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GEORGE HALVORSON:
Kaiser Permanente Leader and Health Care Advocate

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Interviews conducted by
Martin Meeker
in 2013 and 2014

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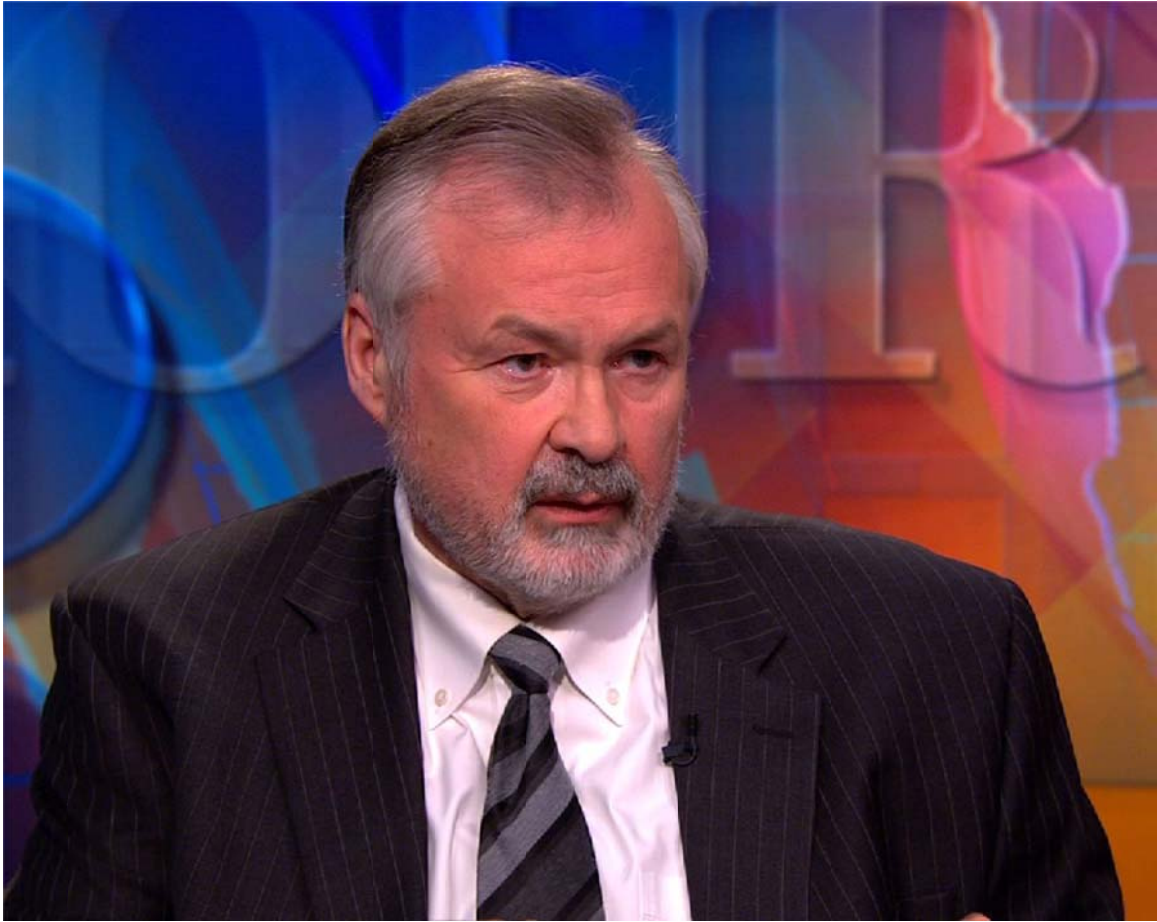
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George Halvorson on the PBS NewsHour, 2014

George Halvorson was born in January 1947 in Fargo, North Dakota, and raised nearby in Minnesota. He attended Concordia College while working as a local journalist. After graduating, he eventually made his way to Minneapolis, where he took a junior position at Blue Cross of Minnesota. He rose quickly in that organization, first building a new marketing program and then establishing a new managed care-based insurance product. He left Blue Cross after being denied the position of president but within a few years was hired to lead the Group Health Plan of Minnesota, one of the nation's founding health maintenance organizations. He facilitated a merger with MedCenters to form HealthPartners, and served as that organization's CEO until 2002. In 2002 he was hired as President, CEO, and Chairman of the Board for Kaiser Foundation Health Plan and Hospitals. He served in that role until his retirement in 2013. In this interview, Halvorson discusses the rise and transformation, successes and challenges of health maintenance organizations in the United States. He details his agenda as leader of Kaiser Permanente, with particular focus on developing a robust electronic medical record, improving quality, establishing good relations with the Permanente Medical Groups, and building a diverse and effective leadership team. He also discusses his thoughts on and roles in health care reform, public health initiatives internationally, and his lifelong interest in improving intergroup relations.

Table of Contents—George Halvorson

Foreword by Karen Ignagni	x
Interview 1: October 21, 2013	
File 1	1
<p>Family Background and upbringing – Childhood in Minnesota – Ethnic and sectarian differences in Minnesota – Family business – Parents work in education – Family’s involvement in civic affairs – Importance of honesty; lessons from parents and from professional life – Politics – Participation in athletics – High school, academics, poetry, and journalism – Attending Concordia College in Moorhead, Minnesota – Travel as a youth – Graduation in 1968 – Publishing a literary magazine in college – Pregnancy of wife – Internship with the <i>Wall Street Journal</i> – Considering attending graduate school – Accepting a position as assistant director public relations for Blue Cross of Minnesota – The health care landscape in the early 1970s, knowledge of health care economics – Assignment to learn political campaigns, and strategy</p>	
File 2	22
<p>Establishing a new marketing and public relations plan for Blue Cross – Getting earned media coverage – Promotion to corporate planner for Blue Cross – Recommendation to establish a health maintenance organization (HMO) – Becoming an executive at a young age, being a “change agent,” varieties of radicalism</p>	
Interview 2: November 20, 2013	
File 3	28
<p>Assassination of President Kennedy, the Civil Rights Movement, America in the 1960s – Recruiting, hiring, and promoting women and minorities – Fitting an HMO into the Blue Cross indemnity insurance framework – Difficulty in getting the HMO plan established – Competition with the Group Health plan in Minneapolis; the Mayo Clinic model – Becoming executive director of the new Blue Cross HMO: Minnesota Health Maintenance Network Plan (MHMNP) – On Paul Ellwood and the rise of HMOs; capitated payment systems – Rationing of care – Establishment of the National Committee for Quality Assurance (NCQA); struggle to get good data on quality outcomes – Beginnings of the Healthcare Effectiveness Data and Information Set (HEDIS) – Developing quality measurements: reducing the number of pre-term births – Response to MHMNP by Blue Cross executives and actuaries – Return to sales and marketing on the indemnity side of Blue Cross – Finalist to be CEO of Blue Cross / Blue Shield of Minnesota; selection of another candidate</p>	

File 4

48

Decision to leave Blue Cross / Blue Shield – Becoming CEO of a new program, Senior Health Plan of Minnesota – Negotiating the first capitation plan for seniors in the United States; later becomes Medicare Advantage – Role of Paul Ellwood and the Health Care Finance Administration (HCFA) – Establishing HMOs around the United States and Jamaica; perspective of the Reagan Administration – Being courted to be CEO of Group Health – Becoming CEO of Group Health; agenda to improve the plan – Developing a strong provider network – Building an electronic medical record – Hiring and retaining quality physicians – Sales and marketing at Group Health; employers as customers – Group Health merger with MedCenters to create HealthPartners – Institute for Clinical Systems Integration (ICSI) and the creation of medical protocols – Influence of W. Edwards Deming – On being the CEO of a staff-model HMO – Business Healthcare Action Group and employer group consumers of insurance

Interview 3: January 30, 2014

File 5

70

Health care quality measurements – More on ICSI and HEDIS – Issuing quality awards to clinics based on performance data – Resistance to quality measurements – Improvement of quality measurements over time – Shared learning and quality improvement – Impact of NCQA on the legitimacy of quality measurements – Use of quality measurements by employers and individual consumers – National health care reform; President Clinton and Hillary Clinton; *Strong Medicine* (1993) – Health systems approach versus an insurance approach; managed competition – Affordable Care Act (2010) “shalls” and Accountable Care Organizations – *Don't Let Healthcare Bankrupt America* (2013) – Health care purchasers and pricing – Relationship between cost and quality – Differences between the United States and Canadian health care systems – More on health care reform in 1993, role of Ira Magaziner

File 6

88

Failure of health care reform under President Clinton – Health care reform in Minnesota; MinnesotaCare (1992); reduction of uninsured in Minnesota; new tax – Concerns about adverse selection among the newly insured – Managed care crisis of the 1990s: Group Health Association of America and non-profit HMOs; rise of for-profit HMOs, Preferred Provider Organizations (PPOs), and competition – Backlash against HMOs, rationing care, and negative media coverage – Media coverage of HealthPartners; HealthPartners as a consumer governed co-op – Non-profit versus for-profit managed care organizations – Rational limiting of care versus problematic rationing of care; reengineer rather than ration; end-of-life care – Communications and public relations strategies

File 7

102

Development of an electronic medical record (EMR) at Senior Health Plan and HealthPartners; Dr. Jerome Hilger and John Alden – Generating physician support for the EMR – Electronic medical records versus electronic claims systems – Apple Macintosh – Functionality of HealthPartners EMR; use of EMR data by researchers – Computers in the exam room – Uganda health co-op: setting up an EMR; background on the Uganda health co-op; importance of hiring local staff for clinics; prepayment risk pools – Lessons from setting up a clinic in Jamaica – More on claims systems and EMRs in Uganda; family identification cards – Lessons from Uganda for the United States

Interview 4: February 2, 2014

File 8

120

Research into intergroup relations and conflict; defining “tribe” and “us/them” thinking; studies of sociobiology and Jungian psychoanalysis – Instinct and change; a theory of “enlightened instinctualism” – Application of these ideas to the creation of Americas Health Insurance Plans (AHIP) from a merger – Critique of social construction theorists – Managing instincts in an organizational setting – Thoughts on engineering the merger between Group Health and MedCenters – Cultural differences within HealthPartners; looking at differences within Kaiser Permanente from the outside – Challenges faced by Kaiser Permanente in the 1990s – Recruitment to be CEO, President, and Chair of Kaiser Foundation Health Plan and Hospitals – Difference in scale between HealthPartners and Kaiser Permanente

File 9

136

Meeting with the search committee at Kaiser Permanente – Departure from HealthPartners, Mary Brainard becomes CEO – Succession planning – Process of learning about Kaiser Permanente from the inside; the IBM-based EMR under construction; declaration to build a state-of-the-art EMR – Redesigning the EMR, hiring of Louise Liang, and assignment of Andy Wiesenthal; selection of Epic Systems to build the new EMR – Judy Faulkner and Epic – Role of the medical groups in selecting Epic – Implementing Epic in the Colorado region – Halvorson’s first staff memo as CEO – Reorganizing the senior leadership team – Creating parallel relationships between regional presidents and medical directors – Dr. Jay Crosson; Bernard Tyson – Dealing with regional autonomy and federalism in Kaiser Permanente – Regional versus national brand identity; the “Thrive” campaign; unique message of “Thrive” – Executive retreat and “us/them” thinking; creation of “unit-based teams”; integrating health plan, hospital, and medical group staff; and establishing best practices – Dealing with cynicism and resistance

Interview 5: February 12, 2014

File 10

154

The “pathway” or “fishbone” chart of goals: brand, credibility, systems, finances, customer service – Teaching interrelationship of main action areas; implementing continuous improvement practices; overcoming “silo-ed” thinking – Different silos within Kaiser Permanente – Bringing about practical and bureaucratic change versus cultural change – Importance of celebrating “wins” – Care Management Institute and instituting best practices – External threats and fears – Introduction of new products, including high deductible plans; business realities, risk pools, and actuarial death spirals – Influence of high deductible products on health care delivery – Problems with the capitated financing model – On charisma – Working with Jay Crosson and the Permanente Federation; importance of complete honesty – Kaiser Permanente as a “care system” rather than an insurance company – Working with Dr. Robbie Pearl, and regional versus national issues

File 11

171

Working with Jay Crosson on the Kaiser Permanente leadership group – Dr. Jack Cochrane and the Permanente Federation after Crosson – Developing a five-year strategic plan, revised annually – Recruiting new board directors – Strategic plan wallet card – Growth for a non-profit corporation; achieving the bottom line; quality metrics; community benefit; industry leadership; capacity building; clinical efficiency; labor-management partnership; “create massive external public credibility” – More on recruiting new board directors; importance of diversity; board committees; board meetings; celebrating achievements and dealing with challenging situations; establishing budgetary priorities – HealthConnect, Kaiser Permanente’s EMR

File 12

186

History as an asset; Dr. Sidney Garfield – Institutional engagement with its history – The burden of history; the “dead puppy” story – The “Be Well” letters; celebrating achievements; engagement with leaders beyond Kaiser Permanente – Learning about innovation throughout the large Kaiser Permanente system – Dealing with difficult issues; palliative care; personal issues – Challenge of institutionalizing innovation – Travel to conferences; learning from the field – “De-productizing innovation,” patents, and protocols

Interview 6: March 13, 2014

File 13

199

Labor Management Partnership (LMP) – Dealing with labor negotiations – Linking labor and quality – Betty Bernardzik, Leslie Margolin – Renewal of the

LMP agreement in 2005, improving processes, and team-based care; example of a functioning care delivery team – Health care reform in the 2000s; origins of MinnesotaCare (1992) in the 1990s – Presenting reform plan in “A Proposal to Cover the Uninsured in California,” *Health Affairs* (2007); role of individual and employer mandates; soft versus absolute mandates; comparison of proposed plan with the Massachusetts plan; the politics of the plan, and its failure to pass; provision of primary care versus coverage for catastrophic events

File 14

213

Kaiser Permanente’s position on health care reform – Thoughts on the passage and content of the Affordable Care Act (ACA) in contrast to the Clinton plan – Origin of ideas in the ACA: *Healthcare Will Not Reform Itself* (2009) and Commonwealth Fund’s Commission on the High Performance Healthcare System; drafting the commission reports – Politics and the work of the commission – White House meeting in May 2009, “a watershed event” bringing together the major stakeholders – The ACA, projected savings, and the Congressional Budget Office – Meeting President Obama – Heading a coalition of health industry leaders; attempt to bring cost-savings to the ACA – Working with congressional staffers; role of Kaiser Permanente – Exchanges – Regrets about the final enacted ACA; accountable care organizations; changing cash flow and purchasing – More on Medicare Advantage – Thoughts on the “public option” – Most influential people in health care

File 15

230

Implementation of the ACA by Kaiser Permanente; challenges and opportunities – Implementing Kaiser Permanente HealthConnect EMR – Deficiencies in the legacy software – Selecting Epic as the vendor – From EMR to a “paperless health system” – Health Information Management Society – Constituent parts of HealthConnect – Research and data – Diversity and culturally-competent care; health care disparities; data on race and ethnicity – Increasing diversity at the executive level – Growth among Asian-American members – Experiencing a heart attack at the age of 59; governance and planning; rehabilitation and writing the book on Uganda – Thoughts on work and retirement

File 16

245

Innovation at Kaiser Permanente; Sidney Garfield Center for Innovation; on not patenting inventions – Connection between Kaiser Permanente and the technology industry – Selling the Ohio region; growth in other regions – Health care affordability; low- and high-deductible plans – Final thoughts

Foreword

George Halvorson has led an extraordinary life that is filled with accomplishment, introspection and leadership. These tapes beautifully capture what he did, but what's especially riveting is how he did it. In listening to the complete set, you come away with nothing but admiration for the sheer magnitude of what this curious, big thinking, self-aware but personally modest man has accomplished.

I've known George for approximately 25 years and believe leaders from different stakeholder communities will find these interviews both inspiring and challenging. While all of us know how successful George has been, these interviews explain how his career unfolded, what drove him, and how he created the circumstances that allowed him to lead very different organizations.

As listeners, we have a front row seat for his thought process, his choices and his perseverance. We learn what a formative experience it was for George not to become the CEO of Blue Cross and Blue Shield of Minnesota, how it made him available for the leadership role at HealthPartners, and how he forged new relationships with physician groups and hospitals long before health policy leaders were suggesting this was the path to the future.

We learn how George worked with Key employers in Minnesota to attack rising healthcare costs, create product transparency and pave the way for a pathbreaking buying cooperative. At the same time, we learn how a busy and successful executive constructed and implemented a plan to bring healthcare coverage to the people of Uganda and teach leaders from the World Bank how to achieve that objective efficiently and effectively.

Even though I had the pleasure of watching George's transition to Kaiser Permanente, I enjoyed listening to him describe why he made the change and what he set out to accomplish in that key delivery system. At that point in their careers many CEOs might have chosen to simply enjoy the ride. Not George Halvorson. He chose to make Kaiser a leader on safety long before it was top of mind for others in large health systems. We learn about his quest to attack sepsis and reorient his hospitals' processes to make that possible. We also learn about what it took to form a strong partnership with the Permanente medical group and exactly what made that work over time.

But that's not all. George was a leader in helping to pass the Affordable Care Act. Here he gives us an inside look at what that responsibility meant to him and how it impacted the country. George has been an actor on the national stage, but what is particularly fascinating is his ability to explain what he was thinking, why and how that crafted his strategy. As a listener, you are transported back in time as he recounts his experience.

George's introspection as a prolific author makes him a skilled raconteur. You root for him, you admire him and you are delighted that you listened. Many CEOs have experiences worth sharing but few have the ability to teach. George Halvorson has that gift, and these tapes make it possible for us to learn, to admire and to respect this unique individual who dared to dream and had the courage and skills to lead.

Karen Ignagni, 8 February 2016

Interview 1: October 21, 2013

Audio File 1

01-00:00:04

Meeker: Today is the October 21, 2013. My name is Martin Meeker, and we are here today with George Halvorson, recently retired as CEO of Kaiser Foundation Health Plan and Hospitals, probably the best way to describe it, and currently Chair of the Board of Directors. This is interview number one, and the way we always get started is just to ask you to tell me when and where you were born.

01-00:00:56

Halvorson: I was born in Fargo, North Dakota, and my father was a student at Concordia College, in Moorhead, Minnesota. He was a World War II vet who had returned from war, gotten married, and my mother went into labor on campus and ended up going to the local hospital across the river to be delivered. A week ago, I received an award from the college, an achievement award, and was able to go to the microphone and say to the people in the room, "On a cold winter's day in January of 1947, my mother went into labor 250 yards from this microphone." [laughter] So, it was kind of fun, yeah.

01-00:1:51

Meeker: What year was this?

01-00:01:53

Halvorson: Forty-seven, 1947.

01-00:01:58

Meeker: You are a young man to be retiring as CEO of a big company.

01-00:02:01

Halvorson: I'm not retiring.

01-00:02:02

Meeker: OK, moving on to different pursuits, then, I guess.

01-00:02:08

Halvorson: Right. I think that what I've done at KP has been training for what I'm going to be doing now.

01-00:02:13

Meeker: Good. We will definitely spend some time getting there, but I think that's going to be a few hours away from where we are right now. So, Halvorson, Fargo, North Dakota—

01-00:02:26

Halvorson: Minnesota people.

01-00:02:28

Meeker: Minnesota people, yes. This background is Scandinavian, correct?

- 01-00:02:35
Halvorson: Scandinavian, yes. Norwegian, Swedish, Danish, Dutch.
- 01-00:02:41
Meeker: How would you trace your family lineage back? I know that there's mother's side and father's side, but how does your family talk about its origins?
- 01-00:02:52
Halvorson: Scandinavian. We actually were Swedish, Danish, Norwegian. The Halvorson is a Norwegian name [Halvorsen], but it has the Swedish spelling. The reason it has the Swedish spelling is that my grandfather, a Norwegian, fell in love with a Swedish girl, and the family wouldn't allow him to marry her until he changed the spelling of the name to a Swedish name so they wouldn't be embarrassed back in Sweden.
- 01-00:03:21
Meeker: No kidding.
- 01-00:03:22
Halvorson: No kidding, so he always says, "I gave up the 'e' for love."
- 01-00:03:27
Meeker: That's cute. Did they reside in Fargo?
- 01-00:03:31
Halvorson: Northern Minnesota. No one ever lives in Fargo; it's just like the movie *Fargo*, no part of that movie is in Fargo. We never lived in Fargo. I was in Fargo very briefly because my mother crossed to a Fargo hospital to give birth.
- 01-00:03:45
Meeker: Sure, Moorhead's right across the Red River.
- 01-00:03:46
Halvorson: Moorhead is right across the river. It's a Twin City situation.
- 01-00:03:51
Meeker: So, where in Minnesota did your family settle?
- 01-00:03:54
Halvorson: Northern Minnesota, by Park Rapids, Wadena, Sebeka, most of the settlers in that area were Finnish, actually. They refer to that as the Finnish Triangle, those towns.
- 01-00:04:08
Meeker: So, you had mentioned there was some embarrassment about a Norwegian name and a Swedish family, rather, was this typical of the different immigrants' families in Minnesota during that era?

01-00:04:27

Halvorson:

Yeah, one of the reasons that I'm writing books right now and setting up an institute to deal with interethnic issues is because interethnic issues were extremely clear to me in my youth. If you ever listen to Garrison Keillor in Lake Wobegon ["A Prairie Home Companion"] and you hear about the Lutheran church and the Catholic Church and that, those were all very true differentiations. They happened. So, we were from a Scandinavian family. There were many Finnish people in the community; there were lines and political battles and turf issues. I lived in a town that had 800 people, and the town was split between Finn Town and the rest of the town, to some degree. A number of the schoolchildren came to school speaking Finn as their first language. So, I was very aware of those issues at a very early age.

01-00:05:32

Meeker:

Aside from the language differences, even though I imagine this common second language, or the common first language would have been English, what were some of the cultural differences that you experienced or you were told by your parents and grandparents that existed between Danes and Swedes and Finns and Norwegians?

01-00:05:54

Halvorson:

Almost no cultural differences—tribal differences. People felt aligned with a different group, but they all spoke English, they all shopped in the same stores, they basically did the same work. So, the differences were ethnic, but they weren't behavioral. So, everybody was Christian, a mixture of Catholic and various sects of Lutheran, and the churches each had an ethnic origin. So, the Swedish Lutheran, Norwegian Lutheran, and English Lutheran, but this was a stage in American history when people weren't particularly tied to the old cultures. There were some ties to the old identities, but in my particular case, it was hard to be tied to any particular identity because my grandparents had very mixed backgrounds. Some of my grandparents were English, I had French Canadian, American Indian, Swedish, Danish, Norwegian, basically seven different ethnic groups in my past.

01-00:07:14

Meeker:

It sounds similar to the way in which historians talk about the creation of an Italian identity, and they say that in Italy, no such thing really existed, right? You were Sicilian or you were from Tuscany, but you weren't Italian. The Italian identity was created by Italian immigrants in the United States once the Italian families arrived, or rather, once the Sicilian and Tuscan families arrived, then they were considered Italian by their Irish neighbors, right? Is this something similar, do you think, that happens with, say, Scandinavian immigrants in the upper Midwest?

01-00:07:53

Halvorson:

Actually, people didn't identify themselves as Scandinavian. No. People identified themselves as being American. The differentiations were American,

white, Indian, black, Mexican, but not Scandinavian. That was largely irrelevant.

01-00:08:16

Meeker: This was your experience growing up in Minnesota?

01-00:08:19

Halvorson: Yep, yep.

01-00:08:23

Meeker: I imagine that probably in the time in which you were growing up, the 1950s, early 1960s, there wouldn't have been a lot of immigrants from Mexico, probably not a whole lot of African Americans outside of the Twin Cities, but I imagine particularly in the rural areas, there were quite a few Native Americans. Then, of course, the different white ethnicities. Is that how you experienced difference? What was your earliest understanding of difference?

01-00:08:52

Halvorson: Well, the differences primarily were Lutheran/Catholic. The other differences were, in my particular town, there were some American Indians, there were the Finnish population that tended to stay within the Finnish population, Finns married Finns, and then everybody else was American/White. So, everybody else intermarried without any issues by that point in history.

01-00:09:26

Meeker: So, that was the sensibility that you were raised with, was that you were American, regardless of the real heritage that you came from.

01-00:09:32

Halvorson: Right. We weren't that far from the Red River Valley, and the Red River Valley had large numbers of migrant workers from Mexico. Many times I saw the shanties, in effect, of the migrant workers that were set up along the edge of the Sugar Beet fields.

01-00:09:56

Meeker: Seasonal workers who had come in for harvest?

01-00:09:57

Halvorson: Seasonal workers who would come in for part of the year, harvest, plant, and they leave.

01-00:10:03

Meeker: Your grandparents' generation, were they farmers, or what kind of work were they doing?

01-00:10:09

Halvorson: Farmers and businesspeople. Both of my grand-fathers ran businesses. My grandfather Halvorson was a carpenter and owned several restaurants, Grandpa Paulson, Walter Paulson, ran many businesses. He quit school when he was fourteen, went to work in a lathe mill and by the time he was eighteen,

he owned the mill. Then, he owned a lumber camp and he ran several lumber camps, and then he owned a number of other businesses—car sales, car lot, that type of thing. So, I grew up with basically people upstream from me ancestrally who were running various kinds of businesses.

01-00:11:05

Meeker: More townspeople, I guess, less rural.

01-00:11:07

Halvorson: More townspeople, yeah. My father was a schoolteacher, but he also, when I was born, he was running restaurants. He and I at one point in time owned a restaurant together. So, the business side of the family, were, actually, CEOs going back for three generations, in a small town setting.

01-00:11:36

Meeker: What kind of restaurants were these? I'm curious.

01-00:11:39

Halvorson: Classic small town hamburgers, chicken, that type of thing.

01-00:11:44

Meeker: Donuts?

01-00:11:45

Halvorson: Donuts and bread, yeah.

01-00:11:48

Meeker: Where working men would go have kind of greasy spoon breakfast, sort of thing?

01-00:11:52

Halvorson: Yeah. Farmers, actually. Small-town farmers would come to town for food and then the people who worked in the town would have breakfast there.

01-00:12:02

Meeker: You said your father was a schoolteacher: did he have a college education?

01-00:12:06

Halvorson: Yeah.

01-00:12:07

Meeker: He did?

01-00:12:07

Halvorson: I was actually born on campus.

01-00:12:09

Meeker: Oh, that's right. OK.

01-00:12:10

Halvorson: Yes, he was a Concordia graduate.

01-00:12:16

Meeker: What year was he born, do you recall?

01-00:12:19

Halvorson: No, do not know.

01-00:12:22

Meeker: I assume he was probably in his later twenties?

01-00:12:25

Halvorson: He was in his teens when he was in World War II, late teens. He was Second Marine Division, fought in Tarawa, Saipan, Okinawa, had some challenging combat background. Came back to the US, married my mother, and started a family. He went to school.

01-00:12:46

Meeker: Had they met?

01-00:12:47

Halvorson: No, they knew each other. They were high school sweethearts. High school sweethearts, then they married after the Marines, and the first thing they did was run a restaurant. Then they decided to go to college. Then, for a number of years, he was a high school principal. He went directly from college to being principal, in two towns in North Dakota. He wanted to get back to my hometown of Menahga, Minnesota, so when an opening happened there in the school, he applied for it and got the job, and so he stopped being a principal and went back to being a straight teacher.

01-00:13:37

Meeker: What subjects did he teach?

01-00:13:38

Halvorson: Business, actually. Taught business classes, primarily. My mother also became a schoolteacher and taught English, and she was a librarian.

01-00:13:58

Meeker: Was she enrolled in Concordia when you were conceived?

01-00:14:03

Halvorson: No. No, no. Mother didn't go back to college, or didn't start college, until I graduated from college. After I graduated, she went to college and she ended up with a couple of bachelor's degrees and a couple of master's.

01-00:14:25

Meeker: No kidding.

01-00:14:27

Halvorson: Yes, so, a lot of education.

- 01-00:14:29
Meeker: So, here you have your father is a schoolteacher and later a principal, your mother was a librarian—
- 01-00:14:34
Halvorson: No, he was principal, then a schoolteacher.
- 01-00:14:36
Meeker: OK, that's right, that's an interesting transition.
- 01-00:14:38
Halvorson: It is, isn't it?
- 01-00:14:41
Meeker: I can actually see it, though. Teaching, I imagine, would be a lot more fulfilling and sustaining, perhaps.
- 01-00:14:46
Halvorson: Every time they had a contest for best teacher, he won. He also coached.
- 01-00:14:50
Meeker: So, it's something that he loved.
- 01-00:14:52
Halvorson: Yes, and he also coached. He loved coaching, and he won a couple of championships, both boys and girls teams. So, really, coaching and sports were important to him. He was an avid hunter, he loved to hunt. So, he and I spent many, many, many hours hunting.
- 01-00:15:15
Meeker: So, your father's an educator, your mother also was a librarian and then later on taught, is that correct?
- 01-00:15:22
Halvorson: Well, she went back to college after I graduated and then became an English teacher and then became an English teacher and then became a librarian, and was librarian until she retired. At one point, she was the head of the state library association.
- 01-00:15:43
Meeker: What this says to me is that education must have been an important value that your parents instilled in you?
- 01-00:15:53
Halvorson: Yes, it was absolutely a given. There was never a question about any issue relatively to education. It was the right thing to do and my parents enjoyed education and enjoyed being educated.
- 01-00:16:10
Meeker: Did you have siblings?

- 01-00:16:11
Halvorson: Two sisters.
- 01-00:16:13
Meeker: Where did you fit within the run?
- 01-00:16:15
Halvorson: I was the oldest.
- 01-00:16:19
Meeker: Did your parents feel about education the same way for your sisters as they did for you?
- 01-00:16:29
Halvorson: They did, but my sisters didn't feel as fond of education. [laughter] So, they both went off to school and both ended up going down different paths and doing different things. One of my sisters has run several companies in multiple fields. She's run human potential development companies, she's run manufacturing, she, for a while, ran a company that used enzymes to clean oil storage tanks. It's an interesting background. Literally, the family has many people who have been in the business world who have enjoyed running businesses, and even when my father retired from being a schoolteacher, he took over a restaurant, motel, little apartment complex and ran that until he had a heart attack and died.
- 01-00:7:31
Meeker: Do you ever think about what kind of qualities within your family amongst your relatives contributed to their desire to do this kind of work, meaning management, or perhaps running small companies? What allowed them to be successful about that?
- 01-00:17:52
Halvorson: Well, they're all people-persons. Each of them was good at working with people and getting people to do things. Both my grandfather and my father were also mayor.
- 01-00:18:08
Meeker: Oh, really?
- 01-00:18:10
Halvorson: Yeah. My mother was deputy mayor. One of my father's—in his third term as mayor, he didn't run, and the town elected him on a write-in. My mother one year had the highest victory total of any candidate, as a percentage, in a contested election in the State of Minnesota. So, people liked them, they liked people, and they're good with people.
- 01-00:18:43
Meeker: One of the things I read, I believe, as maybe a commencement address or another address that you gave at Concordia, you talked about some of your key values. The first one that really stands out and you speak about it in very

unequivocal terms, and that is honesty. That's something maybe that we don't find in a lot of our elected officials, or perhaps even a lot of our CEOs, these days. Is this something perhaps that's quite related to the success of your progenitors in either being mayor or heading up small companies?

01-00:19:22

Halvorson:

I can't imagine my father, my mother, or either of my grandfathers saying anything that wasn't true. I can't imagine it. Maybe if their life was at stake or some horrendous situation, but in terms of the way they chose to interact with the world, it was just honesty just a core expectation.

01-00:19:58

Meeker:

Is this something that they taught to you very specifically?

01-00:20:01

Halvorson:

They modeled it. I got to be relatively good in some cases of not revealing everything. When I started in a little bit of teenage drinking, I was careful not to put myself in a position where I'd have to deny anything, but if I would have been asked, "Are you drinking," the answer I would have said, "yes." It makes life much easier, it really does, because you don't have to remember what you said to anyone and people will trust you and work with you at a different level if they know they can absolutely trust you. I've done that with politicians, I've done that with coworkers, there are people that I advise in government or in Washington who know that if they ask me to keep a secret, I will keep a secret, but if they need advice that I'm going to give them, it's going to be honest advice. There's a great value to that because you're more likely to be trusted and worked with. I've had the same practice; I've now been CEO of six different companies, I've been CEO now for basically over three decades, of one place or another, going back to running the first HMO for the Blue Cross plan and being executive director. I've been CEO of a number of companies, and I've started the CEO process for those companies by sitting down—including Kaiser Permanente—with the executive staff and saying, "I will fire anyone who lies to me. Anyone in this room," I sat down with executive staff, "If someone says something to me that is not true, and if you know it's not true," I said, "I am totally understanding if you're accidentally wrong, I'm wrong all the time. It happens. But if you lie to me, you're gone. Because I need to trust everything you tell me. I need to be able to take anything you tell me and use it with the world, use it with the board, use it with anyplace. So, I need to have complete and total trust in you. So you can't lie to me and I will not have a place for anybody who lies." I have fired people, a number of people, for lying. It's a serious, unforgivable sin. I may not have fired them in that moment of that lie because it may be inconvenient or have other downsides to it, but I will fire people very quickly and I have fired people in a number of settings, and there have been people who deliberately misled me that have gone. I made that clear at KP when Dr. Jay Crosson did a magnificent thing, putting me in a room with the medical leaders when I first arrived at KP. There was no one else in the room except us and the medical directors, and I said, "You need to know a couple of things

about me, and one of them is I will not lie to you. You can ask me any question,” and I said, “there’s some questions I might resent, so don’t get too personal, but you can absolutely count on me not lying to you. And if any one of my staff lies to you, I will fire them. So, as of this moment, you know that anything you hear from anyone on my team is true or they believe it to be true. If you in any way think that somebody has lied, and I’ve made it very clear to my staff that they cannot lie to you, they cannot lie to me, they cannot lie to the board. Just lying is not a part of our culture anymore.”

