saying "being governed by all recommendations in all sections of this Task Force report." I mean these aren't law, we're all good citizens. We got together, we're a blue ribbon, we've given our thought to this. It could conflict in law.

MS. O'SULLIVAN: Are you recommending that --

MS. BOWNE: But I think the language is too strong to say they be governed by all recommendations

that we have made. I mean, quite frankly, some of them have barely passed.

MR. LEE: Could I propose a friendly amendment? The State should seek to ensure that all of the recommendations in all sections of this Task Force apply to Medi-Cal managed care plans.

MR. RODGERS: Some of those sections don't apply.

MR. LEE: I think as appropriate and as feasible.

I tried.

DR. RODRIGUEZ-TRIAS: As appropriate--

MS. BELSHE: As appropriate and feasible.

CHAIRMAN ENTHOVEN: Peter, would you just tell me those words again.

MR. LEE: The -- the statute should apply all the recommendations in all sections of this Task Force report to Medi-Cal managed care plans as appropriate and feasible.

MR. TIRAPELLE: Cost effective.

MR. LEE: Cost effective is part of the feasibility.

MR. RODGERS: I'll accept that.

MS. SINGH: No objection.

CHAIRMAN ENTHOVEN: It's just one more case of asking for us to vote on a sweeping statement whose implications we really haven't examined and don't understand.

MS. O'SULLIVAN: We just for the last months have been passing things that we think would apply to health

plans and I'm just saying let's not forget Medical, that they ought to apply for Medical. If they're good enough for people who aren't on Medi-Cal, they're good enough --

MS. BOWNE: Of course. Of course.

CHAIRMAN ENTHOVEN: It's reinforcing a given.

MS. O'SULLIV AN: So, then fine. Then it's meaningless and you all shouldn't be worried about it.

MR. WILLIAMS: What I'm worried about is --

CHAIRMAN ENTHOVEN: I'm worried that it may have some meaning that I don't know what it is.

MS. O'SULLIVAN: It's not -- I mean --

DR. KARPF: If it's meaningless, we shouldn't have to argue about it.

CHAIRMAN ENTHOVEN: Well, okay. Is there a motion?

MS. O'SULLIVAN: Frankly, I had language in here before that somehow got dropped out and my language goes to the extent that Medi-Cal is stronger.

CHAIRMAN ENTHOVEN: All right, is there a motion for the revised language?

MS. SINGH: This is C1, members.

CHAIRMAN ENTHOVEN: As revised by Peter.

MR. LEE: Yes.

CHAIRMAN ENTHOVEN: Second? Is there a second?

DR. RODRIGUEZ-TRIAS: Yes.

CHAIRMAN ENTHOVEN: Okay. All in favor, please raise your hand.

Those opposed?

It fails, 11 t o 6.

MR. RODGERS: Well, I don't have time to solve the uninsured problem, I see. So, my time is up.

COMMISSIONER: CB1 got it.

MR. RODGERS: All rightee, we still have B1. So, we're going back to B1.

MR. ROMERO: Carl Sagan.

CHAIRMAN ENTHOVEN: What about all the rest of this material?

MR. LEE: We're going to do it one at a time.

MR. RODGERS: Back to B1.

MS. SINGH: We're already to C1.

CHAIRMAN ENTHOVEN: So, we're going back to B1?

MR. RODGER S: Yes.

MS. SINGH: Okay.

MR. RODGERS: Because the State has saved billions and billions of dollars, we are in essence -- the concern is this, as managed care, as more the Medi-Cal population are converted to managed care and more the Medicare population is converted to managed care, as more of the commercial population is converted to managed care, the concern is that the health delivery sometimes will no longer be able to shift costs and therefore that the uninsured will lose a degree of access.

Now, if there is savings from managed care, the principle here is that the State should put those

1 savings back into health care to cover more of the
2 uninsured population. That's the concept. And if we
3 haven't phrased it correctly, I'm more than willing to
4 be open.
5 But what we're really trying to do is to say to
6 the State it should take some of the savings from
7 whether it's Medi-Ca l managed care as it's realized, or
8 from Cal-PERS as it's realized, and using either the
9 counties or creating an expansion of services to their
10 populations, to put that money back into health care.
11 MS. BOWNE: Motion to adopt.
12 DR. ARMSTEAD: Second.
13 MS. SINGH: Those in favor, please raise --
14 HON. GALLEGOS: Discussion.
15 MS. O'SULLIVAN: Discussion.
16 MS. SINGH: I'm sorry, discussion.
17 HON. GALLEGOS: Mr. Chairman --
18 MS. BELSHE: If I could make just two quick
19 comments. Is it in order?
20 MS. SINGH: Yes, discussion.
21 MS. BELSHE: Am I getting away -- number one, the
22 premise of this recommendation is that there are savings
23 attributable to Medi-Cal managed care that never once
24 has been the focus of this undertaking. There is not a
25 dollar to be had. This is raising extremely unrealistic
26 expectations associated.
27 Number two, the premise, the thrust of this
28 recommendation, is a laudable one, to expand access to

the uninsured. This Task Force, if my memory serves me correctly, has beaten this path a number of times, which is a laudable objective not within the purview of the Task Force. I think this is elevating expectations in a very inappropriate and unfair way.

MR. RODGERS: Well, the California Medical Commission has a report about the billions of dollars they have saved. And you can model it different ways, but certainly the State employ ees and the taxpayers have saved in the billions. And through the legislative budget appropriation process, Alain, those dollars are a part of the overall Medi-Cal system that is supporting the safety net, both for Medi-Cal as well as the uninsured is getting into that level of budget.