01-00:24:14

Meeker:

In your years as being CEOs of six different organizations, have you found lying to really be—

01-00:24:21

Halvorson:

Oh, yeah. There are some people who lie. There’s some people that lie. There are some people who will say, “I will do X, Y, or Z,” and intentionally never intend to do it. I had a guy come into my office and told me that he had closed a deal with a major group in Minnesota, I talked to the group and I discovered that he’d made some progress with the group but he hadn’t closed the deal. So, I talked to him directly and said, “Tell me, is that company sold?” “Oh, absolutely,” he said. “I got it. It’s in the bag, totally.” I said, “Really sold?” “Yup.” “You’re fired. You’re gone. I happen to know that’s not true, so go work with HR right now, clean out your stuff, you’re gone.” I couldn’t trust him. From that point on, I couldn’t trust him.

01-00:25:16

Meeker:

I imagine after a while, your reputation probably precedes you.

01-00:25:21

Halvorson:

People understand that to be the culture, yes. I also say to our staff, “You can never, ever, ever lie to the board.” Many companies lie to their boards. The number of companies that lie to their boards at some level is actually quite high, and the number of executive staffs who lie to their board is actually too high. I made it very clear that would not happen on my watch.

01-00:25:42

Meeker:

Well, you see that in Enron and that’s just maybe one of the most extreme recent examples, right? It can get companies in very bad situations. So, backing up a little bit, you had mentioned that your family members had been leaders in the small town, serving mayors, your mom was deputy mayor: did your family have a strong sort of political ideology? Were they strongly associated with one party or another, or did they have a real strong belief system when it comes to politics?

01-00:26:17

Halvorson:

My mother was state chairwoman for the Republican candidate for governor, and my father was the chief of staff to the Minnesota Republican Party for a couple of years. So, they were Rockefeller Republicans, would be the brand.

01-00:26:39

Meeker:

Moderate Republicans, quite different than perhaps the party today. What were the values that were associated with that Rockefeller Republicanism, if you will?

01-00:26:57

Halvorson:

Progressive, enlightened Republican. I had a couple of uncles who were union leaders and fairly liberal in many ways, and we had some magnificent debates over dinner tables at home about the various political positions that people had. One of the things that I enjoyed was the fact that we had those discussions and those debates, and we had a great passion on the topic, but absolutely no personal animosity involved in the process. So, we were blessed to have that. When I was in high school, I actually was the chair of the Teenage Republicans for the county I was in. Then, I went off to college, became much more liberal, and I actually campaigned for Gene McCarthy and did some work on the more liberal side of the agenda.

01-00:28:02

Meeker:

That would have been '68, is that right?

01-00:28:04

Halvorson:

Yes.

01-00:28:09

Meeker:

Of course, during that period of time, the Republican Party changes quite a bit, right?

01-00:28:14

Halvorson:

Yes. I actually wasn't paying that much attention to what the party changed. I just had a sense of what my own beliefs were, and they tended to line up a little more to the left of that agenda.

01-00:28:29

Meeker:

Did the war have anything to do with your change of ideas?

01-00:28:34

Halvorson:

It probably did. When I was a freshman, I volunteered for the Marine Platoon Corps Leader program, and I failed the physical because I had really bad knees from high school football. I spent six years on crutches. Every year, I went out for football. I played quarterback. I loved playing football. Every year, I got injured and ended up spending the winter on crutches. So, I spent pretty much every Thanksgiving in my youth was spent on crutches.

01-00:29:05

Meeker:

No kidding.

01-00:29:09

Halvorson:

Yeah, which is silly. I had very bad knees and should never have been playing, but I would wear weights and do exercises, and I was fast. I ran the

100 and 220, and was the conference champion, my senior year, in the 220 and the 100. I loved to run but I really loved the game of football.

01-00:29:40

Meeker: What position did you play?

01-00:29:41

Halvorson: Quarterback. I loved throwing footballs. I've thrown thousands of footballs. I have five sons, and four of them have caught untold number of footballs. Even the younger two have caught a thousand balls each. When they were tiny, I'd have them run patterns in the living room. {laughter}

01-00:30:09

Meeker: No broken lamps, I hope.

01-00:30:11

Halvorson: A few, occasionally. But they have great hands. They really have good hands.

01-00:30:20

Meeker: Good, well, that comes from good training from young, I guess.

01-00:30:22

Halvorson: Lots of practice, yeah.

01-00:30:24

Meeker: What town was it that you were raised in?

01-00:30:26

Halvorson: Menahga, Minnesota, M-E-N-A-H-G-A.

01-00:30:36

Meeker: Were you there throughout your high school years? Did your family move at all?

01-00:30:41

Halvorson: Yes. Well, actually, the family moved there when I was in fourth grade. So, I was there fourth grade through senior year.

01-00:30:53

Meeker: What high school did you go to?

01-00:30:55

Halvorson: Menahga.

01-00:30:56

Meeker: Menahga, OK, it was just Menahga High School. What was the population there?

01-00:30:59

Halvorson: Eight-hundred-and-twenty-five, when I was in school.

01-00:31:03
Meeker: I assume the high school would have been the town plus country around it.

01-00:31:06
Halvorson: Plus country. About 50-50 country kids, town kids.

01-00:31:12
Meeker: Did you start to develop any particular interest in the academic subjects in high school? Did you have any teachers that were particularly influential to you?

01-00:31:23
Halvorson: English and history, I was quite fond of both of them. I actually did a lot of writing, I wrote a lot of poetry. Did some creative writing. I also worked for the town newspaper as a reporter, and I edited the school paper. So, I was a school paper editor and annual, editor of the annual. I'd been a writer my entire life.

01-00:32:00
Meeker: Then, so, in high school, I know that you later on developed an interest in journalism; sounds like that got its start in high school.

01-00:32:10
Halvorson: Yeah, I actually worked for the local paper and I ended up working for the local paper because I wrote some sports articles for the school paper, and the guy who was the local publisher said, "Hey, how would you like to cover some other sporting things for us?" So, I actually had a press pass when I was seventeen. That was actually very useful. I'd use it for a couple of years to get into different events.

01-00:32:41
Meeker: So, what kind of events were you covering when you were a teenager?

01-00:32:45
Halvorson: Sports. Well, I wrote sports for the town paper.

01-00:32:50
Meeker: What sports did they cover?

01-00:32:53
Halvorson: Baseball, major sport, track.

01-00:32:58
Meeker: Did you have a minor league team nearby?

01-00:33:00
Halvorson: A town team. Every town in those days had a town team.

01-00:33:03
Meeker: OK, so there would have been a circuit, I guess, in the Northern Minnesota era?

- 01-00:33:06
Halvorson: Yes.
- 01-00:33:07
Meeker: All right. Did you ever travel around, following any of these teams?
- 01-00:33:11
Halvorson: No.
- 01-00:33:15
Meeker: What was it about journalism that attracted you? Was it stories, was it getting to witness and meet interesting people?
- 01-00:33:24
Halvorson: I wrote poetry before I wrote journalism. I started as a poet. I read a lot of poetry and memorized a lot of poetry. I wrote favorite poems and put them on the wall of my room. So, I started as a poet, but I've always just loved to write. So, the journalism just happened to be a way of writing that got things published.
- 01-00:33:59
Meeker: Easier than poetry, I'm guessing.
- 01-00:34:04
Halvorson: Poetry's pretty easy.
- 01-00:034:05
Meeker: But as far as getting it published?
- 01-00:34:06
Halvorson: But in getting published, yes, exactly.
- 01-00:34:09
Meeker: Were you more interested in lyric poetry, were you more interested in contemporary poetry, were there some poets that you were especially fond of in your setting?
- 01-00:34:17
Halvorson: Yeah, the usual. Dylan Thomas, Ferlinghetti.
- 01-00:34:24
Meeker: So, you were interested in the beat poets, then, and their predecessors, I guess? But the beat poets don't really come along until '57, '58.
- 01-00:34:29
Halvorson: Right. Yeah, but I read all the classics. I had a library. I bought poetry books all the time, so I had classic English poetry books, I had pick your poet, I kind of read them all, many of them. And Shakespeare, I bought the complete works of Shakespeare when I was in seventh grade and read that.
- 01-00:35:05
Meeker: Is this an interest that you still pursue to this day? Poetry?

01-00:35:08

Halvorson:

Oh, yeah. I stopped publishing poetry. I actually published poetry for a while, I published books in college, and I got hired by the local newspaper, The *Fargo Forum* hired me to be a reporter based on my poetry. They'd read some poems that I'd published in the college journal and the editor liked poetry, and had another reporter come talk to me, and then I ended up being hired to be a reporter. What they had me write initially was obituaries. So, the starting level for a reporter on a daily newspaper was obituaries. The nice thing about obituaries is you can do them in the evening, somewhat asynchronous sorts of things, but that's a very rigorous writing.

01-00:36:07

Meeker:

There's a story there, too.

01-00:36:08

Halvorson:

There's a story there, too. There's a story there and the writing's very rigorous because the family is completely and totally unforgiving if you make any error of any kind. You can't get an age wrong, you can't misspell someone's name. I had a woman call me up in tears because I'd ruined her life because I had spelled her name wrong on her sister's obituary, and now she told me her entire life, she would always—I said, "We're going to print a correction," and she said, "I do not want to tape a correction to that obituary." Anyway, I did obituaries and then I did headlines. Those were the days when you had UPS, AP writers, a couple of different wire services, and so the night editor would pull off a bunch of stories, hand me a stack of stories, and say, "Put headlines on these. This is two columns, three columns," would tell me how many columns I had to play with. So, I wrote a lot of headlines, which I really liked.

01-00:37:15

Meeker:

Did you? It's almost kind of like marketing the news, I guess?

01-00:37:19

Halvorson:

Yes, it is like marketing the news. It's figuring out what's the point in this thing? How do I draw people into this story? What's the in? The discipline, it's like haiku because you've got literally, if it's a twelve-point, three column headline, then you have eighteen characters to work with.

01-00:37:40

Meeker:

Do you remember what the biggest headline was that you had to write?

01-00:37:42

Halvorson:

No. No. The big headlines went to the senior editors. I got the wire copy stuff.

01-00:37:55

Meeker:

So, I read somewhere that there was little conversation with you and your parents about what college you were going to attend.

01-00:38:04

Halvorson:

That was just a given. Dad went to Concordia, my uncle went to Concordia, Dad loved that school and we went over and watched the football games

associated with Concordia, and so on. He was just not really open to another option.

01-00:38:24

Meeker: Did you have any desire, given your experiences, to perhaps spread your wings a little more broadly and fly elsewhere?

01-00:38:34

Halvorson: Well, I was a National Merit Scholar, and because I was a Merit Scholar, I had this large number of colleges write me letters, asking me if I would like to apply there. One of them was Harvard, they sent me a very nice letter saying, "Would you like to apply to Harvard?" They probably had a geographic gap or something in their system, but I had pretty good scores on the tests, and so, that was actually kind of tempting. I'd heard a lot of mention of Harvard in various settings, and that's why my father did the line that Concordia has quoted on occasion, that Concordia is the Harvard of the upper Midwest.

01-00:39:23

Meeker: Is that something that you would contest?

01-00:39:25

Halvorson: I had a magnificent education. I ended up with some professors who were really wonderful. I had a political science professor who was stunningly good, I had a religion professor who went on to become head of a couple of seminaries and he was wonderful. I had a speech professor who went on to be head of a college and brilliant. I just lucked out, having half a dozen really, really good professors. I had an economics professor who went on to run a health program to teach health administrators. So, people who were bright and practical and fun, and I just really liked the liberal arts education. So I think, actually, I was very well-served by that school and I had a good time. Because it was a small enough school, I wrote for the literary magazine, I did some intramural football, I was in some campus politics.

01-00:40:29

Meeker: I'm curious: the way that you had talked about Harvard and other locations, it seems like they were probably fairly remote in your mind, you didn't have a firsthand personal experience of any of these places. Did you travel much, as a young man?

01-00:40:45

Halvorson: As a family, we would take trips. So, we drove across the country and went to Oregon, went down to Mexico, crossed the country, came back. So, I did actually see the country going west, and then east, got into Illinois, Indiana. One of the things that my father would do, he was a schoolteacher in the winter, but in the summer, he was a sales manager for one of my grandfather's companies. That company sold potato combines. At one time, it was the largest manufacturer of potato combines in the world, Dahlman Manufacturing. My grandfather was the CEO and the owner. My father was a really good salesman, and so he sold a lot of potato combines. So, I actually

went on some trips with him out to farmland in Indiana and whatever. My traveling was totally by car. One of my uncles owned an airplane, it was a Piper Cub, so I flew in a Piper, but I was, I think, twenty years old before I was in a commercial airplane.

01-00:42:00

Meeker:

So, you did get to see some of the country. It sounds like you probably went to the Grand Canyon and those kinds of sites, perhaps, when you went on your family trips?

01-00:42:12

Halvorson:

Yes, we went to national parks, state parks, historical monuments, that type of thing.

01-00:42:20

Meeker:

I'm wondering about your college education. I know that you triple-majored, which is pretty rare then, as it is today, in history, English, political science

01-00:42:32

Halvorson:

And I did it in three years.

01-00:42:33

Meeker:

You did it in three years, so I guess you graduated in '68, so that means that you would have enrolled in—

01-00:42:40

Halvorson:

I should have been in the class of '69.

01-00:42:43

Meeker:

All right, so you enrolled in the beginning of '65, or fall of '65.

01-00:42:49

Halvorson:

So, all of my college reunions are wrong because all my friends were in the freshman class of '69.

01-00:42:59

Meeker:

There's a couple of questions. First of all, I'm curious about why you sped through it in three years. I'll let you think about that while you talk about your three majors and how it was that you decided you wanted to have such a broad area of education?

01-00:43:21

Halvorson:

I had one credit short of a minor in religion, as well. Just FYI, but yeah.

01-00:43:23

Meeker:

OK, so let's say four, almost, right.

01-00:43:38

Halvorson:

When I was a sophomore at Concordia, I published a literary magazine and took over as a good friend of mine gave up the editorship and she asked me if I would be editor. So, I took over the magazine, and I wrote in it because I

was the editor. I got to publish a lot of my own things. The newspaper, the *Forum*, read that magazine, as I said, and they hired me to be a reporter. So, I was reporting for the *Fargo Forum*. So, I was going to school full-time and I reported for the *Forum*. I was working basically a forty-hour week. I took a full-time job at the paper, putting out the night paper, and then I realized that if I took a couple of simultaneous classes at Moorhead State College, which was right across the cemetery from Concordia, I could skip an entire year of college. So, I took some day classes at Moorhead State, combined that with the Concordia classes, and I worked at night, and finished in three years. Why did I do that? Because I could, and because I couldn't see staying another year if I could get done there early. I mean, it just didn't make any sense to me to spend that year because I wanted to get the degree and I ended up with the degree.

01-00:45:22

Meeker:

What were you anxious to get out and do?

01-00:45:26

Halvorson:

Write, study. I loved to study, loved to write. University of Iowa had accepted me into the graduate program in writing, creative writing. That's a great program, the creative writing program at Iowa. They accepted me as a teaching fellow in that program. I submitted a bunch of my poetry there and they had liked it, so it was a good thing. I had a Concordia professor, Dr. Helen Sanders, who was very supportive of my writing and helped me get that job. I got married, and my wife became pregnant, and we decided that we couldn't afford to live on a grad student stipend, which was quite low. It would have been enough money for one person, but a little challenging for three. About that time, interestingly, the *Wall Street Journal* had a program that was a national internship program, and they took promising writers from small newspapers around the country and accepted them into this basically ninety-day *Wall Street Journal* residency program. So, I applied for that and got it, and the only actual journalism training I really have is from the *Journal*. I had my daily newspaper writing job, but I got that job as a poet.

01-00:47:22

Meeker:

Did it entail moving to New York?

01-00:47:24

Halvorson:

No. Actually, they had the program set up at Lincoln, Nebraska. They had editors at Lincoln, Nebraska and we put out a *Journal* every day. We put out a *Wall Street Journal* every day as a mock journal, and so, we got to think through what's in the journal, what are the pieces, write the headlines, do the layouts. I learned to do the page layouts and all of the makings of a paper. I have no idea why they had that program, but I loved it. It was really fun, and I had other people like me, who were from other small daily newspapers around the country, who all got together and learned. So, it was a fun group of people, and it was a fun, great teaching opportunity. It was a good credential. A couple of people from that program at that time are now senior editors for The

Wall Street Journal. So, I actually have a shared history. Sometimes, when I'm talking to those folks, we kid each other about whether or not it made more sense to stay with the *Journal* or go into healthcare career. I did the internship and then decided that I needed a job that had a better income, if I was going to produce offspring. So, I looked for a place that paid more money, and so I decided then to go to graduate school, to the University of Minnesota, and notified the Iowa folks. I asked them if they would suspend the teaching fellowship for a year and they said no, do it this year or you're out.

01-00:49:21

Meeker:

So, the program at the University of Minnesota, this is the Twin Cities campus, I'm guessing?

01-00:49:25

Halvorson:

Twin Cities campus, and I was going to do graduate school there.

01-00:49:29

Meeker:

In writing as well?

01-00:49:31

Halvorson:

Actually, I was going to do graduate school in political science. I thought I might enjoy government and I'd been doing some government writing at the newspaper. I applied for jobs at three different places, Control Data, Honeywell, and Blue Cross. I got all three jobs, and the Honeywell job was to be a production engineer trainee.

01-00:50:09

Meeker:

Meaning?

01-00:50:10

Halvorson:

Meaning that I would have helped engineer assembly lines. I'd had pretty good math scores on the math tests, and they were actually willing to hire me and teach me to be a production engineer. Control Data offered me a job as a tech writer for computer instruction manuals, which also would have been sort of interesting and it would have given me a whole new field.

01-00:50:41

Meeker:

And somewhat related to your field of writing, as well.

01-00:50:44

Halvorson:

Yeah, exactly. It was a writing thing. Then, at Blue Cross, I applied for the job at Blue Cross thinking that I was applying for an underwriter job, meaning assistant writer, and it turned out that underwriter meant it was more of an actuarial sort of thing. Just by coincidence, the day that I applied at Blue Cross for the underwriter job, the head of advertising and public relations had just gotten a requisition approved to hire an assistant. He looked at my background, having written for a daily newspaper and *Wall Street Journal* background, and decided that it made sense to give me that opportunity. So, he hired me as an assistant director for public relations advertising. At that

point in time, the Blue Cross plan had no PR program. They had an ad program, advertising, but they had no public relations.

01-00:51:52

Meeker: So, this is Blue Cross/Blue Shield of Minnesota, correct?

01-00:51:56

Halvorson: Right, and while I was back in college, I forgot to mention, I also started a PR firm. I had a little public relations firm on the side, and I did public relations for a couple of political candidates and for a small store, retail store. So, when I applied for Blue Cross job, I could show press releases that I'd done. I could show a little bit of a communications plan that I had put together, and so the hiring the guy thought, this will be a good fit. So, hired me into that job, and I had a good time. I put together Blue Cross publication, I put together press releases, and I basically created a communication plan for the Blues. The man who had hired me kept the advertising part of the agenda; he pretty much left the PR side to me.

01-00:52:57

Meeker: At this point in time, what year are we talking about, here? About 1970s, '69, something around there?

01-00:53:09

Halvorson: Sixty-nine. Yeah, '70, yeah.

01-00:53:07

Meeker: Also an interesting period in the history of healthcare in the United States. There's several competing movements towards healthcare reform, but I'm wondering before this point in time, when you get hired by Blue Cross/Blue Shield, were they combined in Minnesota as a single entity?

01-00:53:25

Halvorson: No, they were actually competing. It was Blue Cross was competing with Blue Shield, and I was there when the Blue Shield failed and Blue Cross took them over. So, I was part of the team, the occupation army that went over to Shield.

01-00:53:47

Meeker: This also happens a little bit later in your career as well, when Group Health of Minnesota takes over Med Centers.

01-00:53:54

Halvorson: What became HealthPartners actually had several antecedent companies, including Group Health and Med Centers. At Blue Cross/Blue Shield, I went through the merger of Cross and Shield, and I went through on behalf of the winning side.

01-00:54:14

Meeker: So, before 1969, you're still a very young man. You're, what, twenty-two years old at this point? At any point in your career as a journalist or in your

education, did you get much education about healthcare delivery systems in the United States? This is not typically something that is really part of people's education around how healthcare is delivered.

01-00:54:38

Halvorson:

Very little. There was a class at Concordia in the economics department that dealt with healthcare economics and the guy who ran that program actually became a good friend, and I taught that class a few times for him over the years.

01-00:54:58

Meeker:

Do you recall what was part of the curriculum in that class? Was there any education around pre-payment group practice plans?

01-00:55:05

Halvorson:

No, no, no. Just basic almost accounting. What happened was the reason that I ended up going down the path I went down into plan management is because I went to work for the Blue Cross plan, I did the communications, and then a new president came to Blue Cross. The new president turned to my boss, my boss's boss, actually, who was the vice president for everything external—so, he ran the marketing, sales, lobbying, all of those kinds of things—and said to him, “Jim, I want you to give me a marketing plan by a week from today.” We'd never had a marketing plan. We didn't know what a marketing plan was. I had done a lot of work for Jim in various communication settings. One of the other things I should mention was he started me off in government relations as well and he got me involved as a lobbyist. So, I went over in the communications side. I spent quite a bit of time going over and talking to people at the legislature, trying to get them to see our perspective on various things. So, in my early twenties, I was a lobbyist, and then—ethics were different in those days—he sent me to national campaign manager school. At national campaign manager school, I learned to run political campaigns. The reason he had me do that training was he lent me out to campaigns for politicians that he liked. This was while I was doing the Blue Cross communications job; I also ended up being assigned to run a couple of campaigns. I love to strategize. That was great fun. Again, if you're trying to figure out how to do strategizing, you do get to strategize in a campaign. You figure out how do we win, how do we get the votes, what are our positions? So, I learned to do the strategic thinking and strategic positioning in the context of a campaign, and actually ran three campaigns. Won two, and lost one. My boss was completely apolitical, so one of the candidates was far left and one of the candidates was actually a Tax Party candidate, who got elected to the Minnesota Senate from the Tax Party and, actually, very quietly ran his campaign. My boss lent me to him as a resource.

01-00:57:56

Meeker:

Tax Party meaning wanting to abolish income taxes, I'm guessing?

01-00:57:58

Halvorson:

That kind of a thing, yeah. Very right wing, extreme right wing. His campaign committee had some very interesting members.

Audio File 2

02-00:00:13

Meeker:

Today is October 21, 2013. This is Martin Meeker, interviewing George Halvorson, and we are on tape two. So, let's continue where we just left off, and that was talking a little bit about your time at Blue Cross. The new president, yes.

02-00:00:40

Halvorson:

A new president—my boss— came to the head of external. Jim had been my mentor. He had nothing resembling a marketing plan to give the new CEO. He came to me and he said, "George, can you come up with a marketing plan that I can give to the new president?" I said, "How much time do we have?" He said, "He wants it at the end of next week." So, I picked up the phone and I called the national Blue Cross offices in Chicago and I said to the guy who was a national head of communications—a friend who I had been doing some work with on communications issues, "Who's the smartest person at Blue Cross about marketing plans?" He said, "We've got a guy on our staff here who's brilliant and he knows everything about marketing plans. Why do you need to know?" I said, "I need to talk to him immediately because I need to write a marketing plan right now." So, I jumped on an airplane. I went to Chicago, and I spent two days with this guy, talking about what all the elements of the marketing plan needed to be. What do you do for research, what do you do for component parts, what's the structure of a plan look like? He went into his files. He pulled out a couple of plans for me. I also went to a business school and bought a book on marketing plans. So, based on that interview, those files, and that book, I wrote a marketing plan for Blue Cross of Minnesota. It was actually a really good plan, in part because I'd been thinking about the company and the positioning strategy and so forth for a while anyway. That gave me a context. What I found out later was that the new president had actually intended to fire Jim and actually the request for a plan was a set-up. He was using that opportunity to get rid of him, and suddenly Jim comes walking in and he says, "Here's the marketing plan. Here's what we're going to do in advertising. Here's what we're going to do in PR. Here's what the products are going to look like." He had a pretty decent plan all laid out. So, he said, "Who did this," and he said, "My head of market research did this." I actually got the new title and the new assignment based on producing the plan.

02-00:03:29

Meeker:

No kidding. So, you had previously been a marketing assistant, it sounds like.

02-00:03:34

Halvorson:

No, I'd been head of communications. I was running the public relations area, I was doing press releases, and press conferences, I was doing media. I had created the new Blue Cross newsletter that had health information in it, and my goal was to have a thousand clippings a year in the State of Minnesota from a couple hundred newspapers. What I did was to send out press releases. I put together a marketing plan for our communications plan. We had a couple thousand employees. Every time somebody got promoted, I sent out a promotion newsletter press release. I asked all employees who were promoted, "Where did you go to college? Where'd you graduate from high school? What towns have you lived in?" I would blitz all of those places with a press release that John Jones has moved from assistant supervisor to supervisor, he's done exceptional work. We got clipping after clipping, and then I also went into health news and I took a whole series of health news and created a brand for us a health experts: Flu season's coming, Blue Cross warns you the flu season is on the way. Blue Cross warns you that winter's coming and wind chill is going to be relevant. I had wind chill indexes printed out in photo-ready copies and I sent them to all papers, and I almost got a thousand reprints out of just that topic over the years. The release said, "Blue Cross Wind Chill Index," and all the papers had an easy story to write. But then, so I had been doing that work, and then got the chance to do this marketing plan. I wrote the marketing plan and Jim then said, "How would you like to stay on as head of market research and market planning?" So, I said fine, and then I hired a few people, put together a department, and did that work. We also didn't have a corporate planning department, and then that president got fired, another president came in, and we needed a corporate planning department. So, I ended up becoming the corporate planner. My job evolved from being the market planner to being the corporate planner. Again, I went off and talked to a couple of people who did that for a living, read a couple of books, and became a corporate planner. The way I got into healthcare delivery was I realized that health plans were about to get started, and there were a number of health plans forming in Minnesota, and Blue Cross probably needed one.

02-00:06:24

Meeker:

Is this as a result of the HMO Act?

02-00:06:27

Halvorson:

HMO Act, and we had local medical societies in the two major counties both deciding that they wanted to form a health plan of some kind, which could be a potential direct competitor. Now, the plan that I ultimately ran, Group Health, was in town, had been there forever, but it had well under 100,000 members and it wasn't growing very rapidly at that point. So, it was a factor, but it wasn't a threat. But there were new organizations coming up that were about to be a threat, and Blue Cross had the biggest market share in the state. So, we had to figure out what to do. So again my leaders said, "Come help us figure out what we should do." I came back and said, "We need to start a plan. We need to have our own network. We have to have our own plan. We have to have some contracted providers, we have to do X, Y, and Z." Again, I went

off to look at a couple of other plans in a couple of other settings and came back and designed, basically designed the plan.

02-00:07:32

Meeker: What year was this, roughly?

02-00:07:35

Halvorson: Oh, early seventies.

02-00:07:37

Meeker: So, you were still in your early-to-mid-twenties.

02-00:07:41

Halvorson: Oh, yes, I was twenty-six or twenty-seven.

02-00:07:44

Meeker: At the point at which you were head of their corporate planning and that you had made this substantial recommendation that it was time for Blue Cross Blue Shield, at that point in time, to establish its own HMO.

02-00:07:54

Halvorson: To form a health plan, yeah.

02-00:07:55

Meeker: Health plan meaning an HMO, is that the way in which it was described? Like a managed care organization?

02-00:07:59

Halvorson: Yeah, it was an HMO. We called it HMO at that time, yeah. So, I put together the plan, I put together the strategy, I put together the reasons for it. Then, I presented it to the board of directors, and the board of directors voted yes and they told Jim that they wanted me to run it. So, he said, "Now would you like to stop being a corporate planner and be an operations guy?" I also had done a plan to turn one of our subsidiary companies into a group life company, and to do some of the things in dental lines, so I actually ended up running a couple of subsidiary companies. The main thing I had to do was put together this new health plan. There were a couple of people who had been on staff who had been some very smart people, who had been doing some good thinking in that area, so I didn't have to start from scratch. There was some talent there, and so I did that. I helped put together a health plan.

02-00:09:11

Meeker: Can I ask you to pause for a second? I want to get back to some of the details about this, as far back as your work in the marketing department. I'd love for you to comment on what it was like for you, as a very young man, twenty-four to twenty-six years old, moving up fairly quickly in this organization, to the point that you actually are voted by the board to establish this new healthcare delivery system within Blue Cross. How did you experience this? What was it like for you to be so young and at the same time, having a major impact within this organization?

02-00:09:59

Halvorson: No, it didn't ever occur to me that that was an issue,

02-00:10:04

Meeker: So, you never received any resistance, that while this guy might have good ideas, but he's a little green or naïve, and maybe we shouldn't be putting so much in his hands?

02-00:10:18

Halvorson: No, but I will tell you maybe a funny story. So, Jim Regnier, the new president, called me up to his office and he said, "I'm about to go to the board about us doing this thing, and I'm planning to recommend to the board that you become vice president and take over this area." I said, "That sounds like a good idea," and he said, "I have a problem, though," and I said, "What's the problem?" He said, "I have several board members who will not vote for a vice president who has a beard." Really? He said, "Absolutely not. They're very conservative, they're very old-fashioned, and they just will have a very, very hard time voting yes for a VP with a beard." So, I said, "What do you think I should do?" He said, "I think you should decide." I said, "How much time do I have?" He reached into his drawer and he pulled out a can of shaving cream and a razor and a white towel, and he said, "My bathroom is right there, you can shave now, or we'll give the job to somebody else." So, I said, "Easy enough," went in, shaved, and lost my beard, and didn't have it for a number of years after that. The really funny thing was the look on my secretary's face when I came back downstairs from a meeting with the president, and I'd gone up with a full beard and I came back clean-shaven.

02-00:12:12

Meeker: But I bet you would have looked even younger then, too, right?

02-00:12:15

Halvorson: Oh, yeah. No, the beard was actually helping. Yes, the beard was making me look a little older.

02-00:12:21

Meeker: I think that beards today don't necessarily have that same connotation, right, but was it that it looked a little countercultural, that it made you look a little—

02-00:12:29

Halvorson: Yeah, they were afraid that I might be a dangerous radical of some kind, so yeah. So, the beard went away, and then a really good friend of mine, very wise man, told me to start wearing pinstripes. I was wearing tweeds and sweaters and that type of thing, and he said, "You need to have people think you think like them so that they will go along with what you recommend, and if they think you're different, they won't follow your lead." So, he said this, and I said, "What's the best way to do that?" He said, "The best way to do that is to wear pinstriped suits because they really, really think that you think like that." I thought, oh, that's easy enough to do, and so I went to pinstriped suits. I actually wore pinstriped suits for about thirty years because of that, and I am

just now, as I'm leaving this job, not wearing pinstripes. David [to David Mays, sitting in the room], how many times have you seen me not in a pinstriped suit? In fact, if I would have known that we were filming today, I would have worn a pinstriped suit. But my friend Bill was right, and what he was right about was if you come in clean-shaven and wearing a pinstriped suit, a white shirt, and the whole thing, then right off the bat, people assume that you're a safe and conventional thinker.

02-00:14:04

Meeker:

Maybe they would have assumed that you weren't, if you looked like a professor or a poet. To what extent do you, looking back to the early 1970s when you're first starting to enter into these conversations with people, think that they would have been right in their suspicions if you had appeared looking like a poet? Meaning, was it a necessary cloak for you to wear? Was it actually hiding something?

02-00:14:47

Halvorson:

Well, it wasn't hiding something. I was a change agent for a while. We did put together the first network, the first capitated network plan, I think, in the country. If it wasn't the first, it was simultaneously the first. So I helped invent that plan. I also invented the new dental plan. I helped invent pre-paid legal care; I actually started a pre-paid legal plan. We sold legal services on a pre-paid basis and invented the first pre-paid worker's comp plan. As a pioneer, we actually took over worker's comp medical coverage and we did it on a pre-paid basis in partnership with a commercial indemnity plan. So, I have invented half a dozen different products over the years. But I'm not sneaking up on anybody. I mean, it's not as though there's a secret agenda that I'm pursuing. I am very visible. When I'm doing a pre-paid legal plan, I'm putting it on the table. I helped get a governor to sign a bill to make it legal to sell pre-paid legal service. That was very public. So, it's not like there was a secret me. What the pinstriped suit and the lack of a beard allowed me to do was to be transparent, not secretive.

02-00:16:18

Meeker:

There's different kinds of radicals out there, is maybe another way of thinking about it. Radicals who are like Thomas Edison, an innovator, who's doing new things that other people have never done before, and then perhaps a radical like Emma Goldman, right, who is political and disrupting the system, not necessarily with a goal of innovation in mind, for instance. Do you think that your radicalism in that inventive sense might have been mistaken as sort of radicalism in the political sense?

02-00:16:55

Halvorson:

Well, yeah, exactly. The Minnesota Care Bill that actually passed the legislature that created a high level of insurance coverage in Minnesota was basically a bill that I helped put together with a coalition of all the health plans and state hospitals to pass. I recruited politicians. We went down to the capitol as a coalition and proposed it to everybody. We got the governor on our side.

It was a very radical thing to do. That law actually got Minnesota to the lowest level of uninsured people in the country. I was wearing pinstripes and a white shirt and was clean shaven to do that work. If I had gone in wearing a turtleneck and a beard and with hair down to my shoulders or something, they would have resisted. They would have worried about the thing at a different level. But if this extremely conservative-looking guy is pitching this stuff, it feels like it can't be that radical because look who it's coming from.

02-00:17:57

Meeker:

Innovative, but not radical.

02-00:18:02

Halvorson:

Yeah, they would take it as innovative and not radical, and that's what you need. If you're going to change things, you need people to trust the context of the change, and people need to trust the change agent. So, you have to not look radical in a way that makes them nervous. Bill was right. He said— it's a small thing to sacrifice because, he said, "Do you really want to change things?" And you want to change things more than you want to wear tweeds? Next year, as a retiree, my wife and I are going to go to Scotland and I'm going to buy some tweeds.

02-00:18:43

Meeker:

All right, on that note, we should probably wrap up for today.

Interview 2: November 20, 2013

Audio File 3

03-00:00:06

Meeker: Today is November 20, 2013. This is Martin Meeker, interviewing George Halvorson for the Kaiser Permanente Oral History Project. This is tape number three. I'm actually going to start today in an unconventional way, and that has a lot to do with what we've been hearing a great bit about on the news. I'm not actually going to talk about the Affordable Care Act; I'm talking about the fiftieth anniversary of the assassination of John F. Kennedy, which is on Friday. So, we're starting to hear a lot of news about it, a lot of reminiscences about it. I want to begin the interview today by asking you to go back fifty years, and tell me where you were when you heard about the assassination of President Kennedy, and what kind of impact that had on you.

03-00:01:03

Halvorson: I was at school. I don't remember what year of school, but I was in school, in my hometown of Menahga, Minnesota. We heard about it in the class. Somebody came into the classroom and said, "The President has been killed." Just total shock.

03-00:01:31

Meeker: How did your teacher respond?

03-00:01:35

Halvorson: I don't remember, actually. I remember it was just such a shocking thing to hear. Everybody kept thinking, that can't possibly be true. Then, asking for details and details weren't very well available. So, we went home and that evening, we saw the evening news and saw the details on the evening news, over and over again. Just shock, is my reaction.

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Meeker: How did your parents respond?

03-00:02:14

Halvorson: I think everybody was just sort of shocked. Just everyone sad, everyone shocked, kind of a sense of this is wrong.

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Meeker: Some people, you know, think about it metaphorically as kind of a loss of innocence. Some people talk about it as beginning of the tumult of the 1960s. Did it feel like that to you, at the time, as a loss of innocence?

03-00:02:49

Halvorson: No, and the reason I say no is I read a lot of history. I mean, I read every history book in the library. I read a lot of history. I knew that assassinations happened. I mean, it struck me as an historic event. I wasn't thinking of it so much in terms of a change in our culture; I was thinking of we now have this in our history. So, I don't think of it as losses. I'd expected, from knowing

history, that leaders periodically were assassinated. There was even a part of me that wasn't surprised.

03-00:03:36

Meeker: Really?

03-00:03:37

Halvorson: Yeah, it just seemed like one of the things I've looked at forever has been patterns, and I'd look for patterns, study patterns, think about patterns, and the historical pattern of periodically assassinating your leaders is something that I knew happened. I did think back to Lincoln. I remember in that moment flashing back on Abe Lincoln being assassinated.

03-00:04:15

Meeker: Had you been aware of a lot of the sort of really emotional political divisions in the United States at that point in time?

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Halvorson: Yeah, we're aware of the civil rights issues very much, yeah.

03-00:04:32

Meeker: So, you knew what was happening in the South. How did your family respond to that? Did your parents ever try to explain what was happening to you?

03-00:04:40

Halvorson: About what?

03-00:04:42

Meeker: About, for instance, the civil rights movement in the South, and that.

03-00:04:44

Halvorson: You know, again, I read a lot. I read magazines, I read a lot of periodicals, I read. So, I think I would have been more likely to explain to them.

03-00:04:55

Meeker: Oh, really?

03-00:04:56

Halvorson: Yeah, what was going on.

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Meeker: So, this wasn't particularly a shock—this was something that wasn't exactly predictable maybe, but—

03-00:05:08

Halvorson: I was shocked but not entirely surprised. Yeah, so I was shocked and I was really sad, but I thought, this happens, this is one of the things that happens in history. It just happened to us and it happened here. I remember thinking, this is an historic moment. So, I mean, and I do think in historical terms a lot.

03-00:05:39

Meeker:

Well, then, in hindsight, looking back on an event like that now, does it seem to you a transformative moment in our culture?

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Halvorson:

No, not entirely. The reason it wasn't transformative is we had all of the racial issues before and we had them after. You know, we had the economic issues before and we had them after. We had political issues before and we had them after. It wasn't as though suddenly America went down a different path. What happened was that a president who seemed to be a lovely human being and a very attractive person suddenly was dead, and that was a truncation, but it didn't change the direction. If anything, I think that we were more likely to get civil rights bills passed with Lyndon Johnson as President than with President Kennedy because Kennedy had all of the traditional issues to fight, and Johnson could play the Kennedy card, which he played really well at that time. Kennedy didn't have an equivalent card to play. Johnson barely got the Civil Rights Bill passed—that barely, barely, barely squeaked by, and Hubert Humphrey worked his tail off for months to get that bill through the Senate. It was really hard for Humphrey to get that passed. I mean, he barely, barely got that done, and the ability to get that done, the ability of Kennedy to get that passed without that emphasis, I think, would have been really challenging. So, in kind of an ironic way—I hadn't really thought about that before—but I think in kind of an ironic way, we probably ended up with a better set of civil rights legislation because Kennedy was shot.

03-00:07:54

Meeker:

Not to mention the fact that Johnson was from the South, himself.

03-00:07:57

Halvorson:

That helped, the fact that he was from Texas made it easier in some ways for him to talk to some of his Southern friends and get their votes. But that bill just barely passed.

03-00:08:07

Meeker:

You know, I know last time we talked a little bit about your family traveling and your growing up: did you ever spend any time traveling through the South?

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Halvorson:

Not much. We went east some and west a lot and very little south.

03-00:08:22

Meeker:

When you were doing these travels, say, throughout your high school and perhaps college years, I mean, obviously you would have had opportunity to observe how different regions in the United States dealt with the differences in their midst?

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Halvorson:

Well, I've been fascinated for a very long time about differences between groups of people and issues between groups of people. I was active in the civil

rights movement. I was pro-civil rights. I was actually a charter member of NOW. I was one of the first members. In fact, when I went to the first NOW meeting, I had a hard time getting in. It was all women, I was the only male in the room, and they weren't quite ready.

03-00:09:23

Meeker: They were probably suspicious, huh?

03-00:09:26

Halvorson: Yeah, I had to leave for a few hours and let everything settle down. I can still remember that meeting. It was halfway up the state, so I had to drive quite a ways to get there. So, and then I had to convince people when I was there that it was a legitimate thing for me to be doing. I've been active in those kinds of issues for a long time, and back in my days at Blue Cross before HealthPartners, I was the first person to hire a professional black person into the company. I was the first person to hire a professional woman into any of the external divisions. There were no women in the external divisions. I hired the first black sales reps. Each of those hirings was deliberate. One of my practices has been to hire stars. So, I hired a black guy from Southern California to be a sales rep for St. Paul. He was a star in California, he was just very bright, very articulate, very charming. He only stayed about two years, and went on to a bigger job in Chicago, but what I learned was if you hire tokens for the jobs, then you're likely to fail. If they fail, then every stereotype is reinforced. But if you hire somebody who is so darn good—it's like integrating baseball: if we would have integrated baseball with somebody who batted .175, it would have been harder.

03-00:11:07

Meeker: Jackie Robinson helped out.

03-00:11:09

Halvorson: Yeah, Jackie Robinson was a star. So, I've integrated a number of companies, and I did it with star players. Anyway, for a very long time, I have committed to integration and also relative to women. When I got my first job—did I mention this to you at all?

03-00:11:44

Meeker: No, go ahead. Yeah, this is new material.

03-00:11:46

Halvorson: Yeah, so when I got my very first job, it was as the bait house kid at a bait shop, so my job was to count worms, sort minnows, sort tackle, but basically, the job was about supplying fishermen. The reason I got the job was because my mother was the bookkeeper for that company, and she persuaded the guy who owned the company to give me a job as the bait house kid. I was fourteen years old and worked ten, twelve-hour days. It was literally 8:00 AM to 8:00 PM working, I loved it. But after I worked there for a number of months and I was talking to some guys out back about how much I got paid and what they were paid, and I learned, serendipitously, that I was making as much money

per hour as my mother, and the guys in the back were making a lot more than my mother. Made me really angry, basically because I thought she was running the place. She was organized, she was doing the books, she had done the payroll. I mean, she really was doing all the administrative work—she was the COO of the place, functionally.

03-00:12:55

Meeker:

She was the professional.

03-00:12:56

Halvorson:

She was the professional, and she was making only what I made to sell minnows. The guys who were out back running the trucks and sorting minnows all made a lot more. So, I talked to her and said I was going to go to the owner and raise a big stink, and she basically said, “Be quiet, this is a very good job for a woman. Don’t make any waves because if you make waves, I’ll lose that job.” So, it made me a little crazy. But I was silent. Then, shortly after that, I got my second job, and that was to be a clerk at the local bank. The bank had the practice of hiring a high school sophomore at the end of sophomore year to work for the bank for two years as an intern. So, I’d come in and do the Saturday checking accounts and do some bank work. I worked in the bank and I had a really good time, and that was a magnificent job because I learned everything about the town. When you work in the bank, I learned who had money, who didn’t have money, who pretended to have money and was broke, and who pretended to be broke and was rich. There was one woman who was supposed to be stone-cold broke and she was probably the richest person in the town.

When I got there, the bank swore me to secrecy and said, “You can’t ever, ever share any of this information with anybody or you’re fired and they won’t bank here anymore.” It was fascinating. I mean, I learned so much from that process, it was golden. But back to my point, then I discovered that there were three women at the bank who were the women clerks, and there were a couple of men who were the bank senior clerks, and the women clerks ran the bank. They did all the work. They balanced the books. They did all the stuff. They set the day up. They ran the day. They gave me my assignments. I discovered they were making about what I was making as an intern, and the men were making twice as much. That also made me crazy. Again, I said, “I’m going to raise hell about this,” and they said the same thing, “Shut up, don’t do that, this is a really great job for a woman, don’t go there.” So, I think those two experiences radicalized me, a little. I think when I got to the position where I could do hiring, I think I deliberately hired more women at higher salaries. I think that I tried to balance that a little bit when I had an opportunity to do that.

03-00:15:39

Meeker:

How did your superiors, how did your bosses respond to that? Not only the impetus to clearly diversify the workforce, but also to potentially hire people at a higher salary than perhaps they’d be willing to take.

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Halvorson:

Well, we actually had a few issues. One of the hires, the first woman I hired at Blue Cross into the first analyst job, after I hired her, they were resistant and I showed that she had incredible credentials, really bright, very talented, star player, and so we went along and we did the hire. Then, I got called into the vice president's office and told that I had to de-hire her because there was a rule in the division that the vice president's secretary had to be the highest-paid person in the division, and this woman was now making more than the vice president's secretary, and the secretary was demanding that she be fired. Which I did not expect. So I said, "Okay, I don't want to fire her, how can we deal with that?" We ended up actually having her work in an HR department on special report—not on leave, but assigned to me—so we had to get her money, we had to get her paycheck, into a different division for a couple of years until the secretary got over it, and then we straightened out the books. We actually created this somewhat contrived cash flow to deal with that. So, yes, there were a few issues along the way.

03-00:17:24

Meeker:

That must have been a surprising turn of events when it was first presented to you.

03-00:17:28

Halvorson:

Oh, yeah, I was stunned. But again, and I talked to the vice-president's secretary—because she was a nice person—and I said, "Why are you doing this?" She said, "I have worked very, very, very hard to get to this position. I take great pride in being the highest-paid woman in this division, and you're taking that away from me. This is a young woman, et cetera, et cetera, so you can't take that from me." I said, "She's really good, et cetera," and you know, we had the conversation and we ended up compromising. I think because we had the good conversation, I think that she could have seen through the compromise, you know, gone through and insisted that we not be allowed to do it through the back door, and she allowed the back door. Then, after a while, she got over it and she was fine with the front door. I didn't expect that, but I've seen that many times. I mean, often people who are in some ways discriminated against end up being enforcing agents for their own discrimination for equal discrimination of some kind.

03-00:18:35

Meeker:

Is this roughly the early 1970s, I'm guessing?

03-00:18:38

Halvorson:

Yeah, it'd be the seventies, early seventies, yeah.

03-00:18:41

Meeker:

You know, one of the points that you see a lot in the literature about equal employment opportunity, for instance, is, you know, at least a willingness amongst fair-minded people to open up the employment base to a more diverse workforce. But then, they oftentimes run against a legitimate concern, which is something you kind of alluded to, which is a lack of a truly qualified

workforce to fill those positions. You know, I wonder how you actually dealt with that in a realistic sense. I mean, you had to go all the way to Southern California for that one hire—how did you find these people who you put into the positions that you thought that they would succeed in?

03-00:19:34

Halvorson:

Well, for women, you don't have to go very far. Women are everywhere. They are all around us. So, it was easy—it's always been extremely easy for me to find highly qualified women. In terms of minority candidates, particularly in Minnesota, I sometimes had to do recruiting, and in that case, I'd talk to friends of mine who had similar jobs in other parts of the country and asked them if they knew anybody that would be good. So, I kind of did my own backdoor recruiting. Again, my standard was you have to be really good to get the job. Actually, I had a woman who was an analyst who was the first African American woman in that company, who had been also the first woman to integrate her high school and the first woman to integrate her college. So, she had been through this twice before, and then she was the first woman to integrate her company. She was a really wonderful person, just a really nice—you could easily imagine that somebody with those experiences could be quite angry, and I'm sure there was a level where she was quite angry, but she was just such a nice person and she just said, "Okay, this is good, we can make this work."

03-00:21:03

Meeker:

To a certain extent, you would also be putting some of your own reputation on the line. Is that ever a concern to you in these circumstances?

03-00:21:10

Halvorson:

No. The reason it wasn't was because I knew that I was hiring people who could perform really well, and I actually looked better. I mean, when I was hiring women when no one else was hiring women, I had star departments because I had smarter people. I had smarter people who were willing to work in jobs for professional pay where a man with that same talent would have been a manager somewhere. So, it never for a moment occurred to me that I would incur risk. I saw it as opportunity.

03-00:21:48

Meeker:

Let's continue a little bit with your work with Blue Cross Blue Shield of Minnesota. I know that we started talking about this a little bit last time, and you told me the story about how you were, I believe, starting this new HMO product and about how I guess the president or the board members wanted to make sure that you looked like them, and so you had to shave your beard.

03-00:22:13

Halvorson:

I lost my beard, yeah.

03-00:22:16

Meeker:

But we didn't actually get to talk much about the product itself, the HMO plan that they were developing there. I think probably the first thing to talk about is

how you first encountered this idea, this healthcare concept of a health maintenance organization or a prepaid insurance system. I'm not entirely sure if this Blue Cross plan was, in fact, a prepaid system.

03-00:22:45

Halvorson: No.

03-00:22:46

Meeker: Well, can you tell me a little bit about, you know, the programmatic elements of this?

03-00:22:52

Halvorson: Sure. The Blue plan was a traditional Blue Cross insurance company. This old standard Blue Cross insurance.

03-00:22:59

Meeker: Indemnity insurance, right?

03-00:23:00

Halvorson: They had indemnity insurance. They had a network of participating doctors, which was every doctor in the state, and they had a network of hospitals that was every hospital in the state. They negotiated prices every year with the hospitals and the doctors, but the price negotiation was literally, send out a letter and tell us what your fees are for next year so we can load it into the claims system. Anybody who forgot to send in their update, we would remind them to send it in.

03-00:23:33

Meeker: That is a fee-for-service system, yes?

03-00:23:35

Halvorson: Fee-for-service system, straight fee for service, and then we actually reminded doctors when they forgot to raise their prices. It was fascinating.

03-00:23:45

Meeker: Do you remember what the inflation rate roughly was at that point in time, for their services?

03-00:23:51

Halvorson: No. A few percent. They actually weren't doing big percent, but the prices were going up, premiums were going up, 5-10 percent a year, and that trend in the US has been pretty consistent. The primary driver of that has been the price of care. So, we had the Blue Cross plan. I changed the benefits. When I got there, the plan was totally full service indemnity and had no deductible plans, and so I was head of product development and I put in the first deductible plans that that Blue Cross plan had. That was kind of fascinating, just to see that transition.

03-00:24:34

Meeker: What was the motivation to do that?

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Halvorson: Drop the premium. Yeah, when all of our competitors were selling \$200 and \$500 deductibles and we were selling full and complete benefits, they had a 10% price advantage over us. So, we had to sell our own deductibles to get to that right price.

01-00:24:52

Meeker: So, the Blues then were perhaps losing market share at that point because of the deductible plans?

01-00:24:56

Halvorson: They started to lose market share until we put the deductible plans in place, and then they ended the market share drop. Although, when I put it in, many of the Blue Cross reps refused to sell it.

03-00:25:10

Meeker: Why was that?

03-00:25:11

Halvorson: They believed in the old product. They had sold against the other deductible products so many times that they just couldn't go out and sell them. I actually had to go to cold calls, one side-by-side with the sales reps, and do the selling myself to teach them that the deductible product was a saleable product and legitimate. Change is always hard.

03-00:25:34

Meeker: Was it just inertia or did they object to the notion that—

03-00:25:37

Halvorson: No, they objected. They liked the old product. They knew their product. They were comfortable with that product. They believed in that product. They had sold it forever. They'd been telling people with their personal credibility, "If you buy this product, it's a great product, it's well designed, we're great." All of a sudden, we're telling them, "Now go tell them the old product that was great isn't as great as the new product." They had been selling hard against the other product, and so, when you've been selling against the other product and suddenly you're selling what you've been selling against, that's hard. I really underestimated how difficult it was. But when we put the new products out and I had no sales for a couple of months, I thought, okay, something's wrong, here. So, I went out and started riding with the folks and I watched that they weren't even pitching the new product. So I pitched a few and sold a few.

03-00:26:24

Meeker: Yourself?

03-00:26:26

Halvorson: Myself, yeah, to show that it could be done.

03-00:26:30

Meeker: What argument did you use, what sales pitch, if you will, did you use?

03-00:26:34

Halvorson: “This is cheaper.”

03-00:26:36

Meeker: Is that the bottom line?

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Halvorson: Yeah, this is cheaper, this’ll cost you less money. You get the same great network, you get the same great hospitals, you get all of the same things you get and your premium goes down by 10 percent, 15 percent, whatever it was. People said, “Oh, I could do that,” and then the sales rep said, “Hmm, that did work.” [laughter] “So, maybe I should try that.” Change is always hard; people like to do what they like to do, and they like to do what they’re used to doing. Particularly if they’ve been selling a particular direction and saying that’s the right thing to do, getting them to do something in a different way is always hard, and that’s true of care delivery, insurance, or anything.

03-00:27:17

Meeker: Well, what then was this HMO product that I’ve heard that you introduced to the system?

03-00:27:21

Halvorson: Right, well, the HMO product. Then we created a network of contracted HMO providers who were willing to accept risk, who were willing to take capitation. Instead of getting paid a fee, they got paid a package price for each member.

03-00:27:39

Meeker: Was it prepayment or was it a different finance mechanism?

03-00:27:43

Halvorson: It was a prepayment. It was a premium. It was a premium, and in exchange for the premium, they got a benefit package. The Blue Cross plan had nothing like that. So, I was head of corporate planning and market research and seeing us lose sales, so I looked at what do we need. At that point in time, there was a Group Health plan in town that was an old staff-model HMO that had under 50,000 members. That didn’t particularly threaten us because that had been around forever and was offered side-by-side in a number of groups. That plan only had, you know, four or five clinics, and they were clearly not a threat. But then, the Medical Society in Hennepin County decided, under the influence of Dr. Paul Ellwood, who was the founder of HMOs—Ellwood coined the term HMO, he got Nixon to pass the bill [HMO Act of 1973]—Ellwood convinced the Medical Society that they should form their own health plan and compete with Blue Cross. They looked very suspiciously like Blue Cross because they would have had all of the doctors in Hennepin County in their health plan. Clearly, that was going to take some business away in Hennepin County, and the doctors were all willing to give their own health plan a discount that they weren’t giving Blue Cross. So, right off the bat, apples to apples, you start with a lower premium for the same benefits if you get a discount down one path and you don’t down the other.

So, the challenge was then for me, as the corporate planner, to figure out what path should we go down. There were several other people who were thinking about it, so it was kind of a groupthink process. We concluded and I concluded that what we really needed to do was create our own network of medical sites, and to kind of do a hybrid between that old Group Health plan that owned other clinics and this new thing. We needed more, and also being Minnesota, I had a lot of respect for the Mayo Clinic and the group model. So, we put together a network of contracted clinics who each—and there were quite a few clinics, so we had about twenty clinics in town, with anywhere from ten to forty doctors—agreed to form a network and accept capitation for their members. Because they were accepting capitation, they were less likely to hospitalize. They had shorter lengths of stay.

So, we set the network up, hired, put the docs in place, but the result of that process was that I ended up running that network plan. Basically, putting much of it in place. So, that was my first experience negotiating with physicians. I ended up running the plan as the CEO. So, the title was Executive Director. We had a Board of Directors, and state law had been passed years ago to support Group Health that required that any time we offer an HMO-like benefit package, you had to have your own board, so we created a board that was a subsidiary board to the Blue Cross board, but it was separate board members. Forty percent of the board members were consumers, by law. There was only one board member overlapped between the boards. I reported to that board, and for a couple of years, we were the fastest growing health plan in Minnesota. We grew well and did well.

03-00:31:27

Meeker:

What was this called? What did you name this?

03-00:31:28

Halvorson:

Well, originally it was the Minnesota Health Maintenance Network Plan, or MHMNP, which is a really horrible name.

03-00:31:35

Meeker:

Minnesota Health Maintenance—

03-00:31:36

Halvorson:

Health Maintenance Network Plan, Minnesota Health Maintenance Network Plan. So, we kept health maintenance, we had network, we had the health plan, so it all worked as a description. But it's not a very catchy name. We ultimately changed the name and the plan became HMO Minnesota, before HMO was a bad name. I stole that name from HMO Illinois. The Blue Cross plan in Illinois also set up their own HMO and they called it HMO Illinois. I thought, you know what? Let's take this state, they took that state and let's take this state and use that as a name. I've actually named quite a few health plans in my life. It's been one of the fun things that I've done.

03-00:32:16

Meeker: I'm guessing HealthPartners was probably your invention.

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Halvorson: HealthPartners, that was my name, yup.

03-00:32:21

Meeker: You know, I wonder if you can introduce me to your initial thinking as you were introduced to this health maintenance concept. You know, coming from a traditional indemnity insurance plan with the Blues, and then you were presented with this competitor through Paul Ellwood, and I assume later on, did that plan become—what's the main competitor for HealthPartners?

03-00:32:49

Halvorson: Well, it became Blue Plus.

03-00:32:52

Meeker: No, but I'm talking about the Ellwood plan, right?

03-00:32:56

Halvorson: Oh, no, actually, the Hennepin County plan was called PHP, Physicians Health Plan. Then, they ultimately expanded into a couple of the counties. They went to Ramsey County Medical Society, couple of others. They became a network looking a lot like Blue Cross. Then the Park Nicollet Clinic and Medical Center in St. Louis Park also decided, "Okay, we've got the new IPA going with the medical society and we've got the Group Health plan, and Blue Cross. We need a plan also," so they set up their own HMO called MedCenters. MedCenters was basically built around the Park Nicollet clinics. Again, the same model that we were using with old MHMNP, that HMO Minnesota, they used the same plan and they capitated their care teams.

One of the things that Ellwood convinced me of early on, Ellwood and Walter McClure—I don't know if you've ever heard the name Walter McClure, but Walter McClure wrote a lot of early HMO literature. Brilliant guy. Still a friend. He's in his early eighties, I think, now. They both convinced me that it really made a lot more sense to have doctors working as teams and working together. That capitation model caused doctors to look at things like length of stay for the first time. They stopped doing eight-day maternity stays. There was a lot of reexamination going on, and it just made more sense. I started very quickly. One of the things that I added to the process fairly early was to insist that the care be higher quality. So, we started doing quality measures in our network. We started measuring diabetic care and tracking whether or not the diabetics were getting the right amount of treatment. One of the reasons we started doing that was that some of the clinics, initially, started taking shortcuts. Once they were capitated, a couple of the care sites started taking shortcuts, and I needed to be sure if I was convincing people to join this network that if they had diabetes, they were going to get the full scope of diabetic care. So, we started tracking some care in a couple of basic areas.

03-00:35:35

Meeker:

How did you become aware of the rationing of care in those clinics?

03-00:35:41

Halvorson:

The first time we became aware of rationing care was when a woman called me up and she said, "My doctor just told me that I need knee surgery and I can't have it until August because it's going to take him that long to build up my monthly capitation to the point where he breaks even on the surgery." She said, "Is that what you sold me?" [laughter] I said, "Not intentionally." So, I took a look at some other cases and I talked to our member service department and they had some other cases, and so, I went out and I met with the individual caregivers. I said, "There's no point in doing this if we're not going to do this well and if it's not going to be good care, and you shouldn't be putting your name on something that you're not proud of as a caregiver." Some people already had that and they were delivering great care, and other people were thinking of it as just another cash flow, and "I'll do shortcuts on this," and so it was important to meet with those people and convince them that that wasn't the right model.

One of the doctors on the north side of town, one of the clinics had a doctor who had created problems with a couple of our patients, so I went up and met with the clinic and I said, "I'm not going to tell you have to get rid of that doctor, but what I'm going to tell you is that specific doctor can't see our HMO plan patients anymore because I've got a couple of complaints, person-wise." We went through a little bit of misery, but they agreed to do it, and they took that doctor out of the channel for our patients. About a year later, he was hospitalized with severe mental problems. So we pulled him out of the cycle ahead of the game because we had the HMO involved. What I realized fairly soon was we were actually adding value at more levels than just cash flow because we had this accountability to the patient and we had this leverage point and we had some information. So I knew that we had an opportunity to do things that a Blue Cross plan couldn't do. There was no way a Blue Cross plan could have pulled that person out of their network short of malpractice.

03-00:38:02

Meeker:

This is interesting. I mean, this is extraordinarily early on for these kind of quality measures that you're talking about. I'm guessing this is sort of mid-1970s, roughly? You know, the NCQA doesn't really begin until the very late seventies, early eighties, and then it doesn't get any teeth, I think, until the 1990s.

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Halvorson:

Well, do you know how NCQA got started?

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Meeker:

Well, tell me.

03-00:38:28

Halvorson:

NCQA got started because our plan was having trouble in our market convincing some of the buyers that we were higher quality care. We had started inside our plan measuring several types of care quality. This was the Group Health plan—I was CEO there. We started measuring C-section rates. We also were measuring follow-up surgeries. If somebody had a primary surgery, what percentage of the patients needed a second surgery because of complications, that type of thing. We actually had a half a dozen, a dozen things that we were measuring that were quality things we were measuring internally. I knew that the community wasn't measuring any of those things because I had basically run a Blue Cross plan and I'd run a network plan and I knew that they did not do that quality monitoring. I also knew that news media and the public didn't know that about quality, and I also knew that the other doctors in town were fiercely resisting the idea that care might be better in the integrated model, even though they were willing to acknowledge that in the Mayo model it was pretty good. But they weren't willing to give us that same credit.

03-00:39:46

Meeker:

They didn't think it could scale up, I guess.

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Halvorson:

Didn't think it could scale. So, what I did was I took what we had done in some quality areas and convened a meeting in Chicago of the heads of the eight HMO plan families. We brought in Harvard Community Health Plan. We brought in HAP. We brought in Group Health of Puget Sound. We brought in Kaiser. We brought all those plans together and we made a proposal that we should set national quality standards that we would all follow as health plans. The other plans liked the idea. We sorted through what we had and about half the things that were on our initial Minnesota list, nobody else could track, so the list shrunk quite a bit at that meeting. But we had a couple of follow-up meetings, and then the plans liked the idea enough that we collectively hired Towers Perrin, TPF&C, and Towers Perrin to come in and—

03-00:40:57

Meeker:

I'm sorry, can you say that?

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Halvorson:

Towers Perrin, TPF&C, was the name of the actuarial firm. They were an actuarial consulting firm, and we hired TPF&C to put together a quality reporting template for us—they were consultants to many employers and many insurance companies—We said, “Can you give us a template that would have a high level of credibility on this stuff?” They loved the idea and they had a couple of their executives who really got excited by the prospect of doing this because this adds whole new levels. I mean, if you're an actuary and all of a sudden now you get to look at many more levels of care, that is exciting. So TPF&C liked it and said yes. We then took that idea collectively

to the Washington Business Group on Health and pitched it to them and said, “You guys should set this as a standard for all of your member companies, that they should require this set of measurements from all of your members.” C-sections were one of the measurements. We said, that they should require C-section measurement, require the number of surgery redos. Then, we added immunization rates, and some basic things that we all could measure. They liked it, and they adopted it, and we HMO plans gave it to them as a gift, with TPF&C’s blessing. That became HEDIS. That literally was a linear extension. So HEDIS then was a spin-off of the Washington Business Group of Health project. NCQA was a spin-off of that. It was the right work to do.

03-00:42:44

Meeker:

Which originally was defined as HMO Employer Data and Information Set later becomes Healthcare Effectiveness Data and Information Set, so it expands beyond the HMO sector.

03-00:42:56

Halvorson:

The first draft of HEDIS was literally written on the conference room desk in Mary Brainard’s [current CEO of HealthPartners] office.

03-00:43:03

Meeker:

Your office at that time.

03-00:43:04

Halvorson:

Yeah, it was my office then, right. Kathy Cooney, who was my administrative assistant at that time, who was Mary’s chief financial officer, is a nurse MBA. She was the person who later co-designed that first draft with me. So, Kathy and I did the co-design, then we went to Chicago together to pitch that. So, what I believed we needed was quality measures for the industry so that we could prove that we were doing a better job. I fiercely believed, because I had seen so much malpractice and I’d seen such terrible care and I’d seen such inconsistencies, when you looked at the claims database at Blue Cross and, could see the horror stories in various fee-based care sites. I knew that there are some really great doctors and there were some really weak performers, and there was no one looking at any of that stuff. When you took the health plan perspective and said, “We’re going to make sure that all our kids are immunized,” then measurement gives you a whole different context for getting things done and being focused. We created HEDIS to help with that focus.

03-00:44:06

Meeker:

Well, then, back to those original efforts in the early to mid-1970s, where you’re, you know, like you said, starting to get kind of these just people waving their hands through the transfer or something like that, right? Letting you know, as the plan, that they’re not getting the exact quality of care that they anticipated, how did you start to systemize the quality measurements? There’s one level which is paying attention to quality, right? You can kind of look out on the field and trying to get a full, broad forest for the trees kind of

view. Then, there's actually establishing measurements, and that's a different process altogether.

03-00:44:49

Halvorson:

Right. One of the things we did at Group Health, we had the medical group, and actually employed the medical group. We hired the doctors. We employed the doctors. I actually was one of the people who decided which doctors were hired and fired. So I was legally the CEO of the medical group for seventeen years, basically. One of the things I did early on was to look at process improvements. One of our doctors led the way. That was an invaluable learning experience. Group Health is a consumer co-op health plan, owned by its members. It has a member focus. Anyway, John, one of our doctors—

03-00:45:42

Meeker:

Dr. John.

03-00:45:53

Halvorson:

—Dr. John, went off to a Deming seminar when he was on a vacation and he listened to a Deming lecture and he came back a zealot. He came to my office and he said, “This is stunning.” He said, “You can think about this totally differently.” He started talking about the process stuff, and he brought me some Deming materials, and he turned me into a little bit of a Deming advocate. So, then we said, “Okay, let's try some of this Deming stuff in a couple of areas,” and so we experimented. The medical director at the time thought it was a good idea, too, because he wanted better care. John and Paul were the two lead doctors. The three of us kind of bonded on it, and we ended up doing several Deming projects to improve care. Paul, John, and George. We only needed a Ringo! The head of our dental practice, Craig Amundson, also became a Deming devotee. Some we had John, Paul, George, and Craig as the initial converts.

03-00:46:37

Meeker:

What were some of the examples of those early ones, do you recall?

03-00:46:40

Halvorson:

Pre-term birth was one of the first ones. How do reduce the number of pre-term births? Turns out you do that by identifying the high risk mothers and intervening in their care, and it turns out there are some standards that you can use to identify the high risk mothers. So, we basically cut pre-term births in half, and that was a marvelous thing. We ran an ad in the paper. We showed fifty babies on the ad and said, “These babies all would have been born prematurely had we not had this magnificent program.” So, I started very early taking advantage of the quality wins to support our brand and our identity. That also changed the way the community thought about it because when the community took a look at it and said, “Oh, systematic care prevented all these pre-term births, there must be something valid called systematic care.” I mean, we were really at a very early stage, and people had no clue. But Dr. John thought this was a really good idea and he convinced me

that we should try it in more settings. We expanded and then we went out and hired a physician who had been the initial medical director for United Healthcare. He had decided he didn't want to work for a for-profit company, and was kind of looking for quality work. One of our lead doctors said, "This guy's available." So, we hired him. Gordon Mosser is his name.

Anyway, so, Dr. Mosser came in and he'd been doing the national medical director job for United Healthcare, and at that stage of the game, they didn't have a very robust set of things that they were doing in quality, and he really liked the idea of doing quality. His father had been head of internal medicine at the University of Minnesota, a famous doctor, famous for the quality of his care, so his son thought this was a nice thing to do as a legacy. He ended up running the Institute for Clinical Systems Integration, later. So, we started down this path and we started measuring quality. We did the things that ended up becoming HEDIS, and the goal was that we will, when HEDIS gets started, win all the HEDIS scores. We'll have the best scores in town to prove to people that we're the right model.

03-00:49:09

Meeker: Was that in fact what happened?

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Halvorson: Yeah. In fact, in the country last year, Medicare gave eleven health plans one to five stars based on fifty-five measures of quality and service, and 11 health plans out of 500 in the country got all five stars. KP has eight regions—KP got eight five-stars. Unanimous wins. One of the other three five-star plans was my old plan in Minnesota.

03-00:49:37

Meeker: HealthPartners?

03-00:49:38

Halvorson: Yeah. Actually, the Medicare subset of that, yeah.

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Meeker: So, it sounds like the rest of the plans in the United States are still trying to catch up.

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Halvorson: Yes.