DR. KARPF: This includes Cal-PERS as well as Medi-Cal care.

MR. RODGERS: I'm speaking to the area --

MR. TIRAPELLE: It's not the State saving through Cal-PERS, it's the State employees. What you're asking is for State employees to dig in their pockets to pay for the uninsured because the State's frozen its contributions. It's the State employees who are saving. It's got to start to recognize it has been saving a lot of money and consider that and start recycling some of those savings.

MR. RODGERS: And arguably some of those savings are being used for the multi-family expansion fund for kids. So, it's all part of competing parties of the

budget process.

MR. HAUCK: Can I just -- what you're saying, these are just General Fund dollars, if I'm correct, Tony. These are General Fund dollars with a finite amount of money, and what you're saying is that this is a higher priority.

Let me first say that I believe improving access really shouldn't just follow one segment, it should be everybody's issues. So, I think to that end I think Tony's point is -- it's you spread the -- the costs among everybody, and that's really the issue. Who pays for access to the uninsured.

But you're making a decision at this point in time that this is a higher priority than, say, education, developmentally disabled, anything else that the Legislature does in the -- in the budget process.

And I just want to make sure that that is the consequences. Or, you know, disproportionate share, things like that.

MR. RODGERS: Can you propose something different? There's something happening now at the local level with this issue. Counties are beginning to look at Medi-Cal, Medi-Cal being moved into managed care, how they are going to take on this uninsured burden and what they're going to do.

And if the State could work with the counties to come up with ways that they can roll some of the County populations, the 7,000 group populations, into managed

1 care, to take advantage of the same savings instead of
2 having to kind of be out of the system, that that would
3 be an alternative.
4 It's -- it's that we -- managed care will change
5 the way delivery of health care is done at the local
6 level. The counties are the ones, I think, that are the
7 most financially vulnerable to this phenomenon.
8 CHAIRMAN ENTHOVEN: Do you have words, Tony?
9 MR. RODGERS: Something to, "This Task Force
10 recommends that the State incur -- work with counties
11 and encourage them t o come up with creative ways to --
12 or innovative ways to -- to include the County-obligated
13 $17,000 -- or 17,000 obligated patients in managed care
14 at the County level." Maybe, Kim, would you have a way
15 that I can say this?
16 DR. KARPF: Mr. Chairman, this goes beyond the
17 scope of this committee but is fundamental to a lot of
18 interest here. Maybe what we should do is take the time
19 to draft some language and make it part of the preamble
20 of the cover of this letter. If there ar e savings to be
21 identified, that they should be used to expand the
22 access down the road and get it off --
23 CHAIRMAN ENTHOVEN: Okay, I was thinking I'd like
24 to address this concisely in the Chairman's letter.
25 MS. BOWNE: I'll withdraw the motion. If
26 somebody would fax me some suggested language, that
27 would be -- I'd just like to continue --
28 MS. BELSHE: How about Tony and I work on some

verbiage for your considerat ion.

CHAIRMAN ENTHOVEN: Okay.

MR. LEE: That will be in the objective summary?

CHAIRMAN ENTHOVEN: In the Chairman's letter.

DR. NORTHWAY: Just a word of caution, before we shift money in the Medi-Cal program where it's managed effectively, at least those funds get funded before we take dollars and put them in some other fund.

CHAIRMAN ENTHOVEN: So, B1 is off the table. Nancy.

MS. FARBER: Mr. Chairman, while you're drafting those words with respect to this issue, I hope you'll take into account that at this point in time, besides Medi-Cal taking up the work of trying to provide insurance to the under-served and the uninsured, that basically it's the hospital industry by virtue of Cobra regulations that is eating the difference.

Historically, this is something that was handled by cost shifting within the insurance industry. And whether you liked it or not, that's how it was handled, and between the insurance industry and the hos pitals for many patients it was handled. Now, one of the partners to that old equation has withdrawn and it's the health insurance industry, and I would suggest to you that the burden on hospitals is increasingly onerous and I hope that some consideration is taken when you draft your remarks with respect to this.

The impact of managed care on the hospital

industry has been a notable subject of silence. And I don't t hink that you can frame all of these wonderful recommendations with the expectation that somehow that industry is not going to be impacted.

CHAIRMAN ENTHOVEN: Okay. I understand and respect what you say. I'm a little concerned that this letter will quickly get over-burdened and fall of its own weight. I'll give it a try.

MS. BOWNE: Nancy could include that in her letter.

MS. FARBER: I'll include that in my letter.

MS. SINGH: It's now 3:23. Excuse me, 4 -- 4. 4.

COMMISSIONER: Wishful thinking.

MS. SINGH: We got several recommendations. C2 --

CHAIRMAN ENTHOVEN: C2.

MS. SINGH: -- 3 and 4.

MR. LEE: Can we see if 2, 3 and 4 is a block, to see if there are specific suggestions to change them and then move them as a whole?

CHAIRMAN ENTHOVEN: Kim.

MS. BELSHE: I talked a little bit with Maryann; can we get rid a lot of this more editorial verbiage about the extent to which the Department is or isn't --

MS. O'SULLIVAN: That came from the Department.

MR. LEE: From "special notice" to the end is deleted. That's not part of it at all. We're only

1 dealing with --

2 MS. O'SULLIVAN: Is that what you're talking

3 about?