03-00:49:49

Meeker: You know, it's interesting—back to the plan, let's see, it was called the Minnesota Health Maintenance Network Plan.

03-00:49:59

Halvorson: MHMNP. We actually called in MHMNP. "How's it going in MHMNP?"
[laughter]

03-00:50:08

Meeker:

Not slurring, it's called MHMNP. I'm wondering, even though you were answering to a separate board, did the sort of parent company at Blue Cross Blue Shield, how did they respond to this new initiative?

03-00:50:26

Halvorson:

They hated it.

03-00:50:28

Meeker:

Well, can you tell me about the basis of that?

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Halvorson:

They hated it. They didn't like it. They were used to the old plan. They liked what they were doing under the old plan. The actuaries really hated the new plan.

03-00:50:40

Meeker:

There was no need for them, or not much need for them.

03-00:50:44

Halvorson:

Right, well, less need for them and the actuaries, they actually did a paper proving that the health consequences of that health plan would only enroll sick people because the benefits were higher.

03-00:50:58

Meeker:

The adverse selection problem.

03-00:51:00

Halvorson:

Adverse selection problem. They said, "So, we're only going to get sick people in the plan," and they actually came to the Blue Cross president and they wanted to shut the thing down. What I did was show that we had already lost some enrollment to the new IPA, the Physicians Health Plan.

03-00:51:22

Meeker:

The Ellwood program.

03-00:51:23

Halvorson:

Yeah. So what I did was this—I had a couple of my clerks pull all data on current relevant groups. We looked at a couple of large groups, like the Hennepin County group. We pulled every single claim. We had to print paper claims for every one of those people. We printed the copy of the paper claims for 10,000 people for one prior year. About 4,000 of them had left us and gone off to join the Health plan. So, I had both sets of data, and then I sat people down with adding machines, literally adding machines with paper tapes, and I made them do multiple copies—because I'd worked in the bank and knew you had to get it right. We added up all the expenses of the people who left compared to all the expenses of the people who stayed, and that data proved overwhelmingly that the people who left Blue Cross to some other plan were healthier. Which was the exact opposite of the actuaries. The first reaction was, the vice president of actuarial science demanded that I—

03-00:52:25

Meeker:

I'm sorry, the people who left to join your plan were healthier?

03-00:52:28

Halvorson:

No, this is before my plan existed. This was as I was building and just starting my plans. I was starting my plan, just getting it going. The actuaries at Blue Cross tried to kill it. So, I pulled all the data and looked at the experience, the actual utilization experience. I've always found data to be useful. So, I pulled all the data for both populations and identified that the people who left us were significantly healthier, which I had believed to be true anecdotally because sick people don't change doctors. That's just generic. Sick people don't change doctors. That was what we ended up proving. The actuaries went crazy. They were angry. They banned my people from all access to computers, and they banned my people from access to any of the data. We couldn't pull any further claims stuff, and they tried to shut the new plan down.

They went to the president and tried to get the president to fire me because I clearly had committed a heresy in challenging the actuaries. I just had a session today, here, a couple of hours ago with one of our actuaries where he and I sparred a little bit, joking about the fact that on some issues that there's an underwriting approach to it and then there's an actuarial approach to it. He is doing the actuarial approach and I'm looking at the underwriting. Underwriting is risk evaluation, and actuarial is more the science of the numbers, and back in those days, in my underwriting role, I took a look and said, "Who the hell is actually in each pool?" The actuaries said, theoretically, who might make this choice and they were willing to live with their theory, but I countered their theory with my actual data. We went through some real misery, and the head of actuarial ultimately left.

03-00:54:31

Meeker:

Did you ever publish any of this research? I'm curious.

03-00:54:32

Halvorson:

No. Yes, actually, a little.

03-00:54:34

Meeker:

It was mostly internal?

03-00:54:36

Halvorson:

Yeah, I did some, but partly I didn't publish because we were using it in the real world to—

03-00:54:43

Meeker:

Set rates.

03-00:54:45

Halvorson:

Yeah, and what I basically did was I took that material and I defended the Blue plan against the new market. When PHP came into a couple of new counties and they were going to take all the business away—I basically went

to their groups, the groups that they managed to get before we stopped them, and I offered their groups \$500 deductibles at half the premium. The group said, "Oh, half the premium, sure, we'll buy that." They stuck our product in and what happened was a \$500 deductible result. People who are sick don't want to go for a \$500 deductible, but people who are well want to have half the premium. So it destroyed their risk pool in the two counties in one year by playing the underwriting cards on the math. In us-them thinking, it felt legitimate to do that because we were us and they were them, and they were coming after our business.

03-00:55:51

Meeker:

Well, and you were also putting, you know, a lot of your own cards on the table, here. You're putting a lot of risk of yourself, right, in getting behind this new MHMNP plan, and you clearly want to do what you need to do to make it successful as well, right?

03-00:56:33

Halvorson:

I tend to do things that I believe in strongly and I tend not to try to spend a lot of my time doing things that I don't believe in. I really believed strongly that this was a superior way of delivering care and financing care, and so I really wanted that to work. I wanted it to work very legitimately. I wanted to work toe-to-toe, apples-to-apples, and be a triumph. So, I worked to set that up. It did work, but the sales people for the Blue Cross plan hated the fact that we had this alternative product. So I had to hire a separate sales staff. I had to hire a separate actuarial staff, and I ended up having to hire a separate claims staff. So, I ended up originally thinking I was going to have the critical mass that came from this massive Blue infrastructure and I ended up creating an entirely separate company with all separate pieces, right down to a separate claims system. Then, they managed to get a rule passed that I couldn't go to any group that was a Blue Cross group without the approval of the vice president of marketing on the Blue side. So, we were the fastest growing health plan in Minnesota and we got all of our growth from non-Blue clients because it was a good product and a good price.

03-00:57:59

Meeker:

At the time that the Blue had such a domination?

03-00:58:02

Halvorson:

Yeah, exactly. At that point in time, the Blue plan, though, with that rule lost business. They on a couple of major groups lost heavily to PHP. And so we got to the end of a couple of years of that approach, and it was clear that that was a losing strategy for those folks, and we ended up with some reshuffling and some people left, and I ended up becoming head of marketing for the whole of the parent company. I ended up going back into being the senior sales person at Blue Cross.

03-00:58:38

Meeker:

In the full indemnity side of things?

03-00:58:40

Halvorson:

Yes, on the indemnity side. I moved back into Blue Cross and was running basically everything external. So, I got the sales and marketing, lobbying, advertising, provider relations. Those functions, basically. My new whole health plan, I turned over to the guy who'd been my chief operating officer on the health plan. And then I grew the Blue side because I knew what to do in terms of product to take business away from the HMOs. So, I grew the Blue side of the operation. Then, we got to a point where the president of the Blue plan said he was going to retire in a year, and there were two internal candidates for the job, myself and the head of actuarial. The new actuarial head, not the original.

The original guy who tried to get me banned was gone. The new head of actuarial had been a chief administrative officer. He was a very bright guy—good, solid guy, about fifteen years older than me. He and I were the two primary contenders for the job, and we ultimately ended up having a board vote and they picked him, in a seven to six vote on a fifteen-member board. Two board members didn't show for the vote. I actually thought I had those two votes lined up. So, it was one of those things where I actually went to work one day thinking that after the vote, I was going to walk out as the president of Blue Cross, and after the vote, I just discovered I wasn't. So, the board asked me to stay on to be the chief operating officer and they chose the actuary to be the CEO. I thought about it a little bit but decided it would be better to leave. So, I left, I gave them six months' notice and left Blue Cross at that point.

Audio File 4

04-00:00:00

Meeker:

This is Martin Meeker with George Halvorson. This is tape number four, and it's November 20, 2013. So, at the end of the last tape, you had just mentioned that you were one of two candidates for the position of president of Blue Cross Blue Shield Minnesota, and you lost out by a vote or two for that position. Not surprisingly, you decided that it was time to bid adieu to that organization and look to other opportunities.

04-00:00:45

Halvorson:

It was really hard.

04-00:00:46

Meeker:

Well, I bet, this was what I was going to ask you about.

04-00:00:47

Halvorson:

I had been there basically fifteen years, it was my entire career, I intended to be president—I saw myself as president—and I was relatively young. The guy who took the job was only fifteen years older than I was, and so, he clearly was going to be there for at least a decade. That turned out to be true, and he was a very bright man, and so there was no possibility, there was no point in

waiting to be president there. I had really grown to like being a CEO when I ran the health plan. I really liked having all the pieces to work with and all the parts, and so, going back in to be a division head in somebody else's CEO constellation wasn't particularly attractive to me. So, I gave basically six months' notice and Andy Cjeckowski was the guy who got the job, and Andy is probably as happy as I ever saw him in my life when I told him that I was going to leave. [laughter] He almost hurt himself, lurching across his desk to shake my hand to thank me for my decision. But it was hard because the board actually liked me a lot, and I'd done a lot of good work with the board, and the board liked him a lot, and it had been a close vote.

04-00:02:11

Meeker:

Clearly, you had a lot of advocates on the board.

04-00:02:13

Halvorson:

Yeah, and I had a lot of advocates on the board. Actually, I think if all the votes would have been in on that day, I would have won. It is what it is.

04-00:02:22

Meeker:

What would your agenda have been for Blue Cross Blue Shield, if you had been president?

04-00:2:27

Halvorson:

Oh, it would have been a lot of fun. It's a great resource. I mean, it was a great resource: I would have converted it into a health plan with half the people in the state. I mean, it would have been a fun thing to do. I would have had a lot of fun with that job. I had decided that, at some point, I was going to take some period of years and do a public service job. So I was thinking that I would do a corporate job, but I would also do some kind of a public service job. So I thought, okay, if I'm not going to get this job, and had a number of other jobs offered to me—I'd been offered a national planning job for the Blue Cross system. I'd been asked to be the national planning director, whatever they called it, to run up all the various Blue Cross plans, do their planning, and had done some presentations to some of their settings. I chaired for them. They had a coalition that I'd chaired for a while on that side. So, I had some experience there, but I went to Chicago and interviewed and did not want to live in Chicago and be kind of a division head within a national network. So, I decided that I would do something that was local and the job that I had in my head for the right job for me to do for a public service job was to run the Heart Association. That was my template job.

I wanted to be the CEO of the Heart Association and help with heart health. That job wasn't open at the time, and then so I called around to people and said what job was open, and it turned out there was a job at Senior Health Plan. Three organizations in town, three healthcare organizations, one of them a hospital system, one of them a large clinic system, and one an operating foundation for seniors, the Wilder Foundation, had decided to create a health plan just for seniors, and to have that health plan be a health plan that

provided social services as well as medical services for seniors. Some of the people who were putting that together called me up and asked me if I wanted to apply for that job.

They were down to two finalists on that job, and I went in, talked to the new board, and it really appealed to me because I thought, you know, I can do some of the things that I was doing before; I can focus on seniors. The program at Ramsey Hospital for seniors was really a very extensive, robust program, and the Wilder Foundation had a great program for long-term care. The hospital system was one of the more innovative hospital systems in the country, and these are the three founders, and I got to be the CEO and start the whole thing from scratch. I really like starting things from scratch, so I said, "Okay, I'll take that job." So, I was the first employee. So, I went from, you know, having 1,000 employees to having none. I then put together the pieces and the parts and I figured out what the network should be and put the contracts together and hired some staff and did some work, and ended up creating a health plan.

04-00:06:05

Meeker:

What was the model? What was it based on?

04-00:06:06

Halvorson:

Basically, it's a pre-paid health plan, Medicare capitation. See, Paul Ellwood and me—while I was at Blue Cross—and Rich Burke, who later became the head of PHP or United Healthcare, rather, for the country, and a couple of other people all went to Washington at that time when I was still at the Blues, and we met with the government. We convinced them to try a capitation plan for Medicare. So, I was in the room negotiating that deal—Ellwood, Burke, myself were the three lead negotiators—and we negotiated the first capitation plan in the country for seniors. That later became Medicare Advantage. But I was actually a founding member of that group. We did that deal, designed that plan, and basically agreed that we would take 95 percent of whatever the average area per capita cost was. We put that pitch on the table. We told the government, you can save 5 percent off the top. Give us your Medicare people as enrollees—we'll take care of them for 95 percent, and you don't need to worry about fraud. It was a good plan. Then I left Blue Cross.

04-00:07:28

Meeker:

So, this 95 percent came from you?

04-00:07:32

Halvorson:

Yeah. Our proposal.

04-00:07:34

Meeker:

So, this was, just to kind of let the readers of this interview know a little bit more about this, from what I recall, was a revision of the HMO Act that happened in the late 1970s, is that right?

04-00:07:49

Halvorson: Yes.

04-00:07:50

Meeker: Okay, and so it wasn't a policy change, it was actually a legislative change that you had to engineer, correct?

04-00:07:57

Halvorson: Well, it was a legislative change and a policy change, so we had to go, we spent time in Baltimore negotiating with the people who ran HCFA at that time, on how to get this capitation deal. We offered them a 5 percent break, and we had a really good time doing that. Paul Ellwood had a lot of credibility at that time because he'd helped Nixon get the HMO Act passed, and so we were one of the very first Medicare HMOs. I think some other people were having some similar ideas in other parts of the country, but I believe that we were the first pilot.

04-00:08:37

Meeker: Well, it was a big question, right, because Medicare comes out in, you know, the 1960s, and there was not a clear way about ways in which HMOs or a capitated program could participate in that.

04-00:08:54

Halvorson: Right, right. Initially, there was no way, and so we came in and offered this as a proposal. Kaiser was not in the room at the time. There was a different agenda. Kaiser was negotiated with the government about what to do, but we were the first capitated plan or offering, and we set the Twin Cities up to be a Medicare marketplace.

04-00:09:20

Meeker: The rationale behind this 95 percent, can you explain that to me?

04-00:09:24

Halvorson: We knew we could sell it. We knew that we were that much better, easily 10 percent better, than the commercial, than fee for service medicine. We knew that we could give a 5 percent break off the top, the government would move for five. We debated, did we need to give them 10, then we said, "5's enough, we think we can get this deal with 5," so we offered 5 and shook hands with 5 and did the deal on 5.

04-00:09:53

Meeker: Who was negotiating on the government side?

04-00:09:54

Halvorson: Sidney Treager was a key person from HCFA at that time, and then there were some elected officials who I can't remember. Sidney was the in-house guy, but then there were some elected officials at the time. It was a good idea, but then when I left the Blues. We had just started to do that Medicare work. The HMOs in town had begun to do the enrollments. That process was going on, and then we said, "What about seniors, though, who are really sick?" Those

seniors need extensive care and needed it, so we said, “Why don’t we enroll them?” This was not “we.” This was the people who ran Wilder and Health Central and Ramsey Hospitals. They decided to form a health plan to do a senior plan for sick seniors and high need seniors. That’s what they were looking for a CEO for, and that kind of appealed to me. I thought, you know what, these are good players, I like these people, I like the idea, I think I know how to run a health plan because I had already set up one, and so, I think I can do this job.

So, I took the job. I started the process, put together the pieces of it, and got a really nice little network going. Both communities. I persuaded the major senior consumer program—the Minnesota Senior Federation—to endorse it and to help me lobby it. And then in Washington, the administration decided to freeze the plan and not give us the contract that we needed to go active. So, I ended up spending many months in Washington lobbying the administration and CPO and getting them to work with the issues of high-risk senior care. We finally, after many months, got a contract. In the meantime, back in the Minnesota side, I was assuming we’re going to get a contract, so we’re building infrastructure and building some staff, and spending. So, that was a bit of risk because had I not gotten that contract, everything that’s with Minnesota would have been a waste, but we did.

04-00:12:19

Meeker:

Were there start-up costs involved in this?

04-00:12:22

Halvorson:

Oh, yeah, because we’d hired staff, built a network, put a claims system in.

04-00:12:27

Meeker:

Who was paying for the start-up cost before any of the—

04-00:12:28

Halvorson:

The three founders. The three founders each put in a few million dollars to make this happen. Those were the days when \$1,000,000 went a long way.

04-00:12:38

Meeker:

It was a risk, then.

04-00:12:39

Halvorson:

Total risk, complete risk. We didn’t have a contract. I was basically doing the design and it had never been designed quite like that before, and there were some social HMOs at that point in time that were forming around the country to try to do the same thing. The government had a separate program, separate from Senior Health Plan, called Social HMO. We ended up merging with the Minnesota Social HMO, further down the road. Anyway, so we got the contract and I went back to Minnesota and cranked this thing up. We ended up getting some enrollment and it was a good plan. I was Senior Health Plan CEO. So I did that during that time. At the same time I did Senior Health Plan, Health Central, who was a hospital system investor in this thing, wanted

to do health plans in several other states. So we formed a subsidiary company called Health Accord, and Health Accord started HMOs in Tulsa, Oklahoma. We helped a plan in a Santiago, Chile. We had a couple of other projects in Jamaica. Went down to Jamaica and started HMO Jamaica. So, I actually was doing the Minnesota plan for seniors and then flying around parts of the world at the same time and setting up these other plans, and having a good time with all of that. I think we delivered pretty good senior care, and I think we invented risk-based capitation.

04-00:14:21

Meeker:

Well, that's what I was going to ask you about.

04-00:14:23

Halvorson:

We pitched them an actuarial proposal that said the same thing: we'll take this high risk population, we'll project forward-based on good actuarial expenses what their risk would be and we'll take that risk for 95 percent. So, I used the same model, except for high risk, and then we basically created a risk adjuster. So, the sicker the people were, the more money we got, against the formula.

04-00:14:49

Meeker:

I imagine the Feds—I'm surprised they didn't balk at that, you know? This was the 1980s, as well, where there's some belt-tightening in Washington, right?

04-00:15:00

Halvorson:

There was some belt-tightening, and also, there were people in the Reagan administration who wanted to kill the whole thing. I mean, so we had that going as well.

04-00:15:11

Meeker:

"Kill the whole thing" meaning HMO, or—

04-00:15:13

Halvorson:

No, any expansion into seniors because they wanted to not expand Medicare.

04-00:15:20

Meeker:

Or devolve it to the states, or something like that?

04-00:15:22

Halvorson:

Yeah, and they were really worried that what we were doing, some people were worried at policy-level about what we were doing was expanding the scope of Medicare and the benefit packages that Medicare didn't traditionally cover. Which was true. Because we were doing in-home care, we were able to buy air conditioners for people who had asthma so that we could keep them from having asthma attacks. I mean, we had a lot of flexibility in the use for money that didn't exist under traditional Medicare.

04-00:15:51

Meeker:

They kind of saw it as a Pandora's box, in some eyes?

04-00:15:53

Halvorson: Yeah, they saw it as Pandora's box. Yeah, they worried that this could really explode and go to a bad place.

04-00:15:58

Meeker: Was that part of your agenda, meaning wanting to work for a public service organization, a nonprofit, that maybe you saw this as an opportunity, in fact, to improve and expand care, just what the administration was fearing?

04-00:16:16

Halvorson: Yeah, what I committed to myself was I'm going to spend some number of years in my career doing public service, and I'm going to count this job as that. This is the public service part of my agenda, so I'm going to do this as public service, create this senior plan. I worked with poor seniors in Minneapolis, I worked with poor seniors in St. Paul. I mean, I worked with the poverty folks, community clinics, and then we put together a good plan to network in the benefits.

04-00:16:44

Meeker: How did you then convince the administration that this wasn't a camel's nose under a tent for expanded Medicare benefits?

04-00:16:54

Halvorson: I think I just wore them out. I just spent so much time pitching why this makes sense and it's the right thing to do, and appealing to the higher ground, and also saying, "No, we are going to do this for 95 percent of the total medical cost for these people, you don't have to add one penny to pay for any of these social services that we're going to provide," and convince them that that's part of the package, that part of the package is that we will provide this for the same amount of money, so you're actually getting more for your federal dollar and spending less in total. So, that was kind of the pitch, and it was true. So, I didn't have, as a goal, trying to somehow expand the scope of the government. I really had as a goal, let's serve these seniors and do a really good job taking care of them in this way. So, and then at the same time, partly because I like to start health plans, and we started the one in Tulsa and we started a couple others, helped some of the other plans get started, and so I was actually doing these things at the same time.

04-00:18:04

Meeker: That's in the context of Health Accord?

04-00:18:07

Halvorson: That was the context of Health Accord, which was a sister plan to and it was headquartered in the same office as Senior Health Plan. Which, coincidentally, was my office. Then, I got engaged to be married, and the woman I was engaged to, after I had been off for several weeks where I was traveling nonstop, said, "It would really be better if you actually had a local job." The Group Health plan in town had called me later and asked me if I wanted to interview for their job. They were the old staff-model HMO in

town, and at that point, they had 180,000 members. They had 180 doctors on staff, and a couple of clinics, 10 clinics.

04-00:19:03

Meeker: Kind of a mid-sized program at that point.

04-00:19:06

Halvorson: Yeah, mid-sized program at that point. Been around for a long time and it was shrinking. It actually had gone from almost a quarter-million members down to under 200,000. Shrinking is not good for that model because there's not a lot of flexibility there for shrinkage. So they were dealing with several issues.

04-00:19:28

Meeker: And adverse selection, I'm sure.

04-00:19:30

Halvorson: Yeah. So, what happened when they asked me to consider working there was I had said, "No, because I'm having a great time." Starting a health plan in Jamaica is a really fun thing to do when you're single. It's less fun when you're engaged, and I suspected it wasn't going to be anywhere near as much fun, married. So, I thought, you know, that could be right, maybe I should talk to them. So, I called up an old friend of mine and said, "Do you remember who the headhunter was on that job?" They had called him, he ran a New York health plan, and he'd said no as well, so I said, "Do you remember who they had as a search firm?" He said, "I think I've got their name in the Rolodex." So, he called them up and said, "George will talk to you now." So, he made that call. They called me, and I said, "I'm leaving town, I'm flying south, but I can meet you at the airport." I said to the search firm, "I'll meet you at the airport and I can talk to you for a couple of hours before I leave town," and then I took off for Jamaica. We really hit it off, the headhunter and I. They had gotten down to two finalists. They had the last two people for the job. When I got back, he said, "The board is holding the job open to have one interview with you, if you wanted to have the interview." So, I met with the board and had a really good interview. I explained to them what their issues were, what their challenges were, and what they were going to face, what the market was. I'd been running a major health plan in that market, a smaller health plan in that market, already. So, for them, it was kind of an easy—

04-00:21:19

Meeker: Do you recall the substance of what you told them at that point in time? So, this is, you know, '85, '86.

04-00:21:27

Halvorson: I said, "If we do this right, we're going to be the best model on the planet. This organization has done a lot of things wrong. You've cut some corners and you've done some things, but if we do this right, there's no reason not to have this model win."

04-00:21:39

Meeker: Were you pretty familiar with the organization at that point so you were able to provide in essence a diagnosis of it?

04-00:21:43

Halvorson: Well, a couple of things—one is that I had competed with it directly for a number of years, and actually had competed against it very successfully. I took the Ford Plant and a number of clients—that was true. Second thing is I had actually been dating one of their doctors for a while, and she told me an awful lot about them, and so I had a lot of insight into the plan that I wouldn't have had, purely as an outsider. So that was totally serendipitous but useful learning. So, when I met with their board, I had insights that they were surprised by that weren't entirely—

04-00:22:28

Meeker: Public.

04-00:22:30

Halvorson: Yeah, exactly, arm's length perceptions.

04-00:22:36

Meeker: What was the problem, then? Why was the plan shrinking?

04-00:22:39

Halvorson: Well, they weren't committed to being the best.

04-00:22:41

Meeker: Okay, well, that's general, right? Can you give anything more specific?

04-00:22:46

Halvorson: They didn't realize that they could take that model and have it be the best care, and so they were willing to be okay, they were willing to be pretty good service, darn good care, but they didn't have a sense of being great.

04-00:22:59

Meeker: So, it was a question of service and quality? Okay.

04-00:23:03

Halvorson: And positioning. I also said, "Yeah, the network isn't exactly right. We will need to build." One of the things when I became CEO, I built a network of clinics that surrounded the Twin Cities Beltway. So, went out in the Beltway and to all of the major intersections of the Beltway, put in sites in each place. You could get anywhere very quickly by car if you joined us as a plan. We built some lovely new sites. The old model, the brand was really different. Because they had been perceived to be the "Commies of Como Avenue," as they were called at one time. They actually built their clinics to be invisible. They actually had invisible clinics. You couldn't find the clinics. One of the clinics was on one of the main freeways. They actually built the clinic to face away from the freeway. So people drove by it, tens of thousands drove by it every day, and from the back, it looked like a warehouse, and that was

intentional. They had actually had this very low-visibility model. I said, “No, what we need to do is raise our visibility, to become extremely obvious that we’re an alternative, and we need to put clinics in high visibility sites, et cetera.”

04-00:24:17

Meeker:

Sounds like these are some of the problems that Kaiser maybe had in the 1960s and seventies, right?

04-00:24:24

Halvorson:

Yeah. Coming to Kaiser was really a very easy transition for me because I’d gone through a lot of the same issues. One problem was that there had been a group of surgeons who had worked for that Minnesota plan who had not been good surgeons. There had been some good surgeons, but there had been some surgeons that weren’t good at all. So, the term used to describe that plan in some circles at that time was “Group Death,” so instead of Group Health, it was Group Death. The Group Death image was not a good image for enrollment. It’s not a great marketing approach. Yeah. Undertakers, maybe.

04-00:25:06

Meeker:

Probably not. So, I imagine some of the problems that it was suffering were, you know, long wait to see physicians, difficult time to actually get to specialists, aging facilities, all that kind of stuff.

04-00:25:18

Halvorson:

Yep, all of the above. What I basically said to the Board of Directors was that there’s no reason not to be great. I have done a capitated model, done a network model, I know what all the models look like and I know what the capabilities are of this model and I know that we can do some really good things. So if you choose me—and I also said that we need the vertically-integrated data. I told that Board that we have to have all of the data for each patient vertically-integrated. I’d figured out that data need from a distance. Although I thought we were going to get the data from a claims system, not an EMR. I was going to use the claims system combined with medical information to have data, full patient data. So, I actually pitched that at the meeting, but one of the reasons I pitched it was I had done that with Senior Health Plan. We put an electronic medical record into Senior Health Plan for seniors. That was probably the first functional electronic medical record in the country for a health plan, and we put it in because a wonderful otolaryngologist who was on the staff at the hospital was a brilliant man. He understood systems, and he had built an automated otolaryngology system to support his multiple clinic sites. He showed me what that system looked like. He actually went from site to site carrying disks, but he put a complete electronic medical record in place—Dr. Jerome Hilger, I’ll never forget his name. Dr. Hilger convinced me that that was a smart thing to do. So we expanded it to all senior care, and we put an electronic medical record in for senior care at Senior Health Plan.

04-00:26:55

Meeker: What was the operating system that you used for that?

04-00:27:00

Halvorson: I don't remember.

04-00:27:03

Meeker: I mean, this would have been before probably even a Microsoft DOS system?

04-00:27:07

Halvorson: Oh, yeah, way before. So, we were running on Honeywell gear, actually. So, it was an old Honeywell whatever system, but it worked. So, I said to the board, "If I come here, one of the things we're going to do is we're going to do what we did at Senior Health Plan because we need all the information about the patients all the time." So, the staff internally initially resisted that fiercely. They did not want to go to electronic record. In fact, the rumor was that I was a co-owner of the systems company. There were also some people who later thought I had co-owned Epic, which also turned out not to be true.

04-00:28:02

Meeker: It would be nice.

04-00:28:04

Halvorson: Yeah, on that one. I would be okay, but it wasn't true. People who were used to the old model and the old approach again, but I said, "If you bring me in here, we'll have better products, we'll have better outcomes, we'll have better service." I said to the board, "Right now, when doctors who practice here are asked where they practice, they say, 'Bloomington,' or they say, 'In the suburb.'" I said, "Because they don't want anyone to know what medical group they're in. I said, "My goal is three years from now, when anyone asks them where they practice, they'll say, 'Group Health in Bloomington,' and they will want everyone to hear that it's Group Health." So, I said, "My goal is to flip that over so three years from now they will take great pride in being here." The board didn't know if I was completely bullshitting them or partially, but they liked the sound of that, and what I said turned out to be true.

04-00:29:10

Meeker: What did the board think of the status of Group Health at the time that you were being interviewed?

04-00:29:17

Halvorson: They were worried. Well, they were worried, and partly, they were worried because they'd been shrinking—the person who ran it before me was Leonard Schaeffer and remember Leonard Schaeffer who ran WellPoint?

04-00:29:29

Meeker: No.

04-00:29:30

Halvorson: Leonard came to California, ran the California Blue Cross, and then he converted Blue Cross into WellPoint. He did well in the process.

04-00:29:45

Meeker: For himself.

04-00:29:46

Halvorson: Yes, he's done well. Leonard, though, had been running that Minnesota plan, and it was the first plan he'd ever run, and he didn't know very much about running a company or a plan. So, the training ground for him before he moved to California to run Blue Cross—Blue Cross of California was the old Group Health plan—and he did some things really well and did some things fairly badly. One of the things he did well was he fired each of the problematic surgeons. He completely cleaned house of the less adequate surgeons. He went to the University of Michigan, hired a top surgeon, and said, "I want you to give me a world-class surgical department." So, when I hit the ground, I had great surgeons, I had great orthos, and Leonard hired really, really well. The people he hired for systems and marketing and internal operations were much, much, much less effective. So, I did almost an entire turnover, but his care staff hiring was almost gifted, he was so good at it. So, I started with pediatricians who were the best pediatricians in town. I had known a little bit of that from the woman that I had been dating, I knew that she took great pride in some of the new hires and some of the people that had been brought in.

04-00:31:10

Meeker: Was this a recognition of the beginning of the transformation of delivery systems? I know that looking at the longer history of Kaiser, for instance in the fifties and sixties, it was a very uphill battle to try to get the most qualified physicians. There was a lot of international hiring being done, for instance, that was actually the best candidates that Kaiser was able to get for a period of time. So, it seems interesting to me that in the seventies and eighties, Group Health, although it was shrinking and didn't have a great reputation, was able to hire some top-notch medical talent. Why do you think that he was able to do that, your predecessor?

04-00:31:55

Halvorson: I think partly it's just the personality of Leonard. I think Leonard just has the kind of personality that he convinced those people that if they came there, he basically said, "You're going to have a couple thousand patients. You're going to run your hospital. You know, you don't have to worry anymore about fees. You get to now focus on the patient. You get to deliver great surgery and you get to hire the people to do great surgery, and you can mold them." The great surgeon did hire some people who he had almost as acolytes. So, if you need surgery in town, you went from the place that you absolutely would not want to go to the place that if you could get in to, you really wanted to go there. Leonard did that, and so when I started, I didn't start with having to do

massive catch-up. I started with some pretty good people in some pretty good positions. That was very useful, and then I started bragging about it, then I started taking the data points public. One of the reasons I got some of the data points was so that I could run brand and sales advertising campaigns with the lowest pre-term birth rate and lowest heart attack rate.

04-00:33:09

Meeker:

Well, that is the other side, then. So, it's marketing and then sales to make sure that people know about the good work that the plan is doing, and then also so the plan is not shrinking, and so that it remains economically viable. How then did you as CEO go about changing the sales and marketing environment there?

04-00:33:31

Halvorson:

Well, I had run sales and marketing at the Blues. I knew who the best sales and marketing people were at the Blues, and a couple of them were willing to join me. So, I took the top sales manager from Blue Cross, made him the vice president of marketing. I'd typically done ads myself. I've been writing ads since I was in college. I worked for an ad agency for a while. So I've always been an ad-writer. So, I did a lot of the advertising work with ad agencies, but I did a lot of the copy myself. Which makes it a lot easier if you're trying to figure out exactly what you want to say.

04-00:34:22

Meeker:

Do you remember some of the copy that you wrote or some of the messages that you were trying to communicate?

04-00:34:26

Halvorson:

Geez, I wish we wouldn't have just cleaned this office out. I had a whole folder of old ads. Yeah, I've got a bunch of those old ads. We won a few awards, actually.

04-00:34:37

Meeker:

No kidding.

04-00:34:39

Halvorson:

Yeah, it was a good set of ads and basically, did a lot of radio ads as well because radio is a really good way of convincing people when you're trying to do that kind of a message. One of the things I did on the radio ads was the radio ads that had data in them about we have 30 percent lower rate of heart attacks or whatever the numbers were, I bought what they call reader ads. Reader ads are when the announcer has to read the ad instead of pushing a button and playing the ad. The reason I bought reader ads—and we're going to do this again with First 5 of California, where I'm going to use that same technique again—the reason you do reader ads is because the announcer has to read it and hear it, and those media people are influential. So, if you get the people who run all the talk shows and whatever reading your ad and speaking on their behalf, saying, "If you go here, you've got a 30 percent lower pre-term birth rate," they hear it, they believe it, they internalize it, and then it

becomes part of the belief system of those key people in the culture. What you want to do is you want to create a critical mass of people who believe in what you're doing and who are credible. Ads are a good way to that.

04-00:36:05

Meeker:

Was your audience at that time, did you think, the healthcare consumer, or the representative of the group plans, the employer groups?

04-00:36:17

Halvorson:

Yeah, employers. I had to get to the employers first. We got to the people by doing ads that were fun and friendly and in fact, I'll show you some. We actually did ads at one point that were about major care. We took a woman that had a heart transplant and she talked about it. We took a kid who had massive surgery because he was so badly crippled, put him on the ads. We took people who were really, really badly damaged by life and care and we showed how we had turned their lives around by being there for them. So, instead of being the place that was trying to duck the sick patient, you know, the old risk avoidance kind of thing, we did just the opposite. We took cancer patients and said, "I had this cancer. But because of HealthPartners I'm in remission and I love HealthPartners" kind of thing. At KP, if you've seen the "Thrive" ads, we did very much the same thing.

04-00:37:14

Meeker:

It's impossible not to see the Thrive ads. I ride BART, so.