4 MS. BELSHE: We're beginning with item 2,

5 everything above item 2, that paragraph is out.

6 MR. LEE: I see that section. I wasn't talking

7 about that.

8 MS. BELSHE: We talked about turning over to th e

9 Legislature, annual meetings, holding double secrets,

10 things like that.

11 If we just start with item 2, the Task Force is

12 asking the Department to prepare -- prepare annual

13 reports that include items A through G separately.

14 Item 3. Item 4, which is now really 1, 2 and 3,

15 from the Department's perspective, we're looking at what

16 we're doing through AMA audits. We're looking at what

17 we're doing through AQRO. We're effectively

18 collecting data associated with A, with the exc eption of

19 B and C. That's to recognize we aren't collecting that

20 information now.

21 Comparison of provider panels, we're not doing

22 that because there are a lot of questions about how you

23 go about doing this. From a mathematical basis, I

24 understand why CQAA and AMA are looking at that

25 question, but we are not collecting that information nor

26 do we have any plans at this time to.

27 Item C --

28 MS. O'SULLIVAN: Do you want me to respond to

that?

MS. BELSHE: Go ahead.

MS. O'SULLIVAN: That's not -- I mean what I'm talking about is where you've got a commercial plan that's contracted for managed -- Medi-Cal managed care, to compare -- so we can understand when -- when AFDC beneficiaries get, say, Blue Cross/Medi-Cal, are they getting -- how is that different from private pay Blue Cross?

MS. BELSHE: So, it's a network comparison as opposed to a provider-specific comparison?

MS. O'SULLIVAN: Yes.

CHAIRMAN ENTHOVEN: So, B says the network comparison?

MS. O'SULLIVAN: That's what was intended.

MS. BELSHE: We're still not collecting, but that's something we can to look at.

Item C, in terms of comparing public versus private, that is not something we're looking at. We don't have that information that would require us to work closely with a variety of different purchasers or private insurance. Again, given all our other competing demands, not the highest of priorities, but just to recognize we do not have that at this time.

In terms of what would now be recommendation 2 and 3, which is looking at the public health system impact as it relates to uninsureds and to more the community based epidemiological-related issues, we are

already doing that, or in the process of doing that.

In terms of our long-term evaluation of managed care, it's an impact on pub lic health. So, our -- our major concern with this is one of the resource and capacity.

Much like all the other reports that this Task Force has recommended on departments and other organizations, we do not have the resources, we do not have the capacity to do this overnight. I would also ask the question of the plans to the extent they are partners in providing us with this data, do they have the resources and capacity, as well, to provide all this information?

MR. WILLIAMS: I would say that you can't do the buyer network comparison without doing the individual buyer comparison because the buyer's practices in multiple settings is a pretty extensive analysis to do this. If someone were quite willing to pay for it, we'd be glad to.

MS. O'SULLIVAN: We did it. I had an intern do it this summer in three counties.

MR. WILLIAMS: I wouldn't want to comment on the quality of that work since I haven't seen it.

MS. O'SULLIVAN: Thank you.

MR. ROMERO: Great intern.

MS. BELSHE: But this goes back to the point we made throughout, the expectations.

CHAIRMAN ENTHOVEN: Let's vote on 2.

MS. BOWNE: Are we hearing -- to delete B and C? A motion.

MS. SINGH: Do we have exact language of B and C?

MS. O'SULLIVAN: I want to make a comment, if I could, that all day long we've been -- for two months we've been assigning things to this new agency th at we're going to do for all the people who can't afford to buy health insurance --

MR. KERR: Can we assign this to you?

MS. O'SULLIVAN: Probably.

CHAIRMAN ENTHOVEN: Let's get going here.

MS. O'SULLIVAN: Now we're asking -- this is one of the few things that has gone to DHS. Three and a half million in Medi-Cal managed care. If we're going to reach that population, see what's going on, just like we're going to collect data on anyone else, I think we need to hav e this basic understanding.

I don't deny that it's a lot of work and it's going to cost some money. We've been doing all day and all month creating things that cost a lot of money.

MR. WILLIAMS: The only point I would make is we can collect lots of data. The question is where can we draw meaningful information that is helpful for making an increased access for these populations? If it's about collecting data, I'll do that. But if it's not producing any real value, then w e're just not --

MS. O'SULLIVAN: Tony told us last time that basically you guys are already collecting data, that's

here.

MS. BELSHE: With the vehicles of D and C, the Department is, generally speaking, collecting data. We do not have the resources at this time to -- to create a legislative report, that's something we would like to be able to do. It does require a certain amount of financial and human resources to make it happen, as do many of the recommendations this Task Force recommended.

CHAIRMAN ENTHOVEN: Should we start with, "The Governor and the Legislature should fund DHS to" --

MR. LEE: -- "should provide resources for DHS to prepare an annual report."

DR. NORTHWAY: How much?

DR. KARPF: Get the calculator.

CHAIRMAN ENTHOVEN: To prepare -- then how about striking B and C? Would that be friendly?

MS. O'SULLIVAN: No, that would be very unfriendly.

MS. FINBERG: She says she'll do it if you give her the resources.

MR. LEE: It's already been done.

MS. BELSHE: To the extent -- to the extent resources are made available. It really is a capacity question, not a lack of desire, itself.

MR. ZAREMBERG: It seems you want on this one to say we encourage the Legislature to make the resources available.

CHAIRMAN ENTHOVEN: That's what I wrote. "The

1 Governor and the Legislature should provide resources
2 for DHS to prepare an annual report," and then run
3 through it all.
4 MS. FINBERG: So moved.
5 CHAIRMAN ENTHOVEN: B is a network comparison.
6 MS. SINGH: It's been moved by Jeanne.
7 CHAIRMAN ENTHOVEN: Moved. A second?
8 MR. LEE: Second.
9 CHAIRMAN ENTHOVEN: Okay. All in favor?
10 MS. SINGH: John just put his hand up.
11 Those opposed?
12 17 to 1. The recommendation is adopted.
13 MS. BOWNE: Excuse me, there are two negativ e
14 votes.
15 MS. SINGH: Excuse me, I stand corrected. 17 to
16 2.
17 CHAIRMAN ENTHOVEN: Recommendation 3.
18 MS. BOWNE: It isn't Christmas yet.
19 MR. LEE: I think we did that as a block.
20 We didn't? All right, I tried to.
21 CHAIRMAN ENTHOVEN: I regret that I said 2.
22 Maybe I should have said 3 and 4.
23 MR. LEE: Can we make a motion on 3 and 4 as a
24 block?
25 CHAIRMAN ENTHOVEN: The Legislature should
26 provide resources for DHS to --
27 MS. BELSHE: Actually, Mr. Chairma n, we already
28 have a long-term evaluation under way that's being

1 funded by a collaboration of consortium of foundations.
2 So, it may be more appropriate for the Task Force to
3 support the Department's ongoing efforts. This is a
4 long-term evaluation, so we are not going to be in a
5 position of doing a report next year. But, Maryann, you
6 can speak to that as a member of our policy council.
7 MS. O'SULLIVAN: What the poli cy counsel has been
8 funded to look at is very short term at the moment.
9 It's just to prioritize what to look at, the impact on
10 the community-based public health infrastructure,
11 whatever.
12 CHAIRMAN ENTHOVEN: This is a friendly amendment
13 then; "The Task Force supports the DHS's ongoing efforts
14 to report to the Legislature."
15 MS. O'SULLIVAN: No.
16 CHAIRMAN ENTHOVEN: No?
17 MS. FINBERG: Why don't --
18 MS. O'SULLIVAN: Their effort is not to report to
19 the Legislature.
20 MR. LEE: Move 3 and 4 as stated.
21 MS. SINGH: It's been moved as stated.
22 MS. BELSHE: With the appropriate caveat, "in
23 terms of resources."
24 MS. SINGH: The appropriate caveat "in terms of
25 resources."
26 MR. TIRAPELLE: I question the need for these
27 things on an annual basis.
28 MR. PEREZ: Regular.

MR. TIRAPELLE: Why don't we get the report and see if it has value before you start analyzing it

MS. SINGH : Periodically. Without objection.

CHAIRMAN ENTHOVEN: If resources are available, a periodic report. The "resources," was that friendly to you?

MS. O'SULLIVAN: Yes.

CHAIRMAN ENTHOVEN: Okay. And then 4, bundle it at the same time.

MR. PEREZ: Yes.

CHAIRMAN ENTHOVEN: Okay.

MS. SINGH: I need a second.

CHAIRMAN ENTHOVEN: Is there a second?

MS. O'SULLIVAN: The same thing, that the Legislature should make available the money. That if the resources are available, the Legislature should make available.

MS. SINGH: Without objection.

CHAIRMAN ENTHOVEN: The Governor and the Legislature should make available -- okay.

MS. SINGH: Should --

CHAIRMAN ENTHOVEN: -- make resources available to DHS to prepare -- all right. All in favor, raise your hands, please.

MS. SINGH: I'm sorry, do we have a second? Ms. O'Sullivan seconded.

MS. O'SULLIVAN: I seconded.

CHAIRMAN ENTHOVEN: You're seconding your own

motion.

MR. LEE: I moved.

CHAIRMAN ENTHOVEN: Lee did.

MS. SINGH: Those in favor, please raise your right hand.

Those opposed?

The motion fails. 13 to 1.

CHAIRMAN ENTHOVEN: Okay.

MR. LEE: Can I change that motion? The same people who --

CHAIRMAN ENTHOVEN: Anyway, move quickly.

MR. LEE: Can I ask -- can I ask for a recount on that? I'm sorry.

DR. RODRIGUEZ-TRIAS: We have a revo te. I have an idea people were not --

MS. BOWNE: What is the motion again?

MS. SINGH: Those in favor of adopting recommendation 2 and 3 as amended.

MS. BOWNE: No, 3 and 4.

MS. SINGH: 3 and 4 is now 2 and 3 because we deleted 1. Anyway -- 3 and 4 as amended, please raise your right hand.

Okay, you got to please raise your hand high, guys.

Okay.

Those opposed?

CHAIRMAN ENTHOVEN: No, I'm sorry, I'm not voting.