04-00:37:20

Halvorson:

Yeah, so, but we did the same thing—we took cancer patients and, you know, day in the life cancer patient, because you want people to have a sense that we're not shying away from sick people and want to help sick people. So, I became the Minnesota CEO, and then started strengthening the medical group, strengthening the marketing, built some clinics, expanded into some new areas, and then I pitched a merger. MedCenters still existed as a health plan. MedCenters was across the river. They had been growing, Group Health had been shrinking. Group health had gone down by about 20 percent enrollment. I flipped it around and got it back to growth, and then I went to the MedCenter's board and I said to the MedCenter's board, "You need to merge with us, and you need to merge because you're going to get hammered this year because it's a seven-county metropolitan area and you're only viable in two counties. Two counties isn't enough, and what Blue Cross and PHP are now going to do is sell total replacements to buyers, and they're going to bump you out of group after group." Their board said, "That's wrong, that's not going to happen," and then their staff said to their board, "That's wrong, that's not going to happen." And they said NO. And then it happened. So, a year later, I went back and said—because enrollment data was all public—"Guess what, it happened to you, and it doesn't need to happen again. We grew last year, you shrank, and you're going to shrink again, next year. Two years from now, you're going to be tiny. Or, you could merge with us, and if you merge with us, together, we're going to be really fierce because the two

counties that you are really strong in are our weakest two, and we've got everything else covered, and so together, the footprint is really good." I gave them the map, showed them the stuff, and they agreed with the information. So, we did that merger, and it was basically an acquisition merger.

04-00:39:41

Meeker:

I'm curious how that happened, particularly from the Group Health side of the equation because there are similarities between the MedCenters and also Group Health, but there's also some pretty profound differences. There's historical differences and there's ways in which the care is organized.

04-00:40:03

Halvorson:

They're both networks. MedCenter's was based on Park Nicollet Clinic, which was a multi-specialty group clinic that was located next to a hospital. They later merged with the hospital. They weren't merged yet, but they were also a vertically-integrated functioning system, so it wasn't that far apart. It was two networks of groups getting together, and on the ownership, I basically said, "We're consumer co-op, consumers run Group Health. They elect our board, whatever. We'll start, we'll name all of your people to the board and then they'll have to stand for election in the next round of elections. But these are really good people, you'll probably do fine." It actually worked just fine and they ended up—the ones who wanted to get reelected got reelected. We converted it to co-op and then we went to the doctors and said, "Who better to work for than the patient? I mean, do you really want to work for stockholders? Really? You want to work for somebody who's for-profit only in your company, or do you want to work for the members? Do you want to work for the patient?"

They said, "That patient thing sounds good." So we got the merger to work. Then, what we did was we created the Institute for Clinical Systems Integration as a consequence of the merger. ICSI, actually is still running. What ICSI was, was a coalition of doctors who worked together to put together medical best practice protocols. The medical director from the old Group Health became the head of ICSI, the operating head of ICSI, and the CEO of Park Nicollet became the chair of ICSI. We reached out to Mayo Clinic and made it a three-way bank shot and brought Mayo in as a third owner. Mayo has a lot of credibility in Minnesota, and so ICSI basically did care protocols based on the best medical minds in Minnesota, and that gave us a real credibility, and all of our doctors were okay with that. If I, as the CEO, would have given them health plan protocols, they would have, you know, firebombed my car.

04-00:42:23

Meeker:

Meaning health plan protocols, protocols developed by the health plan?

04-00:42:27

Halvorson:

Yeah.

04-00:42:31

Meeker: Handed them a cookbook, right?

04-00:42:35

Halvorson: Wearing my health plan hat, if I would have handed them a cookbook full of things to do—here's what you must do for care delivery—it probably would have been the wrong list. But also, the resistance to that approach would have been fierce. But if I come in and say to the doctors, "I don't care what care apparatus you and Mayo and Park Nicollet come up with, I'm going to support what you create. But I want you guys to figure out what's the best thing to do for simple cystitis, to say that." That was one where we actually had 60 different approaches being done. I mean, it was just amazing. Every doctor had their own treatments, and some of them were almost idiosyncratic. You know, grape juice type of thing. We basically identified that there were a couple of really good approaches. We basically cut the hospital admission rate in half. We cut the recovery time in half, and we really did some really good things by having these really smart doctors sit down to figure out the best medical practice collectively. So, then we made ICSI the template for our care delivery.

04-00:43:41

Meeker: What kinds of instructions were given to the physicians? This is, I mean, really interesting because, you know, like what you alluded to, physicians have a very strong professional independence streak, and there is a lot of criticism of care practice protocols and guidelines and such. I mean, it's interesting the way in which you described it, but I kind of wonder, like, what the initial assignment was, in that sense.

04-00:44:11

Halvorson: Well, figure out best practice.

04-00:44:12

Meeker: For what? Like, for everything?

04-00:44:13

Halvorson: For everything. No, for each thing. We made a list, we started with 30. We actually started with 30 things. We said to ICSI, you guys need to develop care protocols for these things. You need to figure out what's the best practice. My only requirement is it has to be science-based.

04-00:44:28

Meeker: Evidence-based.

04-00:44:29

Halvorson: Yeah, science-based, evidence-based, you can't just come up with stuff and you can't have a bunch of doctors getting together opinion-based things, where a bunch of experts get together and do an expert opinion. It's not valid for these purposes. What you have to have is some evidence. Until you say you don't have evidence. We need science to create the evidence. But we will support that with what we're doing. Doctors all want to do the right thing.

Doctors always want to deliver the best care. If you basically say, “Don’t do the cheapest care,” because if you say “Do the cheapest care,” then they’ll eliminate paperclips or something, or they’ll do something inappropriate. But if you say, “Do the best care,” I actually believe, Deming said repeatedly that if you build the best and most elegant system, it will also be the cheapest way of doing what you’re doing.

04-00:45:16

Meeker:

Is this where you’re getting a lot of these ideas? The idea of evidence-based or science-based medicine, at this point in time, is pretty rare. I don’t think that term was even coined until probably some years after, this evidence-based medicine.

04-00:45:33

Halvorson:

Deming, it was Deming.

04-00:45:34

Meeker:

Was it?

04-00:45:36

Halvorson:

Deming and John, whose name I almost had, starts with an S. Now again, I’m getting closer. I read key Deming stuff, I went to some Deming seminars myself. I read his stuff and I came to believe that it really does make a huge amount of sense to have data and do process improvement, and I really believe that if you focus on the best way of preventing asthma attacks, that’s also going to be the cheapest. But if you work on the cheapest way of preventing asthma attacks, you’re going to make a lot of mistakes—you’re not going to get the right care. Care delivery doesn’t lend itself to going down side tracks for expense, but it really does lend itself to getting it right. I brought the same commitment to KP. I keep saying, “Do the right thing. What’s the right thing on this? Do the right thing. Whatever the right thing for care is, do that right thing.” That’s going to cost us less in the end than doing the wrong thing. It does. I know that it works almost 100 percent of the time, and once in a while. If it’s more expensive to do the right thing, but that’s fine, too, because you should be spending your money to do the right thing. So, that’s not a problem because what you get out of that approach and strategy is you get the best care and the highest value, and most of the time, doing it right costs a lot less than doing it wrong. The other thing about that is when doctors know that I actually totally believe that, that creates both a credibility and a sense of alignment that this is really very useful because good things happen in that model.

04-00:47:18

Meeker:

That’s interesting. I’m wondering if you can give me a sense of when you first arrive at Group Health, and then also when you bring the MedCenters into the plan, you know, previously, you had been an insurance guy, right? But now, you’re actually, like you said, the hirer, the firer of the physicians, which previously wasn’t really the case, from what I understand.

04-00:47:44

Halvorson: No.

04-00:47:45

Meeker: So, how did you create, cultivate your own legitimacy in that role for the physicians, which obviously is going to play a role later on here at Kaiser?

04-00:47:57

Halvorson: Consumer. Customer, consumer. The patient. It's a consumer-run health plan, and I wore the consumer hat. I basically said, "I am a patient. I want best care. I'm going to support best care, but I need best care and I need science-based best care and I need to support you giving it." It's extreme legitimacy, saying it is all about best care. If I would have ever said something that was medically specific—like, "And you need to use penicillin on the third day on this treatment," I would have had no legitimacy. It would have been wrong. But when I say, "I need you, who is a very smart person, to figure out when do we use penicillin on this patient. I'm going to support you on that. But I need you to figure it out and I need you to do it right, and I'm speaking on behalf of our patients. Our patients really want you to get it right," there's a lot of credibility to that. That, actually, there's an automatic legitimacy that comes from having that position. If I just came and said, "As a health plan person I want you to do X, Y, or Z," yeah, much harder sell. The doctor-patient relationship is a sacred relationship. I mean, that's something that doctors really, really take very seriously. What I am doing in that setting is helping the patient, being the patient, being representative of the patient, not being chain of medical command.

04-00:49:26

Meeker: Do you think that's where sometimes health plan leaders who are also physicians sometimes get in trouble?

04-00:49:38

Halvorson: Yes. Actually, in some ways, it's easier. If I were a physician, I would be much, much more tempted to decide on which day to use the penicillin. Much more, absolutely. But because I'm not—and don't want to be; I mean, the other thing is I have zero interest in doing that job. If I would have really wanted to do that job, I would have gone to medical school. I don't want to do that job. What I want to do is the job of helping doctors deliver best care. When I got to KP, the physicians here, the leadership and the board, had both read books that I had written and knew what I believed in. So, I started with a leg up—I didn't have to start by saying, "Here's who I am and here's what I'm about." Basically, you could take a look at my books and say, "Okay, George believes in data-based best care and he believes in focus on the patient and he believes in team care." Those things were all part of my belief system and they're in my books for very—you've read the books, very simple, practical approaches.

04-00:50:50

Meeker: Comprehensible.

04-00:50:53

Halvorson:

Yeah, I try to boil things down to really functional and simple, easy to understand points, and I don't debate any of the issues. If somebody comes back and says, "George, you're wrong on this one," my reaction is joy. People have seen that over and over again, I think, "Whoa! I get to be right." I mean, because if I'm wrong, I want to change that to be right. I really want to be right and I absolutely need to be right, but I don't need to be right on any given thing at any given moment. I need to be right at the end of the learning process. So, people in each of the places I work have seen that, that when they can make me wrong on something, once in a while, I feel sad about that if it's something that I've been—but usually, that doesn't happen. There's a joy in continuous improvement. I always say, "We all get smarter every day." I'm smarter today than I was yesterday, and you're smarter today than you were yesterday, and collectively, we're a lot smarter, so let's take advantage of how smart we are today and let's get it right now.

04-00:52:14

Meeker:

You know, I do want to ask you about this development that happened around HealthPartners in the 1990s that was covered quite a bit in publications at the time. It seems like it's kind of been left by the wayside since then, but I'd still like your perspective on it. That's the Business Healthcare Action Group that was established; it's probably something you haven't heard of in ten or fifteen years, I'm guessing, but just to remind you, it was a coalition of twenty-one companies who kind of banded together in a purchasing pool, which we hear a lot about today, to try to get the best services and rates. HealthPartners was an early applicant, I guess, to be the main contractor for this, and it won the first contract. I'm wondering if you can tell me a little bit about the larger issues that this brings up, which is relationships between the health plan and the purchasers, which are typically, you know, the companies who are buying the insurance for their employees, and their desire to get the best deal and perhaps to see innovation on your part, but then also, you know, your desire to make sure that you also have a viable business model. I wonder when this group first got together, was this something that you and HealthPartners saw as an opportunity, or as kind of a, maybe an unwelcome challenge at first?

04-00:54:17

Halvorson:

No, we actually encouraged the formation of it. We helped people get into it. We thought it was a really good thing to do, and we put in a proposal to be the vendor and the infrastructure for it.

04-00:54:38

Meeker:

Why did you think it was a good idea?

04-00:54:40

Halvorson:

Because it makes sense for purchasers to be smart purchasers. My books are all about that, I wrote books and chapter after chapter about why you need to be a smart purchaser, and we thought it was a really good idea to be a smart purchaser. We thought if these people become the smart purchasers, we're

highly likely to win because we're really, really smart product. So, we thought smart purchasing was a good thing for them to do, and so we encouraged it, we set it up. Several organizations bid on the business. Blue Cross was second. We were first. We ended up being chosen. One of the reasons we were chosen was the Institute for Clinical Systems Integration was part of our bid. We put that out there and said, "We're going to do this to get the best caregivers in the state putting together the best protocols." We then were the infrastructure for the process. We set up the data flow. We set up the quality agenda. We took our quality that we had and we used that quality tool kit, but we also enhanced the quality with some additional things. We created our own computer kiosks that provided information about the doctors and care, and we put those kiosks in the major work sites, and we created a whole infrastructure and vendor relationship around that data flow.

We had a good partnership. We had actually a really good relationship with the buyers, and it was a great deal. One of their board members resigned his job as the benefit manager for his company and became their permanent chair. He then started setting up a different relationship. So it wasn't us working directly with the coalition. It was us to him. Then he started adding staff and he started adding infrastructure. Initially, his office was right down the hall from my office, in a space that we gave him for nothing. Then, after a while, he thought that he needed more appearance of independence and he needed to be in a different building, in a different setting. Ultimately, he got to the point where he decided that this was a viable business, and they really needed to spin it off and make it into a separate process. The rhetoric at the time was that there were direct contracts between the action group and all the providers. There were none—not one. There was only one contract. It was with us, and all the vendor contracts were through HealthPartners. So, after a couple, three years, he basically said, "I want you to transfer all the HealthPartners contracts and take your name off the contracts and put our name on the contracts, and we will then become the infrastructure, and then we're going to have this other organization." I said, "What value add is that? As a buyer, you're the best buyer." I said, "As a buyer, you're the biggest buyer organization in Minnesota by far. If you stop being a buyer of this product and if you become a health plan, you will now go from 1,000,000-member leverage done through us down to being a 150,000-member leverage by yourself, and you will now only be the seventh-largest health plan in Minnesota."

04-00:58:05

Meeker:

They become an IPA, I guess, right?

04-00:58:07

Halvorson:

Yeah. So I said, "You can be the seventh-largest health plan in Minnesota and you can get whatever deals that size gets, or you can stay with us, be the biggest buyer in the state, leverage our million members, and end up with your best deal." They said, "You know, we think we need more

independence,” so they insisted on going through this whole transition. So, we resigned the contract. We said, “It doesn’t make any sense. If you want to be a competing health plan, go ahead and do that, you’re welcome to do that. You’ve got a year to build up whatever infrastructure you will need to do that work.” They went off to do it, to hire plans people and data people, whatever. They lost all of their quality reporting for a while because you can’t do the kinds of quality reporting with under 100,000 members that you can do with 1,000,000 members. They lost their volume reporting. So, instead of doing quality reporting, they did quality contests.

They had contests every year for best quality that had a lot of publicity, but it actually was a different infrastructure. Cancelling their contract was not an easy thing to do, but what they were doing relative to some of the people were demoralizing my staff so badly because they were taking all the things that we were doing well, repackaging it, like all of the HEDIS stuff, repackaging it as though it was separate in their agenda. At the beginning they really had no part of any of those agendas. Again, when I talked to their board and I said, “If you want to take great credit for all the stuff we’re doing, then we can do shared credit, that makes a lot of sense. But if you want to go off and spin it off yourself and then compete with us in our own market, selling our own network against us with contracts that you don’t have, what’s the value out of that?” I said, “The only value out of that is that it creates the opportunity for you to have something you can take to market as a separate company.” They had dreams at that point of going around the US and setting up similar plans in other states.

04-01:00:19

Meeker:

That was sort of somewhat of the journalistic discourse on it, which was why do we need health plans at all? Why don’t the physicians just kind of band together and contract themselves?

04-01:00:28

Halvorson:

They talked about doing the same kind of direct contract, not knowing that there actually had never been a direct contract. The part that the journalists didn’t know—but that drove our staff crazy because our people knew what the real deal was, and our culture wasn’t to be dishonest—so, to be presenting our processes and contracts as these wonderful direct contract to all these providers when it was literally our contracts and their name wasn’t even on them, except at the subcontract level with us to get access to them. The whole process of setting up the risk adjustment based on each of the sites was our risk adjustor, our data, so that whole initial agenda for those first years was stuff that we did.

04-01:01:12

Meeker:

How did you, you know, as a health plan leader, respond to these many issues? We’ll talk next time more about the managed care crisis in general, but you know, when journalists just simply got things wrong or they missed a substantial portion of the broader story because healthcare, health insurance, is

so profoundly complex, you know, how do you fit that into 250 words? Clearly, in this case, they kind of went off the rails, right? Or they missed a key component and they were heralding the future might well be just medical groups contracting directly, and we don't need health insurance plans.

04-01:01:56

Halvorson:

What we did was that we didn't attack what they did because we said, "These member groups are our clients, have been our clients forever, and when we resign the account, they're going to be our clients again." And they were. So General Mills came back as a direct contract quietly. What we did not do was correct the public misinformation. But we just got the business back and went on without them. Then, they went off on their own for a couple of years—and they still exist, for all I know.

04-01:02:34

Meeker:

Yeah, I don't know. I don't think so.

04-01:02:37

Halvorson:

I don't know. But basically, for much of the time, there was no there, there. When they were a buyer, they were a brilliant buyer. They were really smart. They really asked for good stuff. They had negotiated great with the role, and they did a really good job as a buyer. We then took our leverage and when we had all the quality data for a million people, you can actually do really good quality stuff. But when you shrink down to the data for under 100,000 people and when they're spread out through a bunch of sites, you can't do it. So, when they were a buyer and they were getting quality data, they were great. Then they decided to become a plan. So we said—okay, go be a plan.

04-01:03:21

Meeker:

It also left in its wake ICSI, I guess.

04-01:03:24

Halvorson:

Well, ICSI, we always owned. ICSI existed before the action group.

04-01:03:31

Meeker:

Oh, okay. All right. I didn't know that.

04-01:03:36

Halvorson:

One of the reasons we got the bid was because ICSI existed. But you're right, some of the people on this who were part of that publicity claimed to have invented ICSI, or claimed that ICSI was part of, and it was never. It was always a subset of us. The only corporate member of ICSI was HealthPartners. Personally, I was the only corporate member, so the action group was never an owner or corporate member of ICSI.

04-01:04:10

Meeker:

All right, let's wrap up for today.

Interview 3: January 30, 2014

Audio File 5

05-00:00:03

Meeker:

Today is January 30, 2014. This is Martin Meeker interviewing George Halvorson for the Kaiser Permanente Oral History Project. This is tape number five, and we are here at his home in Sausalito, so, a different setting than we've previously recorded our interviews in. Last time, we covered a lot of ground: we focused a lot on your period of time as CEO and president of HealthPartners in Minnesota, and one of the things that was brought up in the context of that conversation was the Business Healthcare Action Group. From what I understand, one of the outgrowths of that was the idea to create a system of quality measurements so that consumers could be better informed about their healthcare choices. Am I getting that characterization correct?

05-00:01:10

Halvorson:

It's out of sequence.

05-00:01:13

Meeker:

Please correct me.

05-00:01:17

Halvorson:

Basically, what happened was HealthPartners put together a whole series of quality reports, and we had basically three dozen contracted medical groups who did business with HealthPartners in addition to the large medical group we owned. The medical group we owned was second only to Mayo—Mayo was bigger—but we were number two in the state. We owned a medical group, we had hospitals, and we put together quality measures so all of our consumers could choose between our clinics. So, they could go to a HealthPartners clinic, they could go to a Fridley clinic, they could go to the Coon Rapids clinic, and they would know what the readmission rates were, they would know what the basic care was for diabetes. We measured diabetes on several levels.

05-00:02:15

Meeker:

These were the eight points, right?

05-00:02:17

Halvorson:

These were a whole series of points, actually. These were actually a couple of dozen points that we measured. We actually set up electronic reporting. This was kind of pre-internet, so we set up remote kiosks in HR offices so that people could, as they were enrolling in the clinic, could pull up on the kiosk information about the clinic. We also put profiles of the physicians in the clinic, each of the physicians' profile was on the system. Subsequent to that, a number of the employers in town decided that they wanted to become a purchasing coalition and buy it together. We had actually merged the old Group Health plan with the old MedCenters plan to create HealthPartners. So, HealthPartners was a result of that merger, and when we did the merger

between MedCenters and Group Health, we worked with the medical group at Park Nicollet and said, "We need a process to create care quality standards and approaches going forward." We could do it before, when we owned basically the entire Group Health care system, but now that we're contracting—and Park Nicollet was almost as big as the Group Health medical group—we needed a process to do that. So, we created the Institute for Clinical Systems Improvement. That was written into that merger. So, creating ICSI was part of the merger. We then invited the Mayo Clinic to be part of that, and they were interested at the time in doing some things. So, we created the Institute for Clinical Systems Integration as a part of that merger negotiation.

The medical director and CEO for Park Nicollet, the medical director for HealthPartners, and myself sat in a room at Park Nicollet and actually designed the whole thing and the processes on his white board. It was one of the more fun days we actually had. So, we put that together. Then, the buyers came together and decided to purchase as a group, and they were looking at that point for a series of quality things. So, we offered, as part of our bid process, all the things we were doing on comparative care, and we bid as part of that process, the Institute for Clinical Systems Integration and we said, "This is part of what we will do if you choose us to be your partner. You will benefit from this."

They picked us because we were the logical choice because we were already doing the things that they had written into the specifications. I found over time, if you have the specifications written around what you're doing, you're more likely to get the bid. That's a good strategy. So, that happened there. We got the bid. One of the conditions, though, they said was, "Can we be on the board of ICSI?" So, I went back to the doctors who were the board and I said, "Would you be okay with adding a couple of consumers to the board from the buyers group?" Their response was, "Wow, that'd be great. Love to have these guys on board." So, there was a lot of enthusiasm for having the buyers in the room at that point. So, that was sort of the history, so it wasn't that the buyers created that idea, then we answered it. We actually had created it, and then the buyers decided collectively to support it.

05-00:06:03

Meeker:

How does, then, ICSI dovetail with HEDIS?

05-00:06:08

Halvorson:

HEDIS was long before. I actually started working on HEDIS with a group of seven health plans from around the country: Harvard Community Health Plan was one, HAP in Detroit was one, Health Alliance Plan, so we got a bunch of people, health plans together. We actually met in Chicago, we called ourselves the Chicago Seven for obvious reasons, and identified what we thought national quality standards should be for health plans. The reason we did that was because everybody was saying that if you go to a health plan, you're

getting low quality care, and we knew in those systems that if you went to a health plan, you're actually getting quite high quality care. I used to say that if we have a really bad doctor, we fire him, but don't worry about him—they're available from any other health plan in town. They practice. They don't leave town. They just go to another list. But they're gone from us because we fired him. That type of thing was sort of an anecdotal response and it wasn't sufficient, and so there were concerns about whether or not the care in the care systems was adequate, so we said, "Why don't we build our own standard?"

So, Kathy Cooney, who was my chief planner at the time at HealthPartners, and I sat down with the medical director, and together, we put together a draft set of things that we thought we could measure. C-section rates, surgery readmission rates. We identified a number of things that we thought that everybody should have. Immunization rates. We got together in Chicago and said to these other health plans, "Why don't we create some kind of a national standard where we all track this information and then offer it comparatively to the outside world to prove that we're doing a good job?" We knew we couldn't get data from the outside world, so we couldn't get anyone else's immunization rates, but we could have ours. We had some community data on some of those measures. The C-section rates, for example, were available from the community. So, that group of people liked doing that. So we agreed, as a group, to go down that path.

Then, we hired Towers Perrin. TPF&C, was an actuarial firm, a national consulting firm, and we hired them to come in and help us. Both to give us credibility for the process because they were really expert and well regarded, and help us structure some of the process. They sat down with us and worked it through, did some really good work, had some very smart people. Some of the things, we couldn't collect. Some of the things that I wanted to use, we had at HealthPartners, but they didn't have at other settings. So some of the things like premature birth, was really important to us. That was a major, major goal we had, was to reduce premature birth. Most of the other health plans didn't have any data about premature birth, so we had to take that one off the first HEDIS list.

So, we put together the list and then, with the blessing of and under the umbrella of TPF&C, Towers Perrin, we took it to the National Business Group on Health, who was at that time, the Washington Business Group on Health. They didn't change their name yet. So, we went to the Washington Business Group on Health and we said, "We've got this lovely tool that you guys should look at using, and if you agree to use it, we'll come up with a dozen health plans that will start getting you the data, and you can go down this quality path." So, we pitched it to half a dozen major employers and to the business group, National Business Group, and they said yes.

That process ultimately became both NCQA and HEDIS. So, the first draft of HEDIS, I actually probably wrote the first draft of the first document that

became a report in HEDIS. I knew, personally, that we had to have proof of quality. I could give all kinds of speeches about our pre-term birth rate and our asthma rate, and people would nod and the people who believed it would believe it, and the people who didn't believe it would just shrug it off and think it was some kind of a data trick. As happens, any time you give people data that contradicts a paradigm they hold, they think of it as an anomaly and dismiss it. So, that's how that process started. Then, we used that inside of HealthPartners, and as we were measuring how we were doing in our contracted clinics, we used that data set as a measurement tool. So we had the data set that related to diabetic patients, and we had both our own data and we had the initial stages of the HEDIS data.

05-00:11:38

Meeker:

So, is that the institutional relationship, then, between the HEDIS data collection and the ICSI?

05-00:11:42

Halvorson:

Yes, we were already doing that. We actually invented it—we brought that to the table—and then the HEDIS data said, "Yes, we accept that, that's a good data set." We did that with them, and we did that with them until we parted ways with the buyer group. When we parted ways with the buyer group, they actually lost the ability to do most of the same quality data. So they stopped doing much of that quality reporting and they started doing quality awards. What they did was to give prizes to clinics they felt had the best quality in the prior year.

05-00:12:26

Meeker:

But not based on evidence-based data?

05-00:12:29

Halvorson:

Well, some evidence. I wasn't part of their process so I don't know how they picked their winners. I do know that they used data that we were already collecting with those same clinics for our process, but they lost the process of reporting that to the patient. The other thing that happened was we had about 1,000,000 members, and the action group had between 100,000 and 150,000 members. So, the data credibility for fewer than 150,000 patients is a lot less than the data credibility for 1,000,000. If you take 150,000 people and spread that among 50 care sites, that's very different than spreading 1,000,000 people among 50 care sites. So, part of their problem was that they made themselves small, which was a very strategically strange thing to do. Part of the problem or part of the issue, I think, was some of the people who were part of that aspired to be national. They really wanted to take that agenda and take it to other states. At that point in time, United Healthcare and some other organizations were starting to become national players, and I think they wanted to go down a similar path. Some people, again—it's a complex group of people with many, many parts to it—but some of the people in that setting really wanted to go national. The problem with going national was that in Minnesota, they started with our 1,000,000 members as a base, and they

started with our complete quality program—but any other state they went into, they started everything on quality data from scratch. You can't have credible data about anything—C-section rates, asthma prevention rates, any of that—if you have too few people spread among 20 providers.

05-00:14:27

Meeker: There was no baseline.

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Halvorson: It was a non-starter. Yeah, they had no baseline, and so the business model to go national was highly aspirational but deeply flawed, and so they did not succeed.

05-00:14:41

Meeker: When I conducted some background interviews in preparation for this, several of the people, in fact, I spoke with mentioned the importance of HEDIS measures, and not surprisingly, they also mentioned that the development of these measures, while today make a great deal of sense and are widely accepted, at the time were actually quite controversial. Can you explain to me how it was they were controversial?

05-00:15:13

Halvorson: A lot of caregivers didn't want to be measured at any level. I mean, there's just a natural resistance to measurement, and basically, everybody believes that their population is the sickest, and their population is the most problematic, and there are all kinds of reasons for their data. So, when we said, "We're going to compare how well you did on your diabetics with how well another group did in their diabetics," some people just really didn't like that idea at all. So, that was part of the resistance.

05-00:15:43

Meeker: How did that resistance manifest? I'm curious.

05-00:15:46

Halvorson: Provider groups saying, "I'm not going to do it. I'll just say no," was a response strategy from a number of sites.

05-00:15:55

Meeker: How did you as the health plan respond to that, I guess?

05-00:16:01

Halvorson: We had no problem.

05-00:16:02

Meeker: Yeah, but how did you, as a health plan, respond to that resistance?

05-00:16:06

Halvorson: In our system, we had very carefully selected a network of caregivers that we liked and respected, who liked us and respected us, and we put together a network based on the things that everybody agreed to. So, there wasn't so

much internal resistance inside of our shop. When it was extended to other people outside of our network, there was more resistance, and outside of our state, a lot of resistance. So, when people tried to bring HEDIS into other states, there was resistance, "We're just saying no." But in our setting, none of the clinics—and I used to meet regularly with all of the boards of all of our contracted clinics—there was no resistance. In fact, they thought that we were adding value by helping them look at some of those things. What helped a lot, one of the things I've been blessed with in my career, it helped a lot that we were a care system and not just an insurer.

So, if I sat down with another care system and I said, "We want to measure the C-section rate," they knew that I wasn't asking for something theoretical or academic or hypothetical or political. I mean, I wouldn't say, "We want C-section rates," if I didn't know for a fact that we, as a care system who did C-sections and did a lot of C-sections, if we couldn't measure it ourselves. So, there is a trust level. I very seldom have faced the distrust level that health plans often face in dealing with care sites because I always had my care site hat on. The same thing is true of KP—when I'm talking about things that the country can do and I go out and talk to the hospitals of the country and I say, "We can do this on sepsis," or, "We can do that on pressure ulcers," this isn't the same as Aetna-WellPoint-Cigna coming in and saying, "You should do that." I'm coming in from we're one of the larger hospital systems in the country and we actually did that work ourselves on pressure ulcers. That's a very different credibility, and the motivation is different.

05-00:18:22

Meeker:

I'm also thinking about how these measures may be accepted more over time and why they would have been resisted by some people early on. When the first measurements come out, they're going to be compared against other systems. But then, as they're accumulated over time, they're compared against other systems, but they're also given an opportunity for the systems to compare against themselves and how they evolve over time.

05-00:18:50

Halvorson:

Right, longitudinal improvement is hugely, hugely important. At KP, my last three books have all had charts showing our sepsis results. Sepsis is the number one cause of death in American hospitals, kills more people than stroke, heart attack, cancer, or anything. Sepsis is the number one killer, and 24 percent of seniors who die in California, who die in hospitals, die of sepsis. It's a big number. So, we took a look at sepsis and we had three dozen hospitals that KP owned and operated, and we had a wide range. Everybody knew the science, everybody knew the medicine, but in terms of how well we were playing it, everybody knew it. So, when we measured, we had some that were in the low teens on death rate and we had some that were 30 percent. So, basically, one out of three of your sepsis patients were dying at one site, one out of ten was dying in the other. The hospital managers didn't know that, so when we then brought everybody together and shared that information, then

the worst care sites got better. In fact, some of the ones that were the worst on the first chart are now the very best in the system. We did a shared learning, but we couldn't have gotten to under 10 percent if we wouldn't have had the data and known exactly how those systems were doing.

05-00:20:25

Meeker:

The shared learning is the interesting, key component, right?

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Halvorson:

Yes.

05-00:20:28

Meeker:

You have the data that says that this is the way that things are and how things are changing, the trends, right? But then, the learnings are what help the laggard systems or groups become in line with the leaders. Within the HEDIS universe, for instance, what were the mechanisms for sharing learning?

05-00:20:53

Halvorson:

It varied totally depending on the health plan involved. So, what Aetna did in a community, if they were trying to improve their immunization rates, was Aetna specific to that community and it depended in the model of care sites that they dealt with. Whether or not they were dealing with groups, individuals, whatever. For us at HealthPartners, we had a limited number of contracted care sites, and so, when we dealt with the immunization rates, we knew what everybody's rates were, and then we sat down with each group and we said, "Guess what? You've got the worst immunization rates in town. Here's what the best sites do." In fact, on a couple of measures—and I got to do this because I was the CEO of the plan—some of the care sites were so bad that I said, "We're not going to report you for a year. We're going to give you a year's grace. On this particular measure, this is not reflective of you. You're good doctors. You're good people. This is not reflective of your performance. This would be embarrassing to you if this was made public, and so we're going to hold off reporting your numbers for a year. But next year, you need to be good, and whatever your number is next year is going public. You're not getting a three-year."

Almost without exception—in fact, I think, without exception—groups that were given that status ended up being among the best performers and deserved it. They did a good job. One of the groups I talked to was on diabetic care, and I sat down with them and talked to their board. I said, "I'm going to show you your numbers now, compared to the other numbers in the whole system, and thank you for doing this. It's really wonderful work. Guess what? You were the outlier in the system." They all thought, "Hooray!" They were ready to celebrate, and I said, "You're the worst. You're ten points below anyone else. You really, really have the lowest follow-up on this." They said, "That can't be." I said, "It is absolutely true and you know what needs to be done. You need to do it and you're going to need to make this work. You're going to have to put in reminders on the charts when patients are coming in. You're going to

get the nurses involved in the process. You have to get the receptionists in the loop. You have to do important things. If you do all of those things, you, too, can be great. Guess what? Your numbers are way down here when everybody else is here, and you're here, that would be embarrassing and you don't need to explain that to the community. So I'm not going to publish that, this year." They said, "Okay, thank you for not publishing, let's see what we can do." They literally flipped around: two years later, they were the best in the system and they were bragging about it.

05-00:23:40

Meeker:

Do you think that by giving these providers a reprieve for a year, it demonstrated to them that you as the leader of the health plan were not attempting to be punitive, but rather really were more interested in quality improvement?

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Halvorson:

Oh, yeah. It was, for me, totally about the patient. What's the best outcome for the patient? The best outcome for the patient is for this medical group to get good. So, what's the best pathway for this medical group to get good? It's not by shaming them. It's by helping them and informing them. They needed the data, and then we worked with them to get them to a good place. They knew—because I didn't send a letter; I sat down with a group and talked to them—that I did care deeply and I did believe that they're good people, and well-intentioned, and I really did want to help them get to the place they needed to get. So, it's always useful when you're aligned, in terms of values, and caregivers really want to do a good job.

05-00:24:57

Meeker:

Do you suppose some of the initial resistance to these measures was, in fact, the fear of being shamed in some circumstances?

05-00:25:06

Halvorson:

Shamed or reprisal or negative, or if you didn't trust the person on the other side of the data gathering. This wasn't an issue for us, but it happened in many settings. If you don't trust the person who's gathering the data and you don't know whether or not they're going to use that data against you in some way, and when your relationships with them have been adversarial on other issues, it's hard when you've been adversaries in one area to transfer over and become allies in another. What helped the country immensely was that NCQA was started and the buyers, many buyers mandated that they weren't going to buy from a health plan that wasn't NCQA-certified. So, the health plans had to go down that path. Then, the health plans having to go down that path put pressure on the care sites, said, "I need you in this site, working on these measures of diabetic care because these major employers, GE wants it, GM wants it," and that actually gave a momentum and a credibility to the whole process.

The immunization rates in this country, one of my books actually shows the chart, went from being the worst in the world to actually being relatively good. We actually had really low immunization rates before HEDIS, and then we started measuring that, and the health plans started making it part of what they did. The health plans went to all their care sites and said, "We're going to be embarrassed if we can't show that." The NCQA went through a couple of years of silent collection of data—they used that same model, actually, they went through a couple of years of collection of data before showing it—so they could go back, and ultimately, we ended up with a whole nation full of people getting immunized. That wasn't happening until those steps of the process were put in place.

05-00:27:06

Meeker:

Would these data sets of quality measurements become much more widely available? Not just within managed care instance, but much more broadly, do you find that they're being used by sort of employer health purchasing, like big groups, or do individual consumers pay attention to these?

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Halvorson:

Right now, most of the data is used, it's relevant to the employer and not to the consumer. So, if you were diabetic, you're less likely to go to the HEDIS reports on diabetes, but if you're an employer who employs a lot of diabetics, you're highly likely to want the health plan that does the best job with your diabetics. So, people get steered into the better performing care systems by the employer, not so much by their own choice. What I write about in my last couple of books is the fact that we need to take that now to the consumer level and make it very available to consumers, and we need to focus on things like the death rate because the death rate is hugely different for various kinds of surgery between different hospitals, and the death rate for cancer is hugely different.

So, if you have breast cancer and you go to one care site versus the other, you're four times more likely to die. Three and four times more likely to die if you go to the wrong site for your breast cancer. Those differences exist there. Actually, my books talk about them and show the differences. If you get care for breast cancer in Atlanta versus rural Georgia, you're three times more likely to die in rural Georgia than you are in Atlanta. The care systems are very, very different, and consumers don't know that. So, what we need to do is we need to take outcomes data that's really relevant to consumers, like death is relevant to just about everybody, and put the comparative death data in front of consumers, and when that happens, consumers can then have a higher chance of survival. Some care systems, you're ten times more likely to die of sepsis than you are in another care system. It's really the difference between .7 and 7 percent death rate, and so you're ten times more likely to die. So, if you're a consumer having that surgery done and you're much more likely to end up with an infection on the second site, that information, once it's available, then the sites that are the poor sites can improve. The cancer sites

that have really high death rates can improve their care because it's not mysterious, it's not magical—it's functional.

05-00:29:59

Meeker:

Or they might shut down. From what I understand, as well, the proliferation of these surgery sites, for instance, is one of the reasons that we have inflation in health care.

05-00:30:11

Halvorson:

Yeah, in some markets, they could shut down. In some markets, if there's a couple of heart sites that are doing magnificent work and there's a couple of sites that are doing really bad work, the ones that are doing bad work either should get better or stop doing it. Either one of those models could work. In some cases, volume is important—that if you don't do enough volume of a particular surgery, you're not likely to ever be good at it—but a lot of the cases, it's just your processes are bad, your infection rates are high, your redo rate is high. A couple of care systems around the country have started guaranteeing results, saying that if you have surgery here and you need a redo, it's free.

That process has actually caused some reengineering to happen that have made those care sites significantly better because they then started looking systematically at the cases that were outliers, and that required redo, and changing the processes that caused them to be a redo. There's a lot of opportunity in healthcare for process improvement based on data, and consumers should be in that loop. Consumers should have that, and that's what I argue in my more recent books, and that's one of the reasons Kaiser Permanente, right now, is putting out a lot of data about care outcomes, care consequences, death rates, and making that information available to the public, in part to create a market. The other thing that's true about a market is if consumers have no data, no access to data, and no way of getting the data and don't even know the data exists, then they can't make a decision based on the data.

05-00:32:00

Meeker:

Seems obvious. [laughter]

05-00:32:01

Halvorson:

Seems obvious, exactly, but if they do know the data exists, if they do know that if you have breast cancer in this system, 95 percent of the time you're still going to be alive five years from now, and if you have breast cancer in this system, in some of the Georgia sites, 70 percent of the time you're going to be alive five years from now, that kind of death rate information can cause consumers to migrate, with breast cancer, to the sites that are going to give them the best chance of survival. So, we need to introduce consumers into the equation, and the only way to do that is by giving them data that they can use to make meaningful choices because otherwise, they're just making their choices based on what feels good, and which care sites have the best entry

exam rooms, or something, or have the best lobbies. That's not the best way to choose your care site—although KP now has great lobbies, in most settings.

05-00:33:04

Meeker:

Let's switch gears a little bit now, and I want to talk about healthcare reform, particularly as it manifests in the early to mid-1990s. Now, the history of healthcare reform, obviously, is long and quite complex, and in the 1960s and the early 1970s there were efforts that actually went pretty far but didn't achieve what they set out to do. There was the Edward Kennedy plan, and there was also the Nixon plan in the late sixties, early seventies, and the only major thing that came out of that, I guess, was the HMO Act of 1973. Then, a handful of years later, Carter made an effort at it, but with the economy and a variety of other factors, that didn't really go anywhere.

Seems like throughout the 1980s, the idea of universal coverage and healthcare reform is sort of a moribund idea, and then it comes back with some gusto in the 1992 election, and then with the election of Bill Clinton, the inauguration of Clinton in 1993. Nineteen-ninety-three, as it turns out, was the same year that you published your book, *Strong Medicine*, which provided a good history as well as an advocacy for health care reform in the United States. Can you take us back to 1993, and you, as the CEO of HealthPartners at that point in time, what was your thought on the status of healthcare reform upon the inauguration of Bill Clinton? Were you optimistic that this was going to happen?

05-00:34:56

Halvorson:

I was optimistic, and one of my great regrets, as I look back on my life, was that I didn't get that book done about five months earlier. That book was really needed at that time, to help shape the international context. The book hit the streets after all the key decisions were made, and people who would have been well informed by the basic concepts in the book, many of the people who read the book after that said, "Wonderful." I actually have a really lovely thank you note from Hillary Clinton, on White House stationery, saying, "Wonderful book, really good book," but it was too late. Unfortunately, I got that book out just behind the wave for when it could have influenced the curve. Timing is everything. I missed that wave.

05-00:35:48

Meeker:

If it would have come out in fall of '93, or something like that?

05-00:35:50

Halvorson:

Yeah, if it would have come out earlier, yeah, and actually, I had a working draft at that point. So, one of my great regrets was that I spent too much time perfecting that book and then missed the wave.

05-00:36:05

Meeker:

How do you think the book, if it had come out earlier, could have impacted the discourse?

05-00:36:09

Halvorson:

I think it would have helped people understand why systematic care, team-based care, care focused on patients with chronic conditions, I think the basic elements of the book were about care delivery. People at that time weren't thinking about care delivery—they were thinking entirely about care financing, and they were trying to create systems of care. It was a directionally correct idea, but they didn't really understand what the opportunities were in that construct.

05-00:36:44

Meeker:

When you say "they," who are you talking about?

05-00:36:46

Halvorson:

The people that were drafting the law. Even the people drafting the law, and then the people who were responding to the law, and the kinds of models that I talked about in my book actually would have involved competitive market situations that the Republicans should have liked, and some really good things about systematic care improvements everyone should have liked, actually. It was a little too late, as a book. I was optimistic when the president was elected, and I thought we were going to have some systematic healthcare reform. They actually started down a path. The first part of the bill was actually quite good, and then they added layers and layers to the bill, and it got to be harder and harder to make it work and finally get it passed. I was trying to think of that. I recall that the first version of it was sort of a clean, elegant market model set up to have competing health systems with some data involved. I mean, it literally was set up to be a health system bill, and it sort of deteriorated into more of an insurance bill. With many, many, many layers of regulatory oversight.

05-00:38:14

Meeker:

Will you explain for me the difference between a health systems approach as opposed to an insurance approach?

05-00:38:21

Halvorson:

What I would just say is you want dueling caregivers, not dueling actuaries. What you really want is the caregivers in a given site competing with other caregivers based on their outcomes or their satisfaction levels, the care delivery. What you don't want is an insurance model where actuaries are playing around with the benefit package and the whole model is about how well you can underwrite, as opposed to how well you can deliver care. So, dueling actuaries is the wrong model, dueling caregivers is the right model, and I think they started more down a path of dueling caregivers and ended up, unfortunately, into a path that was more dueling actuaries.

05-00:39:10

Meeker:

So, the dueling care models, is that another way to describe Alain Enthoven's managed competition model?

05-00:39:18

Halvorson: Yeah, Alain Enthoven and managed competition basically is intended to be dueling caregivers, yes, absolutely.

05-00:39:25

Meeker: Part of that, within managed competition, is trying to deal with problems such as adverse selection, right? In other words, having a similar package of benefits and so that there's not certain caregiving groups that attract all of the high cost patients and others, only attract the young people who aren't going to cost them anything. So, that's the actuary model, right?

05-00:40:02

Halvorson: Well, the actuary model is when you allow that to happen, yeah. If you have a dueling care system model, you can do risk adjustment. Medicare Advantage does that now. Medicare Advantage has a very nice risk adjustment model. So, if all the people you enroll have diabetes, you actually get more money than if all the people you enroll are healthy. That makes sense. Then, if you get the right amount for diabetics and if you do a really good job of keeping those patients from having their kidneys fail and go blind and whatever, then you actually do well. So, it's a matter of relative performance based on the population that you receive should be the model. That wasn't so much the model—the bill had political issues. It didn't fail for structural inadequacies. It basically was a political problem.

05-00:41:01

Meeker: As an observer, then, why do you think it went from the care group model to the actuarial model?

05-00:41:11

Halvorson: We've done that even a little bit with the Affordable Care Act. When you look at that bill, there's 100 "shalls" in the bill—thou shall do this, thou shall do that—about 25 percent of the shalls in the bill deal with insurance issues. There are literally eighty-two shalls in the bill that deal with care issues, reporting infection rates in hospitals, data flows between care sites, changing the amount of money that doctors get over time based on the quality of their outcomes. There's a ton of care improvement in that bill. They held a couple of years of hearings—the hearings had all kinds of testimony about care improvement, product condition, that type of thing—those conditions are all written into the bill, and they've been completely and totally not talked about. They're all there. They've all passed.

I actually have a slide presentation that I gave at one time that had the eighty-two care shalls in the bill. I gave that to a couple of audiences and the audiences said, "Well, that can't be, that's not the same bill that I keep hearing about." What the public focus has been about has been the insurance part, and even the insurance part is not for the 90-plus percent of the population who has group insurance or government insurance. It's for roughly the 7 percent of the population who has private market individual insurance. The goal was to

get that 7 percent to grow to a bigger number—12, or some other number—but it wasn't to get that 7 to grow to 20 or 30 or 50. It was literally just to get that number to grow 50 percent bigger than the 7. The exchanges and all of that activity are about that subset of the market. People aren't looking at the total picture, people aren't looking at the total agenda, and people aren't looking at the cost opportunities. I'm, frankly, optimistic about the care improvement parts of the bill. The accountable care organizations, the ACOs, are clearly a step in the right direction. I mean, the ACOs, you take a team of caregivers, organization, focus them on care, and make them accountable by paying them as a package rather than paying them by the piece. That's the right model.

It's what KP does, but that's the model. Medical homes are hugely useful—you get a patient who has chronic conditions and co-morbidities, if they go to a care team—medical home is code for a care team—and the care team has all the information. They coordinate your care for you, and they can do follow-up care. Your care is better. Your care is significantly better. All the fully robust, operating medical homes have done much better care for the people than people who just go to a random, independent solo doctor who has no coordination, no team, and no data. So, there are parts of the bill that are actually quite good and very useful and those parts of the bill don't get any attention at all. But that work is being done. Medical homes are happening—there are now thousands and thousands of medical homes. There are ACOs being formed all over the country. Care is being transformed, and if you add to that, the really brilliant thing they did, which was to incorporate into the recovery package funding for electronic medical records. That is a very good thing to do. When you have all the caregivers in the country with electronic medical records, and when they're using them in meaningful ways—there is a meaningful use requirement in the law, then you have to both have the information and have a meaningful use of that information.

When you combine all of that, then you create the context where you can overlay a template of data use, and actually improve care. It's like laying railroad tracks. You need the tracks. You can't run a railroad any place you don't have tracks. But if you lay the track, which they're laying with the electronic medical record, and then you put over the top of that a railroad, which is the entire set of use of the data, care can get a lot better for a lot of people very quickly. That's all embedded in the agenda, and none of that is being talked about at any level, which is why my most recent book, which I said is *Don't Let Healthcare Bankrupt America* (2013), deals with those issues. That's what I wrote about. I wrote about if we put this process together and if we did it really well, what would the ideal health care system look like? So, there's a chapter on what the ideal care system should look like.

The first chapter basically says, "Here's how screwed up we are—we're not doing this, we're not doing that, we're not coordinating. We don't have any of these pieces that we need, our outcomes are terrible, the fee-based model that

we have actually rewards screw-ups." You make a lot of money if your care is bad. You make a lot of money if you have bad care outcomes, and the book basically says, that's a really perverse and unfortunate economic model, so we need to change that. The second chapter says, "Okay, if we had the perfect system, what would the perfect system look like?" Patient-based care, focused care, team-based care, all the data, care protocols, best practices. Let's put a package together that has the right care so when you go to your caregiver, your caregiver has your information, has your medical science, is updated on the current medical science—because most caregivers can't keep up with medical science—so, you're on to a different system.

Third chapter talks about the pricing. How is pricing set up and how is the pricing model in this country perversely keeping us trapped in the path that we're in? Then, it goes over into a chapter on, okay, let's fix this. To fix it, we need to change our basic business model of care, but to change the business model of care, we have to have somebody who is upstream in the flow of cash. You can't change the business model of care from care. You have to change it from purchasing. So, who's upstream? So, the consumer's upstream, but has very little leverage, no leverage, in fact. The purchasers are also upstream, and have some leverage—but much less.

05-00:47:52

Meeker:

It's the employer purchaser, yeah.

05-00:47:53

Halvorson:

Yeah, they have some leverage, but the health plans have huge leverage because the health plans have contracts, they have obligations, and if the employers motivate the health plans to do the right thing then great things can happen—right now, health plans make a lot of money by not having to do any of the right things because if you're just a pass-through, self-insurance model, and whatever amount people charge, you pay, whatever the caregivers charge, and then you mark up their fee and then you have the employer pay it. I explained that model and cash flow in a lecture at Cambridge a couple of years ago. I had a healthcare economist stand up and say, "Okay, that's the first time I've ever understood the American economic system of healthcare." He said, "They actually have self-insurance and they pay whatever the fee is and then they mark it up?" I said yes, and he said, "I've always wondered why the insurance companies weren't a bigger factor in American healthcare relative to bringing down the cost of care." I said there are a couple of things that create that problem. One is that the consumers were angry when health plans did that work.

05-00:48:55

Meeker:

That's the 1990s, correct?

05-00:48:57

Halvorson:

That was the 1990s. So, there was an anger. But the second reason why was this model works incredibly well for insurers is because when you just mark it

up and pass it on, and take part of the cash flow out as your cash, as this \$2.7 trillion flows by you. Then you take your piece of that massive cash flow.

05-00:49:13

Meeker: Just dip in the river.

05-00:49:14

Halvorson: You dip in the river. It's a dip in the river cash flow model, and that's silly. So, what I say in the book is that's bad, and what you need to do is you need to require, as buyers, that the health plans actually make a difference, that they create change the way care is delivered, and they do these key things. Then, the books says, the fourth and biggest payer is the government, Medicare and Medicaid. So, if you get the government involved as a smarter purchaser, that has massive leverage. If you force the health plans to be better purchasers, that has great leverage. The providers will follow the changes. As soon as their cash flow is affected, the providers will follow.

05-00:49:53

Meeker: I wonder how the role of the taxpayer in funding a portion of the Affordable Care Act will perhaps influence the system by demanding some more cost savings and accountability.

05-00:50:05

Halvorson: Well, that's not going to affect it at all.

05-00:50:06

Meeker: You don't think so?

05-00:50:07

Halvorson: No, because they've been paying premium before. What will affect it, though, there is something that will affect it, and that's the 85 percent loss ratio rule. With the new loss ratios, the health plans now must have premiums based on 85 percent of the money being spent on care. When 85 percent of all of the money flowing through the health plans has to go for care, and when insurers can only keep 15 percent, that 15 percent is a limiting number that changes the nature of the competition. What that does is it puts people in the position where it now makes sense for them to be competitive. Because of the transparency, it makes sense for them to be competitive on the total premium amount.

05-00:50:51

Meeker: And quality.

05-00:50:52

Halvorson: And quality, because the only way you can get to lower cost is quality. There's two paths to low cost: you can ration or you can reengineer. So, rationing and reengineering are the two models. Rationing is really bad. Rationing shortchanges people. It's silly. One of the things I say in one of the books is if you're in a community where people are starving and a loaf of bread costs \$1,000, the solution is not to ration bread. The solution is to re-price bread.

[laughter] So, it is silly in this country: if you've got a cancer drug that's costing \$200,000 per patient to keep people alive for three more months, that's a real issue—a real example. There's a big debate in this country about whether or not we should spend the \$200,000 and prolong each person's life for three months. We've heard that debate. That's silly. That drug costs the drug companies nothing. A fraction of that. They sell the same drug in England for \$40,000, and they make a profit. So, it's a completely artificial rationing issue in this country. The issue is the abuse of pricing on that drug, and that's where the public debate needs to be, not about the \$40,000. If they were charging that \$40,000 for three months, a lot of people would say, "Yeah, that's worth three months." A quarter of a million for that drug is too much to charge. The other thing about the \$250,000 price to keep in mind is—this is really important—all of healthcare is purchased using somebody else's money.

So, you either use taxpayer's money to buy the healthcare, or you use premium money, and premium is somebody else's money. Premium is money collected from other people. You want that money collected from the other people so that that money is available when you need it for your care. So, that's the key issue with premium, is to collect the money so that you can use it to buy care. If the people who are collecting premium are spending \$250,000 to buy that drug, then they have to raise the total premium they collect from everybody to pay for it because premium is just the average cost of care. They have to raise everybody's premium to pay for that drug. If they only had to pay \$40,000 for the drug, they would have to raise the premium less.

So, the prices charged for the drug flow into the premium that everybody pays, and our premiums are the highest in the world by a multiple. Canada buys care by the piece; they don't buy care by the package. They have private doctors. They buy care from the private doctors individually. They have a fee schedule set by the government, and each province sets its own fee schedule. If we used the Canadian fee schedule to buy care in the US, we would cut the cost of care in this country from 17 percent of the GDP to 12 percent, and we would reduce all insurance premiums in this country by 30-40 percent, overnight. That's the difference between us and Canada. It's not single-payer; the difference between us and Canada is the price.

05-00:54:24
Meeker:

Well, in several of your books, you've also talked about some of the other, different factors. So, for instance, the preponderance of MRI machines in the United States, those have to be bought and paid for and turned into cost or profit centers, really, whereas there's so many more of them per capita in the United States than there are in Canada, so there are more institutional problems or differences, I think.

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Halvorson: But you know what's interesting about that?

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Meeker: What's that?

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Halvorson: The MRIs are a good example where that's true, and the other example where that's true is C-sections. We do more C-sections than anybody in the world, and we do more MRIs than anyone in the world. Everything else, we do less of. The average American sees a doctor four times a year; the average person in Switzerland or the Netherlands sees people seven times a year. They get more care in Europe, significantly more care, far more care in Germany, far more care in Switzerland, far more care in France. All those other countries have faster access to doctors, faster access to hospitals, more use of hospitals, longer hospital stays. The truth is—when you look at the volume issue—the only area where the volume has actually made a difference in this country is on imaging and C-sections. In every other area of care, we get less care.

05-00:55:42

Meeker: Interesting. So, I'd like to, before we change the tape, rewind and go back to '93 and ask you one more question. As far as you as an interested observer, watching healthcare reform go from possibility to DOA, why did that happen? You described this institutional change, meaning the focus on care groups to actuarial, but what were the political mechanisms? What were the other things at work?

05-00:56:15

Halvorson: Well, I was actually in the group that was going to Washington to advise people in a number of meetings at the White House ancillary meeting rooms. I was part of the conspiracy to get it passed, and what I remember was that some of the energy was even diluted a little bit in the supporter side by the fact that the thing kept evolving, and there was some evolution. But also, just the politics of it—they waited too long. I think there was a sense that there were people behind closed doors doing system design that wasn't sufficiently transparent for the appetite of the American public at that point in the process.

05-00:57:13

Meeker: Can you give me an example of what that might be?

05-00:57:15

Halvorson: No, it was just sort of a feeling that that was going on, and I think it was more of a feeling because I was sort of in that group. It really wasn't as conspiratorial as it was portrayed. Ira Magaziner was doing his shtick, and it appeared to be less inclusive than a lot of people wanted it to be, or secretly inclusive. There were a number of issues.

05-00:57:49

Meeker: Did you have much interaction with him?

05-00:57:51

Halvorson: A little, a little. Not intense, but some. I was advising the group on various sets of issues, and they seemed to be receptive to the things I was advising about. So, I actually was somewhat optimistic, but the politics of it just, in the end, collapsed. We know the history.

05-00:58:20

Meeker: There are so many different accounts of it, and historians talk about a whole wide variety of things, and then they talk about the campaigns by the health insurance plans that came out.

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Halvorson: Well, "Harry and Louise" [a television commercial produced by the insurance industry], actually, was very effective, yeah.

05-00:58:38

Meeker: That you're going to lose your doctor, and then there was also Clinton, perhaps, expending his political capital on the gays in the military thing, that some people said that that was one of the political reasons why this didn't happen.

05-00:58:47

Halvorson: I'm not enough of a Washington person to know that.

Audio File 6

06-00:00:09

Meeker: This is Meeker, interviewing Halvorson, on January 30, 2014. This is tape number six. So, just one final question about the Clinton healthcare reform efforts in '93-'94, that was when it became apparent to you that it wasn't going to go anywhere, how did you feel?

06-00:00:36

Halvorson: Oh, boy. I do not remember how I felt. It was, I think, clear for a while that it wasn't going to take off. I'd been optimistic at the beginning of the process, but I don't remember having any kind of a moment that said anything significant.

06-00:01:03

Meeker: I imagine different ways to respond to that would have been one, resignation that this wasn't going to happen for a generation, two, let's think about this in four years, or three, well, maybe rather than doing a big healthcare reform effort, let's just chip away at little pieces of it. Do any of those approaches describe the way that you dealt with it after it became clear it wasn't going anywhere?

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Halvorson: First of all, I didn't think it would be a decade or two decades. I thought it was going to take a restart. We needed to reboot the process, I think that some of

the things that needed to be done were clear enough. I didn't have a sense that this was gone forever. Another thing was that I did have a sense that we should do something at the state level, and we actually started doing some work in Minnesota on healthcare reform. We had several commissions on healthcare reform in the state, and the governor named me to each of the commissions. I, actually, was the only person on all of the commissions. But we talked in Minnesota about what did we need to do to make care more affordable, more accountable. Database care—all of those kinds of things were part of that commission process. We ended up with a piece of legislation that got Minnesota to the lowest number of uninsured people in the country. Finally tied Hawaii—Hawaii had a mandate and their level of uninsured was, I think, about 6 percent, and I think Minnesota got down to 6 percent for a while, based on the legislation we passed.

So, we started working on the Minnesota agenda. Those commissions had some bills that didn't pass, but I sat down with the Minnesota HMO Council, at that time, it was HMO Association. We built a bill that offered guaranteed issue coverage to all of the low income people in the state, and then we subsidized that coverage with a tax on healthcare. So, we set a tax on healthcare and we set the tax up to be a dedicated tax. The tax was computed every year by a formula based on the cost of providing care in the prior year to the uninsured people. So, we actually created that, and what we said was, "We need to use a sales tax on healthcare to fund this because a sales tax is the only way of getting money from all parts of the system because self-insured employers don't have to pay a premium tax." Premium tax couldn't get there. All of the employers do have to pay for care, and if there's a sales tax on care, there's no way that an employer can say it's an insurance issue, "I'm not going to pay the sales tax on care."

So, we proposed a sales tax on care, and I personally was the one who both invented and proposed that. I took it to the House and the Senate, and the people in charge. When I did that, the political leaders said, "We can't get that passed. I said, "Well, we can get that passed if health plans come in. We will support you, we'll come in with all the health plans in the state in favor of it, and we'll have positive support from the hospitals and the medical." So, we actually put that program in place. Minnesota Comprehensive Health Insurance Act. It worked. It's a really good plan. To get set up, all health plans in the state to be available, so any person who is low income, uninsured, could say, "I want coverage." They would get guaranteed issue coverage, and the state would then subsidize their premium.

06-00:05:29

Meeker:

So, this was not done through an expansion of Medicaid, this was something entirely different.

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Halvorson:

No. Totally different. Totally different cash flow, dedicated cash flow. I talked to the hospitals. I was on the board of the State Hospital Association, and I was chair of the HMO group, and I said to the hospitals, "This is beautiful because you get to pass a sales tax on it—it doesn't come out of your current revenue stream. It's a new sales tax you add it on top—and the money's coming back to you because all these uninsured people, who you're not getting anything for covering right now, will now be paid for because they'll be members. So, you actually will be a conduit for cash that will come back to you, and you'll be paid for the care." My health plan in Minnesota had actually started a free plan a couple of years before that.

We set the plan up for women in transition. So if a woman was divorced or a woman with kids ended up in transition, we basically offered them a premium for 10 percent of cost for up to two years. We did that if they gave us a plan saying that they were going to be making progress towards a career. A lot of women weren't going to school and weren't doing things that they needed to do because they needed that. Fairview Hospital System partnered with us. So my old plan and Fairview partnered and together we did this free transition plan for women. We had developed a benefit package for that that was very focused on prevention and early intervention and that type of thing. That benefit package later was written into the law, then, for the uninsured people of the state. Then, our plan went away because it wasn't needed anymore with the Minnesota Care. So, instead of saying about health care reform, "If we can't do it nationally, we're not going to do it at all," we said, "If we can't do it nationally, let's do the Minnesota version."

06-00:07:29

Meeker:

I'm curious: the tax on the care that you brought into the system, was this covered by the employers or was it covered by the end consumer?

06-00:07:42

Halvorson:

Well, the employers paid it. Any payer who bought care in Minnesota had to pay the tax, so consumers had to pay it as well. So, if you bought care directly, you had to pay that 2 percent tax.

06-00:08:02

Meeker:

So, it was a fairly low rate. How do you attribute its success, given the fact that you were adding a new tax for both consumers and the Chamber of Commerce?

06-00:08:12

Halvorson:

It created free care. It created guaranteed access to care for low income people. It did exactly what it was supposed to do—it was a dedicated tax, could not be used for any other purpose, and had to be recycled into healthcare. As I said, I served on the board of the Minnesota Hospital Association for a number of years, and that board was always very schizophrenic about that tax. Some people loved it because it created a bigger

insured population, and some people hated to collect a 2 percent tax. It was a really good mechanism that worked really well, and it did get the number of uninsured people in Minnesota down to tied with Hawaii for lowest in the country.

06-00:08:58

Meeker:

I don't know if this makes any sense at all, so tell me if I'm kind of wrong on this, but would the tax also have applied to care paid for by Medicare? Did the federal government pay the tax?

06-00:09:09

Halvorson:

The federal government did not pay the tax. Medicaid did pay the tax, though, but Medicaid was a state program. Medicaid paying the tax, because it was a cost-share from the federal government, the federal government actually paid. There was a positive reason for the state to take that expense through that cash flow, but Medicare didn't pay the tax.

06-00:09:36

Meeker:

Do you suppose it was because of the unique political culture of a place like Minnesota that this could actually work, whereas perhaps in many other states around the country, this model would not have flown?

06-00:09:47

Halvorson:

I think a number of states could have done it easily, and I think a number of other states would have had a really hard time doing it. Minnesota started with 10 percent uninsured and we took it to 6. If you had been in a state with 20 percent uninsured, you couldn't have done it with a 2 percent tax. It would have been a 5 percent tax or something, and tacking a 5 percent tax on healthcare, I think, would have been problematic.

06-00:10:14

Meeker:

So, you didn't get much pushback from employer groups or employers?

06-00:10:20

Halvorson:

By the time they noticed, it was a done deal. So, the employers really didn't pay attention to it when we first got it passed. We got that passed in a real hurry. We had our retreat up in Northern Minnesota at a little resort. Came back down to the legislature. We spent a week building the thing. We came back down, and I had a number of private meetings with some of the legislative leaders. It was pretty wired and pretty fast, and it was based on some of the momentum that had been created the prior year, from a big healthcare commission set up by the governor that had a lot of support and did very good work and it had frustrating results. So, people who had wanted that commission bill to go through in its original form were in favor of this revised bill. There were many of the same elements. There were people who just believed that this is time to get this thing done and this is a nice, clean way of doing it. The whole idea for recycling money inside of healthcare is not a hard concept to sell when you're sitting down, talking to people. We said, "We're just going to use healthcare money to cover more people."

06-00:11:46

Meeker:

This 4 percent of the population who were newly insured because of this, were there incentives built into the legislation for them to enter into a capitated system as opposed to a fee-for-service?

06-00:11:57

Halvorson:

Oh, yeah. They had to choose a health plan. They had to choose a health plan that was a licensed health plan in the State of Minnesota. Nobody went into Medicaid and their fee-for-service model. That would have died. That would have failed.

06-00:12:13

Meeker:

So, everyone was in a pre-payment kind of system?

06-00:12:16

Halvorson:

Yeah. We all basically got our premium paid by the state, and the premium was subsidized by the state.

06-00:12:26

Meeker:

Were there some providers who were not party to this, that maybe would have objected to it?

06-00:12:33

Halvorson:

Relatively few. All of the health plans participated, and there were a couple of IPAs. So, all the health plans participated in the model and people got to choose from the health plans, and one of the beauties was they got to choose from the same health plans that they would have chosen from had they been employed by some place that offered coverage. The same health plans that 3M offered were offered by Minnesota Care. The consumers didn't have a separate ID card. It wasn't like having a Medicaid card; HealthPartners issued the people a standard HealthPartners ID card, so even the physicians in our system did not know whether or not the person had come in to our plan from being employed by 3M or if they were on that Minnesota Care plan.

06-00:13:30

Meeker:

So, these newly covered people who went into HealthPartners, for instance, did you find that they utilized the services at a higher or lower rate than your established population?

06-00:13:43

Halvorson:

About the same. We'd done the free plan for the mothers before that, and it also was about the same utilization that happened. A lot of the uninsured people were young families, so there was no...

06-00:14:06

Meeker:

Adverse selection?

06-00:14:09

Halvorson:

It was clearly a selection, but it was offset enough by the fact that they had subsidies for their coverage, which is part of what they're hoping will happen,

ultimately, with the exchanges nationally, now. The best antidote to the risk selection is the subsidy because the subsidy makes it affordable for a broader set of people.

06-00:14:36

Meeker:

Now, what I want to talk about is what historically is recognized as the managed care crisis of the 1990s. Basically, there's—from what I see, at least, as a historian looking back on that period—a transition in the national mood, particularly around managed care organizations or HMOs. That is, in 1992, in the year of the election, people are looking to HMOs as the answer to America's healthcare problem. By 1996, HMOs are no longer the answer; they're the problem. Is this an accurate description of the change, from your perspective, and if so, why do you think that happened?

06-00:15:22

Halvorson:

Well, there was a change. Back in my very first days going to the national HMO associations, there was a group called GHAA, Group Health Association of America. There used to be about three dozen Group Health's [e.g. Group Health Cooperative of Puget Sound] around the country. They had, many, many years ago, formed this association which ended up expanding to be the national HMO association. When it was originally started, it was almost all not-for-profits, and when I went to the first meetings of that group, there were no vests. There weren't many white shirts, and everybody was in corduroy coats. You had to wear your corduroy outfit to go to the GHAA meeting. It was a bunch of fairly progressive, innovative people who were trying to reform care. Then the managed care momentum started nationally, and soon there were all kinds of additional players in the managed care world. Some of them were for-profit health plans, and some of the for-profit health plans, some of the initial ones made huge amounts of money because they were competing against the original Blue Cross insurance plans that had no contracts, they had no discounts. Most of the Blue Cross plans were basically just paying full retail prices with a full markup.

One of my last years at Blue Cross, they were still sending out a note to the physicians every December reminding them to increase their prices. Literally reminding them to raise prices with the letter. If you forgot to increase your price, you got a letter in January saying, "You forgot to increase your prices, could you please increase them?" They wanted to load the information into the system so that they would pay the right amount. So, instead of negotiating prices for the physicians, the old insurance approach, [this] was actually a reminder to increase your prices. I can remember when agents would make their sales presentations to buyers based on you should buy this Prudential care rather than the competitor because if you buy Prudential, Prudential will pay faster and will pay more. Paying faster and more was actually a competitive advantage for a while in the insurance market. Hard to imagine, but if I wouldn't have seen it myself, I would have a hard time believing it. But that was the initial model.