1 MS. SINGH: 16 to 4. It passes.
2 MR. LEE: Thank you very much for that revote.
3 CHAIRMAN ENTHOVEN: Oh, it passed?
4 MS. SINGH: It passed.
5 CHAIRMAN ENTHOVEN: Passed.
6 MR. ROMERO: Barely. 3 and 4.
7 MS. SINGH: What is --
8 MS. DECKER: It's now 4:45. 15 minutes.
9 MS. SINGH: Are we finished with this?
10 CHAIRMAN ENTHOVEN: Yes.
11 MS. SINGH: The findings; but are we finished
12 with the recommendations?
13 MR. LEE: Move adoption of findi ngs.
14 DR. KARPF: Seconded.
15 MR. LEE: That's all -- strike that -- was
16 commentary about current practice.
17 MR. ZATKIN: I have a problem with the findings
18 at the top of page 3, where we say "managed care seems
19 to present the following challenges that need to be
20 addressed in serving these populations."
21 Under "treating patients with chronic illness," I
22 think that is written in a -- a rather --
23 MR. LEE: Unqualified language.
24 MR. ZATKIN: -- and it needs qualifying la nguage,
25 to "managed care arrangements are -- raise these
26 concerns," which is different from a -- a global
27 statement, as I read it.
28 CHAIRMAN ENTHOVEN: Steve, where are you?

1 MS. SINGH: He's on the top of page 3.
2 MS. BOWNE: So --
3 CHAIRMAN ENTHOVEN: Will you suggest language,
4 Mr. Zatkin?
5 MR. ZATKIN: To say "managed care arrangements
6 may raise issues with respect to the following."
7 MR. LEE: Fine.
8 DR. NORTHWAY: Where is it at?
9 MR. ZATKIN: Top of page 3.
10 MS. SINGH: "May raise issues."
11 MR. LEE: So, "managed care arrangements may
12 raise the quality of challenges."
13 CHAIRMAN ENTHOVEN: "With respect to the
14 following challenges."
15 MR. ZATKIN: May raise -- may raise issues with
16 respect to the following challenges.
17 MS. FINBERG: Okay. And a very little one on
18 page 2, just -- where we refer -- we list the groups in
19 bullets. If we can just say "Adults with disabilities,"
20 "Children with disabilities." I've been asked to
21 recommend that.
22 It does not -- it says "Disabled adults."
23 "Adults with disabilities." "Children with
24 disabilities."
25 MR. PEREZ: I'm sorry?
26 MR. LEE: That's a friendly amendment.
27 Move adoption.
28 MR. SCHLAEGEL: Second.

MS. SINGH: It has been moved. Second by Mr. Schlaegel. Those in favor of adopting the recommendation?

MS. BELSHE : I did have an important point on number 2 in terms of the definitions and I apologize if that's what staff mentioned. I was distracted.

MR. LEE: What page?

MS. BELSHE: Page 2. When you're identifying the bullets, the ones that are being highlighted in this record, the leading sentence is "within these specially funded health care programs," et cetera, you're referencing back to Medicare and Medicaid as the focus of these recommendations.

MR. LEE: No.

MS. BELS HE: Special or vulnerable populations in those programs or vulnerable populations, broadly. And so I recommend you strike that initial part of the sentence.

MR. ROMERO: Yeah, within the real world there.

MR. LEE: Right, okay.

MS. SINGH: Without objection, it's been moved to adopt the recommendation as amended by Mr. Lee, seconded by Mr. Schlaegel.

Those in favor, please raise your right hand. High. High.

MR. LEE: We're getting close. One hand down --

MS. SINGH: Those opposed?

It's been adopted 20 to 0.

1 CHAIRMAN ENTHOVEN: Please turn to the next
2 paper, which is on case study on women integration.
3 MR. LEE: Moved.
4 MR. PEREZ: Second.
5 MS. FINBERG: All in favor.
6 CHAIRMAN ENTHOVEN: Okay. On page 5.
7 MS. BOWNE: What item?
8 MS. SINGH: Item 6K. Tab 6K.
9 DR. RODRIGUEZ-TRIAS: Page 5, recommendations.
10 Managed care improvement task for integratio n: A case
11 study on women, findings of recommendations. 6K.
12 MS. SINGH: 6K, page 5.
13 CHAIRMAN ENTHOVEN: Okay, page 5, recommendation
14 1.
15 MR. LEE: Could I request that we try to deal
16 with 1 through 8 as a block. It may be insignificant,
17 but if people have specific problems with them, mention
18 those problems, then we can vote them hopefully as a
19 block.
20 DR. RODRIGUEZ-TRIAS: We can, Peter, but there
21 have been -- there have been a few -- just a couple of
22 words of cha nges.
23 MR. LEE: Doing those technical changes and then
24 try to treat them as a block.
25 MS. FINBERG: I have one that was suggested
26 earlier in testimony that -- the last sentence, number
27 8, that -- I'm sorry, page 6, that "pre" and "postnatal"
28 be changed to "perinatal."

1 MR. LEE: Perinatal, right,

2 MS. FARBER: Are you --

3 MS. FINBERG: Page 6, number 8.

4 MR. LEE: Change "pre" and "post" to "perinatal."

5 MS. FARBER: I think a lot of people might have

6 done that during testimony.

7 MS. SINGH: That means -- all right.

8 MR. ZATKIN: Number 4. Number 4, I think, is

9 not -- well, I understand the purpose there, so -- this

10 would require us to send out a packet to every single

11 person in the family, and I don't think that is

12 cost-effective.

13 CHAIRMAN ENTHOVEN: Why don't you read --

14 DR. RODRIGUEZ-TRIAS: Steve, would you accept

15 that that be amended as the other statements in oth er

16 papers have been amended, "as requested" or --

17 MS. SINGH: Plans should be required upon

18 request.

19 DR. RODRIGUEZ-TRIAS: "Upon request." Because

20 that's the way we dealt with all the other informative

21 materials having to do with consumers.

22 MR. ZATKIN: If the family says "Please send us

23 another packet" --

24 MS. GRIFFITHS: A dependent wants to get their

25 own copy of the stuff.