So, into that model, suddenly there's competition being created, and the new plan competition is negotiating discounts with providers and they were limiting networks and doing a number of things. They decided to stop paying for Friday admissions for Monday surgery. There were tons of things. Every hospital admission in America used to get a chest x-ray. Every single admission, and whatever you went in for, you got a chest x-ray. That was very profitable for the hospitals. They made a lot of money. When Medicare introduced DRGs, all of those chest x-rays stopped because you didn't get any additional money for them, and they had no medical purpose. So, payment changed and care changed. The first couple of years of care change, the HMOs grew like crazy. They grew like crazy because if the Blue Cross rate had been \$200 and you come in at \$150 because you've got a 30 percent discount everywhere, 150 beats 200. So, there was massive enrollment growth. If you looked at the HMO enrollment growth, it really spiked.

06-00:19:20

Meeker:

That starts to happen in late seventies, early eighties, is that about right?

06-00:19:23

Halvorson:

The seventies, eighties, but it was still happening in the nineties. The nineties, you're seeing a lot of growth. One of the reasons for the National Health Insurance Agenda then was there were a lot of employers who were thinking, "We need something better than this cost increase we've been getting," and so they started moving their business to managed care. Originally, to the HMOs, then to the PPOs, and then to other kinds of managed care. So, there was a huge migration of people to that model to save money.

06-00:19:57

Meeker:

Who were some of these major, for-profit managed care organizations?

06-00:20:02

Halvorson:

A lot of the names are gone. A lot of the names of some of the original organizations that had their various growth spurts and various organizations have been purchased. I think the United Healthcare empire that sits out there right now, I don't know for a fact, but it has dozens of assimilated health plans embedded in it. Many of those early health plans, they were competing against unarmed and helpless competitors, and having better prices. So they migrated a lot of business in. So, there was a lot of migration. A lot of people became enrolled in the managed care plans, and that was fine. The problem was, is the managed care plans antagonized a lot of the doctors by getting the discounts, and so when they'd negotiate a discount with the doctor and then the patient would come in, instead of the doctor saying, "I love Health Plus," the doctor would say, "I hate Health Plus."

There was a negative feeling on the part of many, many, many patients because they were hearing really bad things from their doctors about that. Then, the health plan stopped doing Friday admissions for Monday surgery that made sense. Then they said, "Okay, maternity stays are averaging five

days—you really don't need five days because you don't, really." You know what the average maternity stay is in the Netherlands? Half a day. You're expected to give birth at home. Nobody gives birth in the hospital. It's a failure in the Netherlands if you give birth in the hospital. It used to be a five-day stay in the US, and then it went down to four-day stay, and the health plans said, "Do you really need four? Let's take it to three," and they took it to three. Then, they said, "We really don't need three; two days is enough to give birth, recover, whatever," and they started getting to two. Each time they moved it down, they said to the hospitals and the providers, "We're not going to pay you for that third day, we're not going to pay you for that fourth day, whatever." That then created a backlash for HMOs because the doctors were talking to the patients, said, "If you were to give birth two years ago, you'd be here for a week, but guess what? You have to go home tomorrow, and my health plan's making me do it."

So, you got into the perceptions of the health plans, and a lot of the health plans handled that very badly, very ineptly. Some plans were pushy, arrogant, somewhat cold in their response to both the providers and to some of the other issues. People were really convinced that you didn't need a five-day stay, that that was an abusive amount of money and an inordinate number of days. So, they got it down to two days, and then they went a bridge too far and tried to take it to one. Literally, there was a national movement in the nineties to get to a one-day maternity stay, and then they started making jokes about drive-by maternity. There was a backlash from the care sites. There was a backlash from the hospital. There was a backlash from the patients. Then, there were horror stories that came forward, and most of the horror stories that I actually saw were not legitimate, but some were.

There were some people who said, "You can't go to that site for that care," and it was a care that people needed and it was a site that needed to be used, and so there were some restrictions that happened that were inappropriate, and there were many restrictions that were appropriate. The caregivers, who were having their fees cut for the first time in their entire career, were saying, "This isn't good. I hate these people." So, we had that combination. So, there was a chemistry there—all those pieces had flowed together and created a backlash. Then, the media went on a feeding frenzy. There were some very negative stories that would hit in various places. Many of the stories were about issues in experimental surgery or experimental treatments. People would be on the front page of the local paper, saying, "My HMO won't let me get this experimental care in Atlanta, Georgia," and those made headlines. So people had the sense that the health plans were denying coverage even though the inside data said health plans actually had a richer benefit package than the old insurance plans had, and actually were providing more coverage.

Those highly publicized outlier cases created a real nastiness and anger. I can remember those days. If you said, "We're not going to pay for this experimental care in Georgia. They're using refined peanut butter for cancer,"

or something, "and that's really not scientifically proven," the media would run the story, put the person on TV, and do interviews and make the plan look bad. If you said, "Medicare won't pay for that either and Medicaid clearly won't pay for that because it's unproven and totally experimental," that information had no impact on the public because the new paradigm at the time was that the health plans were gouging and out to make money and evil, and therefore it didn't make a difference if Medicare and Medicaid also weren't paying for that experimental care. It was hard to have, for a time period, a rational conversation on those issues. Then the fact that some health plans actually were making abusive amounts of money, and some of the people who were doing that were bragging about it and did real damage.

06-00:26:02

Meeker:

Well, they were being traded on the stock market, as well.

06-00:26:05

Halvorson:

They were being traded on the stock market. In Minnesota, we kept for-profit health plans out of the state. So, every health plan in Minnesota's is actually not-for-profit. I actually went to the legislature year after year and testified about the need to not let the for-profits in. I would basically say, "When someone's making a decision, do you want that decision to be about the stockholder or do you want that decision..." Even in Minnesota, where we only had not-for-profits, we had some of the news media going down the same paths, doing some of the same stories.

06-00:27:01

Meeker:

Everyone has access to the national news media, as well.

06-00:27:03

Halvorson:

Everybody has access to national news media, so we had some of the same kinds of issues. One of the ad campaigns we ran in Minnesota was six different patients—I should send you the ad campaign, it's fascinating—who all had horrible, horrible, horrible health conditions. One kid who couldn't walk, had this massive surgery, a woman who we talked into having a heart transplant who didn't want one, and now her life was saved, and now she's helping immigrant children. The health plan was the hero of every story. The health plan saved all of these lives. We put together an ad campaign full of hero stories about really incredible things we'd done for people in a really big way, and we talked about the fact that we're spending more money on these things than anybody around. So, our image wasn't as bad as many. People kind of had a sense of maybe we were different.

The other thing that I had working in my favor at HealthPartners, useful much of the time, was the fact that we were a consumer co-op, and our board was elected by our members. Every year, we'd have a big, annual meeting in downtown Minneapolis or downtown St. Paul. We rotated. We'd invite all of our members to come in. We'd get 1,000-2,000 people would show up, and then we'd do presentations and then they would come to the microphone and

have debates and make points. So, we were very clearly a co-op, and so, when I went to the legislature, I was always able to go as the elected head of a consumer group. I wore one hat, where I came in as the head of a medical group, another hat where I came in representing the hospitals, and I had another hat where I came in representing the consumers who elected me because the consumers elected my board, and my board elected me.

In fact, we had contested elections for the board. We bought about ten hours of television time, broadcast television time, on the least popular TV station and we let the candidates basically debate about the issues when they were running for the office. The guy who ran in favor of expanding the benefit to include chiropractic care won by a large number, and as a result of that, we actually adjusted our benefit package. It was great fun. Then, I was on the board of the National Cooperative Business Association. I made sure that our co-operatives linkages were strong, so I worked both with the Minnesota Association of Co-Ops, and also, I got on the board of the national association of co-ops. So, I could go to members of Congress as a co-op, as opposed to going as an insurance company. That's good positioning.

06-00:30:03
Meeker:

This is interesting. Your description of how and why this happened in the 1990s, I think, is extremely helpful, and you did explain to a certain extent how it was that you dealt with this and respond to it, from your perspective or your perch at HealthPartners. I guess the question I want to ask is did this public backlash against managed care have any negative consequences for HealthPartners? I know in California, or rather, in the Kaiser Permanente system, they had a series of losses that coincided with that same period of time, and there's some debate about whether those losses had any close relationship to the managed care crisis. Arguably, there is something to be said there. Did HealthPartners suffer at all from this larger backlash against managed care, and if so, how did you as the CEO respond to that?

06-00:31:27
Halvorson:

We didn't suffer in terms of enrollment marketing because we were who we were, and we were doing what we were doing, and we were doing good things. We were the first health plan in the country to have an electronic medical record. We actually invented our own. We did it long before there was a commercial product. We had the Patient Profile System, PPS. All of our doctors had electronic information about the patients. We did follow up care. We set a standard of reducing the number of second heart attacks by 50 percent and initial heart attacks by 25 percent, and we set internal health quality standards. Then we worked collectively as teams to achieve those standards. So, we were doing a lot of really good things, and our members perceived that. Our member satisfaction levels are incredibly high, and our loyalty levels were incredibly high. Just like KP. Actually, KP and HealthPartners have the highest member loyalty levels in the country. So, it

pained us, it was painful, to have people feeling badly about us because we were a health plan.

There were some people who were angry, but it's hard to be an activist consumer group and coming against us when we were sitting down with our doctors and saying, "Do the right thing for every patient, and let's make care continuously better," and the caregivers believe that and the patients believe that. So we weren't a very easy target. We did a lot of reform things. We sponsored reform stuff. We chaired that effort, but we were a voice for reform. I periodically ran full-page letters from me to the community on healthcare reform issues. I would say, "We need to fix this," or whatever, and I was one of the first people to do a national or do a full-page letter on the abusive drug prices. I actually met with Paul Wellstone, Senator Wellstone, and talked to him and was part of the inspiration that got him to drive those buses up into Canada full of seniors to buy cheaper drugs. He was inspired, to some degree, by the things that I wrote and published about that. We were a consumer co-op, supported by the other co-ops in the state. So, in terms of us being damaged, every once in a while, you'd get a politician that would go rogue and do something odd or bizarre for a while, but it wasn't a problem, and it wasn't part of our identity.

Our identity was we were a bunch of people who were doing a really good job. Before I left HealthPartners, Robert Wood Johnson set up their Pursuing Perfection awards, and they looked at a couple hundred health plans and they ended up distilling down to a small number of plans, and then giving a pursuing perfection award to a couple of top plans in the country. We were one of them. When they came in to do the site visits, they did blind site visits. They just went to a couple of our clinics randomly and checked to see if the things that we said we were doing, relative to patient follow up and continuous improvement, were real. They came out of it and said, "These people clearly have taken the Kool-Aid because every place we went, people were saying the same good thing about quality."

Part of that was the fact that I would write letters to the people at health plans. I wrote letters in Minnesota, too. That wasn't a Kaiser invention. So, I wrote periodic letters to our staff in Minnesota. I've had people from Minnesota run up to me in an airport and say, "I don't miss you as a leader, but I do kind of miss your letters." [laughter] So, our people knew what we were trying to do, why we were trying to do it. So internally, we felt good about ourselves. Not every single person, but we generally felt good about ourselves, and that helped a lot, relative when the backlash was going on.

06-00:35:57
Meeker:

You had mentioned that Minnesota was able to keep the for-profit managed care organizations from taking a hold there. How was it that Minnesotans were able to prevent that incursion?

06-00:36:12

Halvorson:

At one time, it was true, many states had that rule. Many states.

06-00:36:18

Meeker:

So, this was actually legislative?

06-00:36:19

Halvorson:

Yeah, there were dozens of states, I think, that at one time had laws against for-profit health plans. When they first formed, they were co-ops, and there were rules about the corporate practice of medicine, and there were rules about for-profit companies getting involved in all kinds of related issues. There's always been—including Minnesota—for-profit insurance companies. Just not health plans. So you could be a health insurance company. Prudential had an active presence in Minnesota, but to be a licensed health plan in the state, you had to be a not-for-profit. I have nothing against for-profit health plans. For-profit health plans do a lot of good work in a lot of places and it's not a model to fear—but in Minnesota, we had a bunch of relatively fragile not-for-profits, and it seemed to be better for public policy to create a nurturing environment where those plans could thrive, instead of being taken over by chains. So, the chains basically have not ever gotten to Minnesota. United Healthcare started in Minnesota. The very first health plan that United ran is a Minnesota plan, and they still run that plan, but they run it as a contractor. The plan is not-for-profit. It has a separate board, separate organization, and then they buy administrative services from United. So, United has a presence in its home state.

06-00:38:01

Meeker:

There's kind of a conceptual question I would like to ask that is related to this. I might talk a little bit here to try to figure out how to say it. This is apropos of some of the problems that managed care organizations have in the 1990s, and that is, there's, on the one hand, a need particularly amongst managed care organizations to keep an eye on the number of procedures that are being done because the more procedures that are being done, the less likely that their economic model is actually going to work, unless the capitation rates continue to go up and up and up. In the 1990s, I know that there was a growth in a lot of procedures that were happening. I think this even happened to a certain degree within HealthPartners. So, this is arguably a problem, assuming that even in managed care organizations that should be able to control the expansion or increase in number of procedures that's still happening. Then, on the other hand, you have the marketing apparatus of healthcare in general that likes to show success stories, but also, that runs everything from, "Look at all the new equipment that we have," to, "This extreme case of somebody who shouldn't have lived in any other circumstances, but we do miracles here." I mean, you actually see, for instance, the [UCSF] Benioff Center, the Children's Hospital. Their whole marketing plan is built around miracles.

Can you see how there's a potential conflict here between realistically, not wanting to ration care, but limit care to necessity, and then having kind of

marketing apparatus that says, "We can do everything under all circumstances, even if it's a little crazy." Did you ever have to confront this at HealthPartners?

Let me give you one more example, and that is, I think in one of your books, there's an example of the one-pound premature baby that was born, and it was sort of cast in the idea of, "Look what we can do in our system and how amazing healthcare is today," even though this child was going to go on to probably have \$1,000,000 in healthcare bills every year. Now, that's possibly great for the parents, possibly great for the kid, but it puts a massive burden on the economics of the system.

Do you see what I'm kind of getting at, here? I don't know that I'm really able to put it into a question; just it seems like there's these two forces, and I'm wondering with you as CEO of a health plan, how do you bring these two countervailing pressures together to one, be a house of miracles, and two, be a place where care is rational and inflation doesn't happen extensively?

06-00:41:37

Halvorson:

A couple of thoughts on that. One of them is my experience has been and my belief has been that you should do all of the things for the patients that work for the patient and are the right thing to do for the patient. You don't save money, you don't have a better outcome, by rationing anything that should be done. So, what you need to do is figure out what needs to be done, what's the right number of CT scans to run? Not how do you cut back on the number of CT scans, but how do you do the right number of CT scans and make sure they run, and then if you do a CT scan, how do you make sure that scan gets used three times instead of having three different duplicate scans done?

There's a whole series of process points, but it goes back to my point earlier, about you need to reengineer, not ration. There's no upside for denying needed care, and in the very few cases that are the extreme [expense?] outliers, they're relatively rare. These are a tiny percentage of the total cost of care. Since I wrote that book and since that happened, I had a grandson born who was only a couple of pounds. They not only delivered magnificent care to him, but they saved him, and now he's four and he's great. He's strong, he's energized, he's bright, he's active, and the things that they learned to do, taking care of that one-pound baby, are the kinds of things that actually gave him the opportunity to fully thrive as a couple-pound baby. If we just would have written it off and not done all that care for those one-pound babies, we would never have learned how to save the two-pound babies and three-pound babies. We need care to get better.

The whole point of care should be to continuously improve. We need continuous improvement as a model for the country, and continuous improvement costs less than any of the other models. It costs less to do continuously improving care than it does to ration care, unless you have

extreme rationing, and then you end up with adverse outcomes that are so terrible. So, at HealthPartners and KP both, my influence has been in favor of, let's do all of the things that the patients need, and let's do them when the patients need them. If you're looking at things that are completely and totally experimental care with absolutely no change of survival, even some of those things should be done, but none of those things should ever be done without the patient being fully informed of the consequences and the likely outcome. One of the studies that I have some slides about that's fascinating took stage IV cancers, four basic cancers—I don't know if you've ever seen this—late-stage cancers, colon cancer, breast cancer, lung cancer.

There's two different treatment paths for these patients; you can go down one treatment path where you do everything, you do the chemo, you do the surgery, you do the radiation, you do every heroic thing. Then you could also do hospice care and you do palliative care and you basically take care of the patient during the dying process—what do you think the difference is in life expectancy between those two paths?

06-00:45:13

Meeker:

Probably very little.

06-00:45:14

Halvorson:

A hundred and twenty days, on average—120 days. The key point is to know that those patients in hospice care actually live longer. Yeah, for those stage four cancers, hospice care patients lives longer because that patient hasn't been burned, they haven't been cut, they haven't been poisoned. Hospice patients live, on average, for all stage IV of those cancers, 120 days longer than the patient who gets the full boat of heroic and intensive care.

06-00:45:37

Meeker:

And it's less expensive?

06-00:45:39

Halvorson:

It's also less expensive. But my point is never that it's less expensive; my point is every patient, if I was at that condition and I had stage IV cancer and I looked at the alternatives, I would want to know what are the choices available to me and what are the likely outcomes? If I know that they have never had a late-stage lung cancer that lived more than a year at that stage, and if I go down this path, I'm more likely to live the year than if I go down this path, if I have them take out my lungs and do all the treatment and do the chemo and do the radiation, that's a short death rate. Those people tend to die faster. We should fully inform the patient and we should let the patient make that decision. That's why I'm in favor of informed decision making, and that's also why I'm in favor of better cancer care. If you do better cancer care, you have a much higher cure rate, and you're much more likely, if you intervene earlier, you'll have a better cure rate, and you're likely to spend less money than you do with that cancer care.

06-00:46:42

Meeker:

So, actually kind of bringing this around, you're making some very interesting, subtle points. Then, thinking about the managed care crisis and the press coverage around those issues, which are very related, I think, to what we're talking about right now in the 1990s, how then do you as somebody who needs to communicate the perspective, the subtle perspectives of a health care organization, communicate these subtleties to the public, who's simultaneously being fed much more black and white perspective from politicians or people in the media?

06-00:47:22

Halvorson:

Well, I have a somewhat unique communications strategy: I write books. I write books about all those topics. All those topics are in my books. I actually write about them, I speak about them. I do interviews about them. But I also write about them. I write about them as explicitly and clearly as I can because I want people to understand those issues. The example I just gave about living 120 days longer is in one of my books. Those kinds of things. I can point people to those, if people are asking me, "How do you feel about X, Y, or Z," I can point people to that in a book. My book on healthcare disparities, I don't know if you read that book, but it's very, very, very clear on disparities—the existence of disparities, how horrible they are, just the fact that we need to fix those.

And what really causes them, and what can we really do to deal with them. One of the advantages of writing that book on disparities is I actually was in a care setting where we made those choices and where we did that, and so I can talk about what happened when we really did focus on those issues. So, personally, how do I communicate about those issues? I write about them. My writing gets shared internally, so people who I'm working with get to read that. When I was advising people on the Affordable Care Act, I also did it from the perspective of a number of those people having read *Healthcare Will Not Reform Itself*. I don't know if you read that book, but it's a nice tee-up for the act. People who wrote parts of that legislation read that book.

06-00:49:18

Meeker:

The Commonwealth Fund Report, as well. We'll talk about that later.

Audio File 7

07-00:00:07

Meeker:

This is Meeker interviewing Halvorson on January 30, 2014. This is tape number seven. So, I want to actually ask you about the development of the electronic medical record at HealthPartners. What was the status of the medical record when you first arrived at Group Health?

07-00:00:27

Halvorson:

Paper, it was a paper medical record. The standard paper that everyone used as a medical record. The organization that I ran before HealthPartners was an

organization called Senior Health Plan, and Senior Health Plan was a social HMO. It was a small HMO. I was the first employee of that HMO. I was the founder, basically, and we had a contract with the medical group at what was then Ramsey Hospital. So it was the Ramsey Medical Group. That medical group had a strong senior focus. They ran the teaching program for the University of Minnesota geriatric care. What we did there, in the Senior Health Plan model, was work with a doctor by the name of Jerome Hilger, to build a computerized medical record.

Dr. Hilger had invented an electronic medical record for his otolaryngology group. So, he had a small group, otolaryngologists. He was in three different cities, and he thought it would be much easier for him to take care of patients in three cities if he had the information on a computer. So, he actually hired a really brilliant programmer to figure out, with those old programs how to do that. He actually carried floppy disks with him from town to town, as he did his work, so he would have current patient information on the local machine. So, Dr. Hilger invented the electronic medical record, and Dr. Hilger was somebody who was a good friend of a friend of mine. He came and talked to me and said, "You really need to do this for your seniors because if it's working for me in otolaryngology, it will be even better for seniors. I thought, "Okay, that makes sense," because we were working on team care. We were trying to trying to figure out team care. It was obvious any type of work with seniors. You very quickly understand that they have multiple health conditions and you really need some kind of team care to deliver best care.

So, we thought maybe we could do something that would make sense, electronically, to support that. So, we hired the same guy—John Alden—who had done the otolaryngology record, to come over to the Senior Health Plan and build an electronic medical record for that patient population that would be run out of that clinic. The head of that clinic was a brilliant physician as well who said, "This is really wonderful, to have this information available electronically, I get to combine my medical records," and because we were using only one hospital for that clinic, it was easy to include hospital information into the electronic medical record.

So, we actually started on seniors in that one site to build that medical record. Then, I was recruited to go run Group Health from that job, and when I went over to do that job, I got to Group Health and discovered that the medical record was paper and incomplete and hard to use. They had a tradition—because they were a multi-specialty group—of having the information centrally available in as good a form as you can without doing it on a computer.

07-00:04:07

Meeker:

How did they actually get the central record to the different clinics?

07-00:04:12

Halvorson:

That's a really good question. There were a fleet of vans that carried paper medical records that drove around town, going to the different clinics. When I got there, I think there were eighteen clinics, and when I left, about three dozen. When I got there, they had these big vans and they had the central storage area. The vans would drive around, and so if you had an appointment on Wednesday, they would send basically a flyer to the central place, and they would bring your medical record to the clinic if it wasn't already there.

07-00:04:42

Meeker:

Unless somebody shows up at the emergency room, right?

07-00:04:45

Halvorson:

Yeah, well, and the best thing about that van process was they were nice vans and they had good logos on the side, so they were actually moving billboards for the plan. The good news was they were ad carriers. But even so, I sat down with the medical leadership and said, "It worked really well for us in Senior Health Plan to have this information electronically. We're going to bring it here as well." Medical group was pretty progressive, and they said, "Huh," because there were no electronic medical records anywhere. I could not point to anyplace in the country or the world and say, "Look at this one," because at that point in time, nobody other than this otolaryngology group had that information automatically. So, we made the commitment to flip our system over. In doing that work back at the Senior Health Plan, we had tied it to the claims system as well.

So, we built a claims system into it. At GroupHealth, we incorporated electronic medical information and blended the claims system. The claims system that was in existence at the group health was a very weak, clunky, inadequate, and incomplete claims system, so I knew we had to change claims systems anyway. So, we used that as an opportunity to basically build from the Senior claim system into a more robust claims system to run an entire health plan, but then blended that into electronic medical record. So, when you were in the clinic and you entered your information into the medical record, you also were filling in the claim and you're also doing the actuarial accounting. It took us a couple of years to build that.

07-00:06:49

Meeker:

Who built it?

07-00:06:52

Halvorson:

The contractors we hired directly. John Alden was the gentleman I talked about who had done the first one. I asked John to come in and take over as acting head of our IT shop and to run IT while he did that. John is one of the smartest people on the planet. He is just a brilliant man. He used to be able to do seventeen lines of code in his head and then write it down. I've known very few people with more technical genius than John, and he was intrigued by healthcare. He thought it was really fun to be doing healthcare types of things.

He was a high school dropout who was a walk-in athlete, in college. He became the starting defensive end for a division II football team and a computer engineer.

John has lots and lots of interesting personal background, but one of the things he really stands out for is he's very innovative. He doesn't have a sense that things can't be done. So, when people would say, "No one's ever done this," John would say, "Well, that's fine, so what? Sounds like it should be doable." So, we put together what was labeled the PPS, the Patient Profile System, and the doctors at HealthPartners and the old Group Health clinics actually had the PPS system in to support them in their care.

07-00:08:26

Meeker:

How did they initially respond to this? One of the reasons I'm asking is that I interviewed people around the creation of the electronic medical record when it first started up in the Northwest region, in Kaiser, and the people who I talked to about that said that there were certainly people who were interested and advocates of it, but also, a number of physicians for a variety of reasons didn't like it. They didn't necessarily like people being able to closely review their diagnoses and descriptions in people's medical records, for instance. When you type it in, there it is for everyone to see. Some just simply didn't want to learn how to type, right?

07-00:09:24

Halvorson:

Yeah, there's that.

07-00:09:25

Meeker:

There were some people who apparently retired rather than learn how to type. That's probably an extreme case, but how did the physicians in the HealthPartners system respond to this new innovation?

07-00:09:37

Halvorson:

Well, several things. One was we actually invented it in our clinics. In Portland, they actually imported somebody else's system. They initially brought Epic in. That's a good thing to do, but what we did was we built our own, and we got a couple of associate medical directors who were really well respected, likeable, and very bright men to be the leaders of that project. They basically struggled with the issues and figured the things out, and then they were champions for the process internally. The medical group, at that point, had a couple hundred doctors in it, and the truth is that a couple hundred doctors is a doable size group to work with. John was very likeable, creative, intelligent guy, and loved problem solving with them. Since he'd done the otolaryngology group, and the Senior Health Plan, it wasn't his first rodeo. So, he got to work with them and provide input and also learn from them. So, there was a good chemistry and a good synergy there, and the result of that was that they came up with some things that were actually pretty workable.

07-00:11:00

Meeker: What year was this, roughly?

07-00:11:03

Halvorson: I would have to go back. I don't know.

07-00:11:06

Meeker: Early nineties, maybe?

07-00:11:08

Halvorson: Well, it was right after I got there. This was immediately after I joined Group Health. I immediately put John as head of the IT shop and started down that road.

07-00:11:21

Meeker: How long, from the initiation of the idea to the actual introduction of the electronic medical record, was the development phase of it, roughly?

07-00:11:32

Halvorson: It wasn't much longer than a year. We did it relatively quickly, and it was green field. We weren't replacing something; we were basically starting something. He had already done the template for the seniors in my last site, and he'd done the template for the claims. The claims system took a couple of years. Claims systems are always, always really hard. Claims are one of the hardest things to do. I would much rather do a medical record than a claims system any day.

07-00:12:05

Meeker: Technology, then, obviously wasn't what it is today.

07-00:12:07

Halvorson: No. [laughter] Not even close.

07-00:12:09

Meeker: Everything from the hardware to the networking capabilities to various software programs that could support something like this. How did you deal with the limitations of the technology? How was that addressed, at the time?

07-00:12:29

Halvorson: One of the things we did, initially, was to do a lot of things on Apple. John actually had done some Apple developing work, and I actually still have one of the first fat Macs ever developed.

07-00:12:47

Meeker: What did you call it, a fat Mac?

07-00:12:48

Halvorson: A fat Mac. It was called the fat Mac. Macintosh was first and then they did a Macintosh that had twice the memory. A fraction of the memory my cell phone has, but it was called the fat Mac. I bought one from the developing company when John had that role, but HealthPartners was probably the last

health plan in the country to go away from Apple and Macintosh as a system vendor.

07-00:13:21

Meeker:

Well, this was actually brought up in one of the pre-interviews I did with somebody, and they said ask you to tell the story about keeping the Macs for two years too long. What is the story? What is the lesson, here?

07-00:13:33

Halvorson:

Oh, well, with the Macintosh, it was a lovely, wonderful, flexible little computer. We did a lot of good work with it, and we actually got medical record to run way ahead of anybody else doing a medical record. I also had them using the Macintosh for our administrative work and for our other things that we were doing. Our IT shop came to me and said, "Everybody's on Windows. Can we please get out of this environment and into the IBM environment?" I kept hoping that Apple would catch up because I'm still an Apple user. I never owned a PC, I hate to admit. I got to the point where some of the IT people said, "We're going to quit and go work someplace else because we can't get any standard equipment, the accounting systems are all written in Windows, and if we were an ad agency, we could stay with Apple because they do some great stuff on imaging, but this is not working for our business model." So, I was probably a little stubborn on that one and didn't move quickly. I definitely moved two years after I was asked to move.

07-00:15:13

Meeker:

So, the lesson is, perhaps, learning how to watch your own stubbornness, for lack of a better word?

07-00:15:24

Halvorson:

Yeah, I was comfortable with that Mac model. Actually, I probably moved it one year too late. I moved two years after I was asked, and moving exactly when I was asked, it was still, at that point in time, a superior piece of equipment. I had some other internal people who knew it, loved it, and did not want to move. So, it wasn't unanimous that the IT staff wanted to move, but the head of IT wanted to move and he was right.

07-00:15:59

Meeker:

Well, it is an interesting question about when is the right time to innovate, when is the right time to make change, and that's certainly a relevant question.

07-00:16:08

Halvorson:

If I were doing that one over again, I probably would have made that move one year earlier. I don't think I would have done two years earlier, though, because at two years, we were still, on most things, outperforming the Windows.

07-00:16:23

Meeker:

Can you give me a description of the functionality of the medical record, the electronic medical record, as it was constructed at HealthPartners versus the functionality of Health Connect, as it was developed under you at Kaiser?

07-00:16:48

Halvorson:

Well, the PPS, two things—one is that PPS had all the patient information about every patient and had it available pretty close to real time. So, we had the system fed by the lab system. It fed the billing system. It wasn't the billing system, but we had a billing system that was fed from it. The membership system was completely connected with it, so it was interconnected with the membership system, and so we were aiming for basically close to a paperless environment fifteen years ahead of anybody else doing a paperless environment. It was very functional. But the technology did not allow nimble access to our database.

The part of the database that wasn't Apple was MUMPS [Multi-User, Multi-Programming System] so we actually used the MUMPS programming language, which the VA was using at that time. Epic came along and they were using it as well. But we were rare in using MUMPS. So, we had MUMPS programmers internally, and the MUMPS system is very, very nimble relative to being able to do some complex things. So, the combination of MUMPS and Apple made us an outlier because everybody else was using the other languages and using the other equipment. But it worked.

We actually had better medical information than anybody. We had it in roughly real time. When I left HealthPartners, at the end of the month, within two days, I could get all of the information and all the financial information, but I could also tell you, for any group, a ton of data. I could tell you for General Mills exactly how many Vioxx prescriptions had been written in the prior month. We actually had real time data that I could project forward in each of the groups showing what the likelihood was of certain health problems in the group based on the health status we identified from the group. So, I had a really strong sense of what you could do with that kind of technology because we were doing a lot of it.

07-00:19:11

Meeker:

Was there a research group within HealthPartners that was utilizing this data?

07-00:19:16

Halvorson:

Well, yes. HealthPartners Research Group, Andy Nelson runs that, and he has chaired the national HMO Research Association Collaboration a couple of times. He's a very bright guy. I created that research area and then hired Andy to run it, and he's still running it. He's doing a great job. Yes, there was research, but more importantly, the caregivers used it to do process improvement on the fly. So, it wasn't an academic. It wasn't, "Let's spin this data out and send it off to some researchers." I was more, "How do we get the immunization rate up? Let's run through our database and figure out who's not

getting immunized, and let's fix that." So, it was used in a very practical way. So, when I got to KP, it wasn't a mystery to me about what you could do with an EMR or what an EMR should do for case management because I'd been doing it for a long time and had completely, totally committed to it and knew what it could do.

07-00:20:25

Meeker:

So, it was beyond simply convenient access to information, it actually had to do with quality improvement?

07-00:20:31

Halvorson:

Oh, absolutely, yeah. That's why HealthPartners won Pursuing Perfection.

07-00:20:36

Meeker:

So, at HealthPartners, were there computers in the examining rooms early on? There were, interesting.

07-00:20:46

Halvorson:

Not with the same kind of interaction with the patients. There were computers for input, but not for much output, but yes, there were computers right in the care sites and the doctors went to the screens and pulled up the data. It was clunky, and we had to pull up screens in sequence, and it wasn't as nimble and the ergonomics weren't as good. It was more like sorting through paper files electronically than it was getting nimble access to an electronic dataset. So, it was a step on the learning curve. So, when Epic came along and had their system, we looked at their system and our system, and our system did some things better than theirs, but theirs did quite a few things better than ours, and one of the things that they did was they gave better access to the doctors. Better formats, better sequence of the screens. At that point, we had the choice between reverse-engineering our own system to bring it up to the functionality of their system, or just saying, "Let's change systems."

That was really not an easy decision to make because I loved the PPS system. For me, that was something that I had supported and funded and done a number of things with, and I really liked that system. We put Epic into a clinic and said, "Okay, we'll try it." Looks good, let's give it a shot, we put it into a couple of sites, actually. Tested it out, and I came back and talked to the caregivers and said, "You're been using PPS, you've been using this new intrusion process, what do you think?" They said, "We like the new one." So, we flipped, but it was the right thing to do. We weren't a system development company, it would have been impossible to go back and retrofit all the pieces of the PPS. It wasn't an entirely easy process to go there. The woman who actually led that work and who was the champion for the change it and who led it and made it a success was Mary Brainard. Mary Brainard was my chief operating officer at the time. She's now the CEO of the plan, and she's brilliant. She's a really capable person. When Mary said to me, "We need to flip," my decision was hugely based on my confidence that she was making the right decision.

07-00:23:53

Meeker: Investing in computer hardware and software is not a cheap endeavor. It's not a cheap thing to do. Sometimes, even though it's apparent, it still requires a lot of buy-in from people. Having a consumer board, who I imagine is probably paying pretty close attention to the costs of care—

07-00:24:15

Halvorson: Expenses, yeah.

07-00:24:16

Meeker: —is probably going to look at this very critically. Did you have any trouble convincing the board that this was a necessary step?

07-00:24:25

Halvorson: No.

07-00:24:25

Meeker: Not at all?

07-00:24:26

Halvorson: None. Not a microsecond.

07-00:24:32

Meeker: How did you present it to them?

07-00:24:33

Halvorson: The only smart thing to do. [laughter] Really, no alternative.