26 DR. RODRIGUEZ-TRIAS: If a teenage child, for

27 example, that's part --

28 MR. ZATKIN: I think that's okay.

1 MS. SINGH: Plans should be part of --
2 CHAIRMAN ENTHOVEN: God forbid.
3 MS. SINGH: -- to provide, upon request,
4 information.
5 DR. RODRIGUEZ-TRIAS: Upon request, right.
6 MS. SINGH: Without objection.
7 MR. LEE: No objection. Other wording changes
8 requested?
9 MS. BOWNE: In number 7, the -- the breadth of
10 the term "reproductive health care," does that include
11 all kinds of infertility tre atment, as well?
12 DR. RODRIGUEZ-TRIAS: No, the way it was defined
13 here, the operative words are "full range of standard
14 medical practice." They do not include infertility
15 services, as far as I know.
16 MR. ZATKIN: Could we make sure that it doesn't?
17 MS. FARBER: Let's put, parens, "does not include
18 infertility services."
19 DR. RODRIGUEZ-TRIAS: Yes.
20 MS. SINGH: This is on number --
21 MR. LEE: Number 7.
22 DR. RODRIGUEZ-TRIAS: Number 7, insertion of the
23 word "and pharmaceuticals" after "authorize." It says
24 "including a full range of contraceptive devices,
25 methods and pharmaceuticals, and a full range of
26 standard medical practices." It does not include
27 infertility.
28 MS. O'SULLIVAN: Another piece that came up

during the testimony --

MR. LEE: Slow down a little bit so everybody can keep up with what we're doing.

MS. SINGH: Without objection. Okay.

MS. O'SULLIVAN: -- 5B, to add at the end "as well as sensitivity to the unique needs and concerns of women."

MR. LEE: That's 5B?

MS. O'SULLIVAN: 5B, yeah.

MR. PEREZ: I thought you were saying you were opposed to it.

MR. LEE: Absolutely not.

MS. SINGH: Sensitivity and uniquenesses.

CHAIRMAN ENTHOVEN: Are we dealing with everything?

MR. LEE: We're trying to do it 1 through 8.

CHAIRMAN ENTHOVEN: I want 7 and 8 to be considered separately.

MS. SINGH: We got to finish this 5B change first.

CHAIRMAN ENTHOVEN: Mrs. O'Sullivan.

MS. O'SULLIVAN: "As well as sensitive to the uniqueness and concerns of women"

MS. SINGH: -- uniqueness and concerns.

DR. RODRIGUEZ-TRIAS: Ready for the next? 5C to read instead of "women should be allowed direct access," to read "plans shall be required to allow women direct access."

1 MS. SINGH: Is there objection?
2 MS. FINBERG : No.
3 MS. BOWNE: Well, wait a minute.
4 MR. TIRAPELLE: Will you read it again, please.
5 MS. SINGH: Instead of saying "women shall be
6 allowed," "plans should be directed."
7 DR. RODRIGUEZ-TRIAS: "Shall be required to allow
8 women direct access."
9 MS. SINGH: Should be required.
10 CHAIRMAN ENTHOVEN: What do the plans think about
11 that?
12 MR. WILLIAMS: Well, I think -- I think plans
13 want to -- this is too global. That's what it comes
14 down to, is that I think there 's general agreement
15 that --
16 MS. FARBER: Can you speak up?
17 MR. WILLIAMS: Yes, I think the point I'm
18 concerned with is that this is too broad. That I think
19 there's general agreement that there should be access
20 for routine care and that a woman has the right to see
21 an OB/GYN. I think there needs to be a recognition
22 again of the role of the primary care physician, the
23 ongoing overall care relationship. I'm struggling with
24 what the right words would be.
25 DR. RODRIGUEZ -TRIAS: May I make a comment to
26 that, Ron? I honestly think that where women prefer
27 their primary physician, very often they will go to that
28 provider for their gynecological care, it will happen.

1 But that, again, women often come into the health care
2 system through gynecological care elsewhere, have formed
3 attachments, bonds, et cetera, or have preferences.
4 I mean, I -- I'm very friendly with my internist,
5 but I'd rat her my own, you know, GYN person take care of
6 my reproductive health needs.
7 MR. LEE: Can I suggest that we pull off C for a
8 moment, similar as we did with Alain's 7 and 8, so we
9 deal with as a block 1 through 5, A and B.
10 MR. ZATKIN: Question on 3. Is that intended to
11 be a mandate to pay for out-of-network services or --
12 MR. LEE: No.
13 MR. ZATKIN: Something less than that.
14 MS. FARBER: No, it's not.
15 MR. LEE: It's an encouragement.
16 MR. ZATKIN: So, let the r ecord so state.
17 MR. LEE: The record will so reflect that it says
18 "encourage."
19 MR. PEREZ: I don't know if you want to read the
20 record.
21 MR. ZATKIN: Task Force's intent.
22 DR. RODRIGUEZ-TRIAS: It's an encouragement on 3.
23 HON. GALLEGOS: I was distracted.
24 DR. RODRIGUEZ-TRIAS: Additional discussion.
25 MR. ZATKIN: Intention of number 3 is not to be a
26 mandate.
27 MS. SINGH: On 3, Ms. Farber.
28 MS. FARBER: We're talking about --

CHAIRMAN ENTHOVEN: We're talking about number 3.

MR. LEE: We're talking anything.

MS. FARBER: I thought we were talking --

MR. LEE: We're clarifying amendments.

MS. FARBER: I didn't --

MR. LEE: Except for C7 and 8.

MS. FARBER: I don't want to be out of order, but I did want to talk about 5C.

MS. SINGH: I think at this time we will hold off any -- any further discussion on recommendations 1 through 5B.

MR. LEE: And 6.

MS. SINGH: And number 6.

MR. LEE: Right. Which I didn't hear any concerns about.

MS. SINGH: Is there a motion?

MR. PEREZ: So moved.

MR. KERR: Second.

CHAIRMAN ENTHOVEN: Perez moved. Kerr seconded.

Those in favor of adopting recommendations 1 through 5, and 6, please raise your right hand.

MR. PEREZ: We've got four minutes.

MS. SINGH: Those opposed?

22 to 0. The recommendations are adopted.

MR. LEE: Now C.

MR. SCHLAEGEL: 5C.

MS. FARBER: I'd like to say something. Can I speak now?

MR. LEE: Just wording, Nancy. Do you have a change to make it go?

MS. FARBER: I think that in many plans the obstetricians are allowed to function as primary care providers and they're given that status. This isn't as big a deal as you might think it is. It's just that it's not a uniform practice. And for many women during their reproductive years, t hey're more comfortable getting their primary care in a continual forum with all their other health cares and their OBs are very good about recognizing when they need the services of an internist or someone else.

I think that, you know, making it a uniform practice is a human thing. It's not a revolutionary thing. It is, I think, the standard of practice. Now, I know you don't like that term, but it's true, this -- this is what a lot of plans are doing.

So, I don't thi nk this is a big fat revolutionary deal. I think what you ought to do is start making it consistent.

MR. LEE: Can we do a poll?

MS. FINBERG: I'd like to move on C.

MR. LEE: Move C.

MS. SINGH: It's been moved by Ms. Finberg to adopt 5C as amended.

MS. FINBERG: Correct. Correct, yes.

MS. SINGH: Everybody knows what the amendment is?

MS. BOWNE: What is the amendment?

MR. LEE: Plans should be --

MS. SINGH: "Plans should be required to allow women direct accesses to their reproductive health care providers," et cetera, et cetera.

CHAIRMAN ENTHOVEN: It's been moved by Ms. Finberg and seconded by somebody.

MR. LEE: Lee.

MS. SINGH: Lee. Any discussion?

Those in favor, please raise --

MR. KERR: According to Kaiser, it would raise -- direct access to OB/GYN would be raised one-third of one percent.

MR. LEE: So, what's your hand doing down? Thank you very much.

MS. SINGH: That's no fair, please raise your right hand.

Those opposed?

18 to 0. The recommendation is adopted.

MR. LEE: Are there proposed amendments to 7?

MS. SINGH: Number 7.

CHAIRMAN ENTHOVEN: Okay, I'd just like to speak to number 7 and 8 and say, first of all, coverage issues are a matter as between employers and health plans, so employers call the shots on that. And that aspect of ERISA is exceedingly unlikely to be changed.

We haven't made coverage recommendations elsewhere, such as in the case of mental health parity,

1 and it's somewhat anomalous that we should do so here.
2 And, third, I haven't been able to achieve
3 clarity on this, but I either hope it doesn't or I'm not
4 sure whether these words are code words for abortion.
5 If and to the extent that they are code words for
6 abortion, I think while, you know, this pleuristic
7 society is totally respective of women, women should
8 have the right to have an abortion within the scope of
9 the law.
10 But I'm just very concerned if what the purpose
11 of this is to put the Task Force on record as favoring
12 coverage of abortion or expanding the coverage in that
13 respect, that it's going to be a sort of poison pill and
14 it's going to attract a lot of -- going to be a
15 lightning rod. There will be a lot of people who will
16 oppose us, write us off because of this.
17 And I have th e feeling if -- if this is the case,
18 so we can talk about what these words -- how these words
19 will be understood -- but if this is the case, then I
20 think, unfortunately, the -- the Task Force is being
21 used for another agenda which would not be too helpful
22 from the point of view of furthering the -- the agenda
23 of the Task Force.
24 MS. FARBER: Point of information,
25 MS. DECKER: One minute left.
26 MS. FARBER: Could you please explain to me what
27 the ERISA issue was -- did that relate to sexually
28 transmitted diseases?

1 MS. DECKER: ERISA says you can't mandate what
2 the benefits are in a plan, you can't tell us we have to
3 offer this. "Us" being employers that arrange plans.
4 MS. FARBER: How many plans don't offer coverage
5 for sexually transmitted diseases?
6 CHAIRMAN ENTHOVEN: I frankly doubt there are
7 any. What I'm worried about is the meaning of -- under
8 number 7, of the "full range of standa rd medical
9 practices to meet reproductive health needs."
10 MS. FARBER: Okay.
11 CHAIRMAN ENTHOVEN: Now, if I could be assured
12 that that is --
13 DR. KARPF: I can't stand -- I would oppose that
14 irregardless of whether it's code word for abortion or
15 not, because when you leave that in, people will come
16 back and say the standard of care also includes
17 artificial insemination, includes --
18 DR. RODRIGUEZ-TRIAS: It does not include
19 infertility.
20 MS. FARBER: It specifically says it does not
21 include infertility services.
22 DR. KARPF: Where is that?
23 MS. FARBER: We --
24 MR. ZATKIN: Isn't that current law, Maureen?
25 MS. FINBERG: Maureen said these don't --
26 MAUREEN: There's current legislation pending
27 that's awaiting your decision.
28 MR. ZATKIN: I thought the recommendation --

1 MS. BOWNE: I'm concerned about this because I
2 think it does translate not only into code word for
3 abortion but code word for mandated benefits, which
4 falls solely and exclusively and predominantly to small
5 business. Because the ERISA plans don't have to meet
6 the mandates, and I'm -- I understand the intent of
7 this, but I am concerned about including this in our
8 report.
9 MAUREEN: Can I just address this, that health
10 care service plans would have to cover all care for a
11 sexually transmitted disease, has to cover all care --
12 you know, prenatal, postnatal care, all maternity t ype
13 care, reproductive care, for any gynecological problem.
14 Plans do not as a -- as a matter of mandated
15 basic health care services, have to cover prescription
16 drugs. That is an optional benefit that the employer
17 can purchase.
18 There is a bill that is pending that our
19 association is nigh on that we require a plan when you
20 do offer prescription drugs that you do cover a variety
21 of prescription drugs for contraception. We also have
22 to cover by law on a variety of followup ca re. Family
23 planning services, that's part of the regulation.
24 So, there's -- in addition to, for example,
25 contraceptives that are prescriptions, we would also
26 have to cover counseling and other devices. So, there's
27 a pretty broad range of mandates in existing law. So, 7
28 and 8, for the most part, are taken care of. They cover

1 infertility services, so --

2 CHAIRMAN ENTHOVEN: So, what do 7 and 8 add to

3 existing law ?

4 MAUREEN: Nothing except for the contraceptive

5 suggestion. It suggests that that be part of the basic

6 health and service package, which right now doesn't even

7 include prescription drugs. So, you would be tacking a

8 prescription drug onto --

9 MR. ZAREMBERG: I think one unintended

10 consequence -- and, Maureen, correct me if I'm wrong,

11 and Jeanne, you might be interested -- I think most HMOs

12 cover contraceptives, so that this would not result in

13 any increase in price. What the unintended consequence

14 is, that there are PPOs where you might draft something

15 to fit your needs and reduce your costs, that you cut

16 that out to reduce your costs, and what you're doing is

17 making that disparity greater between the PPO and the

18 HMO because this probably doesn't increase costs in HMOs

19 because I think most of them offer it. But those PPOs,

20 that -- they don't offer it.

21 So, you're just going to increase that

22 differential in cost. I think it's an unintended

23 consequence, but I think that's what the consequence is.

24 Maureen, correct me if I'm wrong, I think the HMOs

25 already provide it.

26 MR. PEREZ: I move 7 and 8 because they haven't

27 been moved.

28 MR. LEE: Second, and call the question.

CHAIRMAN ENTHOVEN: Okay.

SINGH: No further discussion?

CHAIRMAN ENTHOVEN: All in favor of 7 and 8?

MS. SINGH: As amended.

Those opposed?

8 to 8. The motion fails.

MR. PEREZ: Move the finding.

MR. SCHLAEGEL: Second.

MR. LEE: Call the question.

MS. SINGH: Those in favor -- without discussion, those in favor of the findings, please raise your right hand.

DR. KARPF: Findings will reflect --

MS. SINGH: Findings as amended to reflect the recommendations as adopted today.

HON. GALLEGOS: Findings based on?

MS. SINGH: The recommendations adopted today.

CHAIRMAN ENTHOVEN: Before you fly, let me just -- oh, yeah.

MS. SINGH: We haven't voted yet.

CHAIRMAN ENTHOVEN: Before you go, I got just one --

MS. SINGH: Okay. Those in favor, please raise --

Those opposed?

Okay, 19 to 0. The findings are adopted.

CHAIRMAN ENTHOVEN: I just want to make sure that it's generally understood that we are authorized and

1 directed to go back and make conforming changes of the
2 sort that was the case with malpractice and
3 accountability. That is where a recommendation got
4 wiped out. Then we'll take out the explanatory language
5 up front, et cetera.
6 DR. KARPF: Right.
7 CHAIRMAN ENTHOVEN: Right.
8 MR. SHAPIRO: And the background materials.
9 CHAIRMAN ENTHOVEN: And the background materials,
10 too. Without objection.
11 MS. BOWNE: What are the hours of the
12 January meeting?
13 MR. LEE: January 5th meeting are what hours?
14 MS. SINGH: 9 to 5. Just block the whole time.
15 DR. KARPF: Is the 5th going to be here in this
16 building?
17 CHAIRMAN ENTHOVEN: As far as we know right now.
18 DR. KARPF: Are you going to attempt an executive
19 summary, Alain?
20 CHAIRMAN ENTHOVEN: We're doing an executive
21 summary. I'm going to attempt a Chairman's letter. I
22 think -- what I said earlier, I'm going to do a
23 Chairman's letters where I, you know, ramble on about
24 various things like uninsured and so forth.
25 MS. GRIFFITHS: Your dissent.
26 DR. KARPF: There is no dissent.
27 CHAIRMAN ENTHOVEN: Right now I'm not heading
28 that way.

DR. KARPF: I would anticipate a minimum number of minority reports at this point in time, if any.

(Whereupon the meeting adjourned at 5:05 p.m.)

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REPORTER'S CERTIFICATE

I hereby certify that the foregoing transcript, consisting of 371 pages, is a true and accurate transcription of my stenographic notes taken at the aforementioned time and place.

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Beverly D. Toms, CSR

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