07-00:24:41

Meeker: Is there anything more that you'd like to talk about as far as the electronic medical record? We'll certainly pick up more on it and Epic when we get to Kaiser.

07-00:24:53

Halvorson: Actually, one other thing, and you might be going there, one of the things we did was when we did the health plan in Uganda, we actually set up an electronic medical record in Uganda that ran on laptops.

07-00:25:06

Meeker: I did read about that, but let's get to Uganda and you can tell me about it in that context. So, first, why don't you just tell me about this? You've written a book on the Uganda health co-ops, but maybe you can just tell me a little bit about how it was that you, a CEO of a health plan in Minnesota, ends up helping set up a health co-op across the world in Uganda?

07-00:25:38

Halvorson: Would love to. Interestingly, I just got an email—did I send it to you? I thought I would send it to you. I didn't, okay. I just got an email from Joy Batusa, and Joy Batusa was our CEO in Uganda when I was at HealthPartners. Joy read an article in a national magazine last week about me, where I have a quote about the fact that I really like working with women

executives, and that part of what I do to add value is to get women executives to succeed in various environments. Since she had been the first woman to be a CEO of anything significant in Uganda, she wrote me a note saying, "I just read this article and I can vouch for the fact that that is in fact what you do and one of the things that it's good that you do." So, anyway, Joy and I are back in contact. I haven't talked to her or been in contact with her for a decade, so it's really good.

So, Uganda: Uganda happened because HealthPartners was a co-op, and Land-o-Lakes was a co-op, and we did some political things together and we did some operational things together with Land-o-Lakes. We provided coverage to a lot of their people. Land-o-Lakes does some wonderful missionary work around the world. They go to several different countries and they set up co-ops in these countries, and usually dairy co-ops. In some cases, they've done goat co-ops, but they usually do dairy co-ops. They had set up dairy co-ops in several villages in Uganda, and the head of Land-o-Lakes went over to visit the co-ops in Uganda. Some of the people in the co-ops thanked him for setting this up. In one of the villages, somebody said, "We now have veterinary care for our cattle because of the co-op, but we don't have healthcare for our children, and is there anything you can do through the co-op to create healthcare for our children?" He was intrigued by the idea, so he came back to Minnesota, called me up, and said, "Let's have lunch."

We talked about it, and he said, "Is there anything you can do to create healthcare in Uganda?" I had started a health plan in Jamaica, I'd gone to Jamaica and done HMO of Jamaica and put that in the place on the ground, there. I'd helped start a health plan in Santiago, Chile, and Banmedica is still running in Santiago. It has a million members and owns a bunch of hospitals. They're doing well. So, I had done a little bit of international work up to that point. I'd actually also helped to start a health plan in Madrid. I'd gone over and designed it. So I liked doing international things, starting health plans in other countries. I said, "Let me take a look at the Uganda situation." So I took two of our lead physicians. Both of them had done missionary work in Africa, medical missionary work. And we went to Uganda.

I took our lead contractor, the person who was doing all the contracting for HealthPartners with the contracted medical groups of Minnesota, Scott Aebischer. Scott said, "Why are you taking me? I'm not a doctor, I don't know any of this stuff." I said, "Because if there is a model to build in Uganda, it's going to involve contracting, and so what I need is somebody who is an expert contractor. So, Scott, why don't you get on the plane with us?" So, the four of us went to Uganda, and USA ID was working with Land-o-Lakes on the dairy co-ops. So they had a support infrastructure. They took us to villages in Uganda to do sightseeing and fact-finding. So, I went to see in place infrastructure, things that could be converted. Could we create a critical mass? Could we get a sufficient number of people enrolled? Could we get people enrolled quickly enough so that we would become an insurance model. And

could we do these things for relatively low administrative cost? Clearly, you can't have any level of administrative cost.

The average amount of money spent on care in people in Uganda, for the country at that point in time, was about \$10 a year. Literally, \$10 a year was the average amount of care, spent on everything. So, there's almost nothing in the US—\$10 of care was the co-pay on an office visit, and it's not a lot. I went to look and I went to the villages. I met with some of the people and I met with some of the co-op leaders, and hosted public meetings and answered questions. I basically said in the settings, if we come here and help set up a co-op, would you recruit people? Would you go bring people in? Would you collect the premium? I said, "Here's the key steps you'd have to do. Would you do those things if we came here?" In village after village, they said, "Absolutely. If we can't afford healthcare for our kids, if a kid gets sick, we go broke. If my wife needs a C-section, we lose our cow." They basically said, "We really need some kind of protection, and so yes, if you can give us a model that works." In fact, a couple of villages, people said things like, "Don't tease us. Don't hold this hope out for us."

The fact was that I led a co-op already. So I could say to the villages, "I work for my members. My members hire me. My members elect my board," so I actually came to it and I said, "There are no stockholders. I don't own our company. Nobody owns our company. All of our members own our company." So, coming from the perspective of the co-op was good, particularly since I was in the context of Land-o-Lake co-ops, and Land-o-Lakes have already set them up to be in their co-ops. So, people said, "Yes, we should do this, please do this." So, then we went back and sat down and figured out, okay, what would it take? Scott, of course, fell in love with Uganda and the idea. The two physicians who were part of the process were wonderful as well. One of them later became the chair of the board of regents of the University of Minnesota. A very bright woman. She's just a very impressive person.

So, we went back to the States and we said, "What would it look like? What would we have to do to make this work?" What was fascinating about it was that to figure out how to make a health plan work in Uganda, you have to boil that health plan down to the essence. You have to reduce it to the most simple elements because you have to have premium of some kind. You have to have a contract of some kind for care. You can't afford to pay a claim because we set a premium goal of \$1 a month, and if a premium's \$1 a month and we set a cap on administrative costs of 10 percent of that. I just arbitrarily set those numbers for our goal. HealthPartners is administering for less than 10 percent. I had said to the people, when they said, "How much money did the insurance companies take out," I told them, "We take out less than 10. We take out about 7."

So, I set the goal of 10. That number that gives us then a dime to work with on administration. So, we have to then figure out, okay, what do we need? Clearly, you can't pay a claim and you can't send out a bill. You can't have a postage. All of the pieces that you have to have need to be just what you need. You have to boil it down to cash flow that turns into care, and into a defined set of care. We figured out how to do that. So then we went back to the villages and I met with a couple villages and said, "This is the model we think we can do." Then, Scott agreed to take this on as a major agenda, and the people who were our Land-o-Lakes partners over there helped us recruit some staff, and they brought in.

07-00:34:46

Meeker:

Local staff?

07-00:34:47

Halvorson:

Local staff, yeah, because one of the things that I learned in Jamaica was I actually ran the Jamaica plan for a while with a guy from the US, and it was a complete failure. The guy didn't assimilate. By the time he did assimilate, he over-assimilated. But it was really a mess. So, I had straightened out the Jamaica plan by having Jamaicans run all of the key pieces of it. So, I'd already learned that lesson, so I didn't go to Uganda thinking, "I'm going to drop some Americans in." I went to Uganda saying, "I've got to find some good Ugandans who can really do this job," and found some. Joy was one of them, and Scott and I both thought, "Wow, she is a wonderful person, really great, very bright." Her father was an Episcopalian bishop, which gave her a little bit of credibility with some of the people because she had her father's halo, so to speak, giving her some credibility. Joy did a spectacular job, and she went from village to village and enrolled the people in the villages. Then, we hired some additional staff.

So, we went back and we pitched this to a couple of villages, and the villages said, "Yeah, we will do this." Then Scott and I met with the local hospitals and said, "Can you do this model?" We said that was good. You'll get cash flow every single month. We will guarantee that you will have cash flow from hundreds of people, and they will pay you at the beginning of the month, and they will collect it from their dairy co-op money. So, we actually paid the premium, in some places, in liters of milk, and we paid premium in other places with baby goats, and we later paid premium in other places with coffee beans and with tealeaves. So, we created a barter system that actually paid the premium with whatever the co-op happened to be organized around, in a way that guaranteed the cash flow for the hospitals. That new cash flow kept a couple of hospitals alive because a lot of those hospitals were dependent on foreign charity. They were dependent on charities in London to send them money, and that's very uncertain because the charities can change their funding priorities and whatever. We gave them the local cash flow, so the hospitals loved us.

I explained the risk pool issues. So, we used the 75 percent rule: we will not start the co-op until 75 percent of the people in the dairy co-op have enrolled with us. Usually, we went a little beyond the 70 before we kicked off. It worked fine—those co-ops are still running. Decades later, they're still running in those villages, and they're still self-governing, and the process is working just fine. The co-ops people made decisions about the key issues in each village. They decided who'd be in their risk pool, they decided what their benefit sets would be. One of the things that I write about in the book is that one of the benefits that was often discussed is maternity benefit.

The question is, is maternity an insurable event or is it a budgetable event? Some people said, "Women are pregnant all the time and it's budgetable and it's affordable, but what's not budgetable is a C-section. C-section will bankrupt the family, but a normal birth doesn't." We had midwives for the normal birth. Half of the co-ops covered all maternity, and half of them only covered C-sections. Most of them put a process in place that said, "If you don't do at least two pre-natal visits, your delivery's not covered," because they wanted the women coming in before the pre-natal visits so they wouldn't have more complications. So, they actually invented some really cool interventional kinds of things. In the same way on malaria, they required the people to buy mosquito netting and to keep their kids sleeping under mosquito netting because malaria was the number one cost for kids.

So, these local healthcare economies focused on these issues, and they put in preexisting condition exclusions. If you missed that first open enrollment, when 75 percent came in, and you got HIV or you got some other condition and you came in six months later or a year later, they basically said, "Either you're not covered for this condition or you're not covered for this condition for a year." So, it forced people to enroll early and not wait until you get pregnant. None of the villages allowed women who were pregnant who missed that first open enrollment to come in during their pregnancy and get coverage. So, the stuff that we talk about in the preexisting condition stuff in America today, each of these villages voluntarily invented that pre-existing exclusion process for their own people, to protect their risk pool.

07-00:40:12

Meeker:

This is actually an interesting question because one of the points that I imagine that would have been difficult for you is coming in and having a very broad and deep understanding of healthcare systems, healthcare economics, and then going into a new setting that doesn't have this knowledge already. I would guess that in your position, you would have a little trepidation about what knowledge you want to share, for fear of putting sort of something foreign and not so workable into a different system. Does that make sense?

07-00:40:59

Halvorson:

Let me back up on that one, one sec. When I went to Jamaica, I totally blew my initial Jamaican strategy. I knew that in the US, that the things you did

was to have everybody focusing on the cost saving from managing the hospital cost, you negotiated really good hospital contracts, I knew the negotiations that needed to be done. So, I went down there to put in place a care system that had really good hospital utilization levels, and I thought if they have a five-day maternity stay, we'll bring it down to two, or something. So, I went in with a prepaid thought template and a package ready to lay out and make it work. I got there and discovered that nobody went to the hospital, that healthcare was delivered in people's homes, and that the cost of a day in the hospital was \$10, and the hospitals basically had no infrastructure. No windows. I toured some of the hospitals and they were amazingly primitive.

All of the things that I knew how to do were irrelevant. There was a small Blue Cross plan in Jamaica, and I met with the guy who ran the Blue Cross plan, and I said, "Explain to me your business model and how it works." It turns out the number one cause of expenses in Jamaica is prescription drugs, and the prescription drugs costs were very high. The medical culture of Jamaica is if you go to a doctor and don't get a prescription, you have failed as a patient. So, every doctor writes a prescription for every patient for every visit. If you go to the doctor and don't get a prescription, the patients are angry with the doctor. They were paying full US retail prices for brand name drugs. So, everything was brand name, everything was retail and the costs were really high. There was a business that actually had the right to import all drugs into Jamaica, and they were charging very high prices, American prices.

The guy who ran the Blue Cross plan actually told me that in the prior month, the amount of money he spent on prescription drugs exceeded his total premium. At that point, the J-dollar was dropping relative to the US dollar. Even without that, it would have been 80 percent. So, I looked at the situation and said, "Okay, we need a network, we need good caregivers, we need the good benefit package, and we need to deal with the prescription problem." So, I put together a network of doctors that used generic drugs. We had really good support from the biggest labor union in Jamaica. We met with their unions. They had a lot of leverage, and we managed to get the government to allow us to do some direct importing of drugs at a lower price.

We put together a very successful plan, and we got some of the doctors to prescribe vitamins instead of antibiotics as the shot that they gave patients, which was much better, medically, because a lot of the patients should not have had antibiotics. But it met the cultural need to get the prescription filled. So, I had to solve all of the problems from a perspective different from the one that I had had in Minnesota, for the plan. But we still, in the end, put together a plan that was actually a good plan. When I got to KP, that plan was still going in Jamaica. I know that because a guy who was the CEO there called me up and said, "I'd like to sell my plan to KP." We're still going and we're doing well, and now that you're at KP, we'd like to sell you our plan." I said, "If the first thing I do at KP is buy a plan in Jamaica, that's not going to be good for my credibility in California." So I turned him down.

Back to the point about flexible solutions: when I landed in Uganda, I landed and I said, "I'm going to assume I don't know anything. I'm going to assume that I know nothing. I'm going to assume that I don't know what the costs are, I'm going to assume I don't know what the infrastructure is, I'm going to start from scratch. Blank slate—and figure out what the pieces are. Working from those pieces, I'll come back and figure out the answers and the plan." Had I not had the Jamaican experience, I probably would have landed in Uganda with that same set of thinking, believing I could just transplant a US solution into that country.

07-00:45:49

Meeker:

You knew already there were some things that you didn't want to put in. For instance, like a fee-for-service system, that you wanted to do a capitated system as opposed to a fee-for-service system?

07-00:45:07

Halvorson:

Right, absolutely, in both countries. I ended up capitating Jamaica and I ended up capitating Uganda. Yeah

07-00:46:06

Meeker:

So, there are some things, perhaps, that are universal?

07-00:46:08

Halvorson:

Yeah. Well, and the medical record—in Jamaica, we ended up with a single claims system that I had all the medical information for the patients and the claims system was fed back to the doctors, in the sense, that it was a limited number of things. The claims system and the medical record were basically the same thing. In Jamaica, we actually got one laptop computer per village and put it at the hospital, and the hospital and the clinic agreed to put all the co-op patient information in it. Oracle volunteered some, it was lovely people, Oracle people volunteered, when they heard what we were doing, to help to do some of the programming on that system. One of my favorite meetings was in Minnesota, in our board room, when the Oracle people from California flew in. They said, "We heard of what you're doing in Jamaica, we really want to do a nice thing, we'd like to help you with this process. So, here's what we'd like to propose: we're going to do this hub and spoke system." We had done on mini-laptops for some of our programs and our partners, "We know you want to do this and expand this, so we're going to create this hub and spoke thing, and here's what it'll look like."

I said, "That's a really good model. That's a really cool model. But there is no way in Uganda of connecting the hub to spoke." They said, "Well, we'll just use telephone lines," and I said, "There are none. These villages—there's not one telephone line in any part of this country, and if anybody ever puts one up, it's gone by morning because will people strip it for the wire." So, they said, "Well, what if we do X, Y, or Z?" I said, "You can't do that." And so we ended up having to do a system that relied on laptops, free-standing laptops. Some villages had no electricity, so some of these clinics, we actually had to

have a generator that we would turn on. The hospitals loved it because we basically gave them a laptop. So, they went from having no computer support of any kind—you have to remember, this is a few years ago, so they're more ubiquitous now—but at that point in time, we were the first piece of electronic equipment in some of those villages. It worked just fine.

Then, we created a plan co-op, or a coalition of all of the healthcare delivery support systems. We could do that because Ireland is actually supporting some care in some places in Uganda. France was supporting some places. England had some support places. So, what we did was we got together, we convened a group, and for a temporary period of time, I was the chair of the Federation of Health Plans of Uganda. I chaired the first couple of organizational meetings, got that organization going, and turned that over to Scott and he chaired it for a couple of years. We got the other health plans, then, to agree to do the same kind of laptop thing and we shared our technology that gave us some data. So, we started doing a little bit of studies, trying to figure out best care. On Malaria, for example, we discovered that every care site—even though it's the number one issue in the country—we discovered that there were multiple treatment patterns for malaria, and they were different and had different success in the different sites. We actually managed to standardize malaria care for some sites in the best practice way in the context of that co-op.

07-00:49:43

Meeker:

There's so much to ask about this. I'm wondering: there must not have been a huge availability of qualified care providers in Uganda, and I'm wondering if there was any question amongst the ones who you did talk to, who you were available to bring to the system, about the financing mechanism of not billing patients, but rather, accepting prepayments, and how that would relate to their workload, for instance?

07-00:50:23

Halvorson:

Each care site required an explanation process. We'd sit down with the caregivers and say, "Here's the deal, you will get X shillings every month from your patients. It'll come to you in a pool, and in exchange for that, you need to provide all of the care that's listed on this list of care services." So, they sold the package of services, and it wasn't kind of unlimited care. It wasn't heart transplants. It was: You take care of births. You take care of cuts. You take care of whatever. So, we had these services on the list, and any people come in with these services and you will bill them for this amount of money. The number of times you're going to deliver care is going to work out for you, and if it doesn't, we'll figure out at the end of next year what the premium needs to be for the following year. You're going to have your costs guaranteed upfront." One of the things we learned about in Uganda, there had been a number of insurance schemes that had been set up that had stolen money from the people.

So, we set up our process so there was no money. That was an elegant cash flow. Part of the other elegance of the system was to have no reserves ever, anywhere. So the money went directly from the patient to the care site in prepayment through this collection mechanism. In that way, there was no time when it was sitting in the bank where somebody could steal it or embezzle it or whatever. So, a very elegant system. People brought their milk to the creamery. Part of the milk fee was considered to be their premium. Part of that went directly to the local care site, and the care site got the money to provide the package of care. Providers are very smart—if you're smart enough to get through medical school, you're smart enough to understand the beauty of having that guaranteed cash flow every month. So, we had support from the care sites, particularly, they didn't have to beg donors in Europe for contributions to survive financially. The local people, when we set those plans up in each village, had celebrations. Literally, they would sing and dance.

I went to a couple of the openings just because it was so much fun to be there for the opening. At each opening, we would call each family head up to the front and hand that person their family ID card because that was the only thing we produced—a family ID card. It was a laminated picture of the family with their health information and names on the back. So, we handed them the ID card, and then everybody would applaud. A couple hundred people, 200 people would get applause. This was the first time they'd ever had insurance. This was the first time they could provide care for their kids. So, it was a lot of fun. One year, I had a couple of board members from Minnesota who were a little wondering, why are we putting time and effort and some of our creativity into this little country in the middle of Africa? So, I had a couple board members go over for one of the openings, and the village, when opening, they would typically sing. So, when Scott would go to an opening, they would sing, "We love you, Scott. You're wonderful, Scott. Scott, you're glorious. Scott, we are so happy we know you, Scott." It's actually not an entirely bad experience to have the village choir anywhere singing that you're wonderful. So, we gave the village the board members' names, and they sang to the board members. The board members came back thinking, "This project is a pretty good idea."

07-00:54:14

Meeker:

So, I have one final question. I don't know if you can answer this in five minutes or not. Maybe you can answer it in two seconds. Are there any lessons from your Uganda experience that you think can be brought back to the United States?

07-00:54:29

Halvorson:

Oh, absolutely. There was a major teaming in Uganda. Reduced to the essence: What we did at KP, when I got to KP, was that I said, "We're going to be completely, totally electronic. Just like Uganda. We're not going to have any paper. KP will be a completely paperless environment." I was a proud part of that plan. People said, "It may not be possible. It may not be a good idea." I

said, "No, there will be no paper at KP of any kind when our systems are in place. When we do a lab result, when we do anything. That information is going to flow. That's going to feed the billing system automatically. We're going to cut down all of these administrative functions and make them go away." Anything that involved processing paper, moving paper, billing, paper went away. I said, "We're going to move to electronic billing. We're going to move to electronic everything." So, my conviction and plan to do that was totally reinforced by the ability to do it in Uganda. If we can do that in Uganda and if we can be entirely, totally paperless in Uganda and if we can take administrative costs in Uganda down to a dime, there's no reason not to learn that lesson and do it in the US.

07-00:55:32

Meeker:

Anything else? Anything broader, kind of more conceptual about it?

07-00:55:40

Halvorson:

Well, people really want to have coverage. People really, really want to have coverage. The fact that everybody had the celebration was important. Those villages had their dances and their feast. That is a really good thing. People on a very basic and visceral level want the security of knowing that their children can get healthcare when their children need healthcare. That was reinforced in Jamaica. It was really reinforced in Uganda. So, that's part of my background for the thinking that we need to do here about covering everyone.

07-00:56:20

Meeker:

Good. I think that's a good spot to end, today.

Interview 4: February 2, 2014

Audio File 8

08-00:00:14

Meeker: Today is February 10, 2014. This is Martin Meeker interviewing George Halvorson for the Kaiser Permanente Oral History Project. This is tape number eight. We are at his home in Sausalito. So, when we wrapped up last time, we were just on the verge of you starting to engage with Kaiser Permanente as a potential job candidate. I know this story's a lot more complex than you applying for a job—in fact, it doesn't really work out like that.

08-00:00:50

Halvorson: I actually didn't apply for the job.

08-00:00:51

Meeker: You didn't apply for the job, so maybe before we even start talking about Kaiser, why don't we step back and let you tell us about what your life was like at age fifty-five, when you did make this transition. What were you working on, and how did you see your future at that point in time?

08-00:01:18

Halvorson: The path that I was on at age fifty-five was a dual track. On one track, I was running a health plan—HealthPartners, roughly 1,000,000 members, vertically integrated. We owned the hospitals, clinics, very much a Kaiser-like model. I was running that and doing work to continuously improve the processes inside that organization. We had just won the award, Robert Wood Johnson Award for best health plan, basically, in the country, relative to quality. So, it was a good path. I liked that job a lot. Writing books on those topics. Having a good time. And basically intending to stay there. The path I was on was a path to retire at age sixty. So, I'd set myself up financially and set myself up logistically to have the ability to go to track two of my career. Track two was to work on issues of diversity and ethnic conflict. The work that I wanted to do was to help groups of people understand why they fight with each other and why they're at war with each other, and then to help people figure out ways of not fighting with each other. I wanted to help people to create a collaborative environment that's good for everyone. I wanted us to be on a path to get to a win-win environment for the country, and not just healthcare. I was doing all kinds of work and research and preparation to do that work.

I started doing that work in a very direct way, back on a trip that I took to Wales, back in 1987. I went to Wales and I was helping them with health plans in Wales. They were studying what we had done in Minnesota, and they wanted to know whether or not they could do something similar to create vertically integrated care, systematic care. So, they'd heard what we had done. They'd read some of what I'd written, and they invited me to go to Wales and present to the board. I made the mistake of saying what an incredibly

beautiful, lovely, English setting we were in, and they explained to me that it wasn't England and it was Wales, and that England was basically their oppressor and their captor. They said that they hated the English and they were deeply insulted by me not knowing the difference between Welsh and English. Basically, the project went nowhere, died, and the anger surprised me. I actually said, "Wait, isn't the Prince of Wales the person who's going to inherit the throne in England?" They said, "That's an honorary thing, that's a token thing, that's basically just something that they've given us so that we feel better about being captive to the English." I said, "Okay, this is not what I expected." What was fascinating was, as I'd talked about that and then immediately following that, talked to some people in Scotland who expressed very similar feelings, it was that I heard language and inter-group anger and conflicts that were exact parallels to what I'd heard back in the US. I had been working on civil rights. I'd done some civil rights work in the Twin Cities. I'd done a little bit of work with the American Indian Movement, I had friends in the American Indian movement where I was helping with some of their issues. I had been doing a little work for the *Spokesman Recorder* newspaper in the Twin Cities. It was a black newspaper, and I thought my goal was to help with those issues and those agendas. I was on the board of the community clinics for the Twin Cities and doing some work in that area, and I heard the same language and the same anger and the same stories, basically, in Wales that I had heard on the south side of Saint Paul.

08-00:05:44

Meeker:

This is something that goes back 400 or 500 years between Wales and England.

08-00:05:49

Halvorson:

It goes back centuries, yeah. So, I said, "Wait, this seems to be an inter-group thing, and maybe we didn't invent racism in the US." So, I started to study the conflicts that were going on in the world, and there were many, many conflicts. There were conflicts in Kosovo. There were conflicts in multiple places. They were always described in the newspapers as being ideological—left-wing, right-wing in these countries. Two political parties at war with each other. So, I started looking at these countries, drilling down, I discovered that every single one of them was tribal, that every country I went to and looked at the conflicts that were going on, were tribal conflicts and I saw that they followed the same patterns of the racial divide that we saw in the US and that we were seeing in Wales and London. So, I started studying that topic and those conflicts.

08-00:06:40

Meeker:

Can you define for me what you mean by "tribal?"

08-00:06:43

Halvorson:

A tribe is a set of people that has a common identity as a tribe. They speak a language as a tribe. They have a shared history as a tribe, and if you ask the

people in the tribe who they are, they say, “I’m French,” or they say, “I’m Bogandan,” or pick a nation.

08-00:07:02

Meeker:

So, it could be national, it could be religious, it could be racial?

08-00:07:06

Halvorson:

The tribes are mostly ethnic and literally cultural, but one of the things I learned later is you can actually trigger the same sets of instincts and behaviors based on religion or based on other issues. But even on the religion side, when I drilled down into religion, I found tribes. I thought that the issues in Ireland were religious—everyone says they are—so I went to Ireland. I looked into religion. Religion has nothing to do with those conflicts. It’s the people who were from Scotland who were imported to Ireland who still live in Northern Ireland, and they basically hate the people who are the original Irish extraction. They hate each other, and it’s totally tribal. It’s masquerading as religious, but it’s not religious on any level. And I saw that intermarriage doesn’t happen between those two sets of people based on tribal issues. So, I talked to people on both sides, in Northern Ireland and in Ireland, and then I looked at those issues around the world. The Shiite/Sunni conflicts that are going on in the world are always tribal. The religious aspect of that goes back a couple thousand years. All of those people made selections as tribes, and they picked a path, and now they dislike each other as tribes, and nobody converts from one tribe to the other. One of my standards for whether the issues are religious anywhere is if there was a real conversion opportunity, you could actually make an individual choice to be a Shiite or a Sunni. That doesn’t happen. There is so little opportunity to do that that both sets of those folks in some countries will execute anyone who attempts to convert to anything else. So, it is totally tribal.

08-00:08:51

Meeker:

Intermarriage, for instance, as well.

08-00:08:54

Halvorson:

Intermarriage is, yeah, forbidden in those settings. I went to Bangladesh and talked to a family in Bangladesh, and they basically said, “If our daughter married someone from the next village, that would dishonor our family to the point where the rest of our daughters couldn’t marry anyone.” It’s just totally our group, our ethnic group, and there’s no intermarriage. I did work in Africa. I set up health plans in Uganda. I went to Africa and actually set up the health plans, and I learned, after we did the first two health plans, I was told that I had to do the third health plan in a different tribal area or we would be forever branded as being captives of that first tribe. There are forty tribes in Uganda, and we had done two sites with one tribe, so I was told that we had to do the third site with another tribe, the fourth site with another tribe, and that made us Uganda instead of Bogandan. That changed the dynamic. In Uganda, I sat down and I talked about these issues, instinctive issues, us/them issues, with some of the leaders and had a lot of positive energy. Some of the leaders

started using what I was talking about as teaching for our interactions because I basically said, “You guys are just hating each other for purely instinctive reasons. You really don’t deserve to hate each other. You’d be much better off if you’d come together as a country and as a region and do things collectively. The only reason you hate each other is because you have instincts to divide the world into us and them. If somebody’s an ‘us,’ you’re protective, supporting, nurturing. If somebody’s a ‘them,’ you’re territorial, antagonistic, and hateful, and suspend conscience, and it’s purely instinctive. They don’t really deserve to be treated that way. You just feel that because your instinct is activating valves that cause you to feel that. So, basically, I told them, you can rise above it. Invite this other tribe to be an ‘us,’ and then you together can be collectively strong.” That actually was situationally influential. There were people who believed that and looked down that path. I started that work in Wales. I started doing the research, and two years later, I wrote my first draft of a book on inter-group conflict. Then I started looking for the additional research. I started reading what is available out there on those issues, and discovered there was very little available on the tribal issues, but there was a lot available on sociobiology. So, I started reading E.O. Wilson and I started reading Francis Crick. There are a series of really good people who are writing insightful works that talk about how affected we are as human beings by sociobiological issues, how much our world is structured by our biology and structured by our instinctive behaviors.

I was actually doing a little bit of personal psychoanalysis at that time with a Jungian psychoanalyst who I really loved. He was a great guy. He was basically talking about Jung believing that time was a common pattern across the planet. The common pattern, he told me, exists for instinctive reasons. He said that the only thing that’s universal, that could drive the same patterns of behavior everywhere, is instincts because we all have instincts and there’s no teaching mechanism that can get those behaviors to every site. So, I started looking for instincts and I started making lists of instincts, and I started trying to figure out what instincts the patterns would look like. I started identifying patterns of instinctive behaviors in organizations, in communities, and I identified the fact that if a behavior was absolutely universal and if it was historical, if we could see it back into history, and if there were parallel versions that happened for other species, hierarchies, turf, there’s a whole series of beliefs that we have—lions, wolf packs—where there is an obvious parallel behavior in other species, then there was a high likelihood that the behavior was instinctive. Then, I started looking at how instincts affect us, and how do we follow instincts? What drives us to do things that are instinctive? When you look at bees and you look at ants, you see incredibly complex choreography of behavior that comes from sheer instincts. When you look at humans, you’ll see somewhat similar patterns. We have maternal instincts, so everywhere on the planet, we’re maternal. What we do that’s different than the ants is we create cultures (cultures are rule sets), which we instinctively create. Every group of people that exists creates a culture for that group. We embed in the culture the tools we need to achieve each key instinct. So, I have

a maternal instinct, so every culture creates its rules and infrastructure to be maternal. We have territorial instincts, so every culture creates its rules and its instincts that actualize our territorial instincts. We have hierarchical instincts, so every culture creates a hierarchy, and some hierarchies are elected, some hierarchies are appointed, some are hereditary. There are all kinds of variation. We can be very creative, in the specifics of each culture, but the culture always supports the instinct and the instinct is the same, so the underlying pattern happens everywhere. So, I learned that and I started writing about it and doing various work with it, and then I recognized that that was absolutely true in corporate management. So, as I led the organization I led, and that was an organization with 10,000 employees and seven labor unions and multiple levels of professions, doctors, nurses, pharmacists. I saw that there were all kinds of behaviors inside the organization that were tribal, that we had behaviors where there were some issues with the doctors versus the people around the hospitals. Clear us/them thinking. Before that, I'd been a senior planner for a large hospital system, the Health Central system. When I did that work, I saw the same thing there.

08-00:15:27

Meeker:

Can I ask you to pause for a second? As you're starting this course of study, and clearly there must be moments of epiphany happening as you're traveling around the globe and recognizing how some of these patterns tend to repeat – not only tend to repeat in the context of clearly identifiable tribal systems, but then on mini-tribal systems within workplaces, for instance. This idea that there's an instinctual basis for this has caused many people to feel helpless in actually changing these hierarchies and changing these tribal affiliations and changing these hatreds. At some point, I imagine you must have hit a point where instinctiveness seems immutable, so therefore it's never going to change. How did you wrestle with that idea?

08-00:16:27

Halvorson:

I'm a problem-solving person by nature, so I don't look at a problem and say, "Okay, this is insurmountable." I look at a problem and say, "How do we fix this?" I did the same thing with instincts. I took a clear look at instincts and said, "We clearly have instincts to divide the world into us and them, and we do all of these horrible things to them and we do these good things to us, so how do we deal with that and keep us from doing the negative things?" What I learned to do was create "us." I learned to create "us." I actually put together a list of six things that you can do explicitly to create an "us" in any setting. The list called for us to create a sense of common danger, of collective gain. I identified six triggers, just like Sun Tzu and *The Art of War lists*, I identified the strategies that you need to use to create "us" because when you bring people together and they become a new "us," then they start treating each other differently, and you get ethical behavior and you get positive behavior. So, what I realized was we can't get rid of the instincts, but we can use the instincts in our favor when we clearly understand what they are. We can do instinctive things that are transformational. I developed a theory of

enlightened instinctualism. So, I identified the tool kit of instincts that we need to get to the end game we want, and then I used them in corporate settings. I ran a couple of trade associations. I actually brought the members of the trade associations, who are very disparate people with all kinds of different agendas, and I brought them together and I created a sense of common enemy and I created a sense of alignment and I created a sense of common purpose. I created a sense of collaboration, team behaviors on particular things. Because I knew what all those tools were and I had articulated them and taught myself to use them, I could use them in all those settings. There had been three different health plan trade associations in the country. I led the merger negotiations successfully for all three, and I used the techniques that I knew from my sociobiological training to bring people together who had been adversaries into being allies. If you do the right thing, people move very quickly into the right directions.

08-00:19:00

Meeker:

So, to drill down into this, are you referring to the creation of AHIP, America's Health Insurance Plans?

08-00:19:05

Halvorson:

Right.

08-00:19:06

Meeker:

That was created out of, I guess, the Group Health Association of America, correct?

08-00:19:13

Halvorson:

Well, originally it was AMCRA and GHA. AMCRA was the for-profit insurance companies, and GHA. So, we did that merger and created the first AHIP. Then HIAA was the other organization. HIAA had been the "Harry and Louise" organization, and HIAA was a very powerful trade association. I actually negotiated the HIAA merger as well, so I did both those mergers, and I did both of them in the same way. I created a sense of a common enemy, I created a sense of external danger. I created a sense of common gain and collective gain.

08-00:19:50

Meeker:

With the first one, because I know a little bit more about that one, Group Health Association of America, this was the sort of labor-affiliated, slightly lefty, non-profit prepayment health plans like Group Health of Puget Sound, Kaiser Permanente came in a little bit later to the organization, but I think that Group Health of Minnesota was part of it, was one of the founding groups. So, these were, in the health care universe of the United States, they were kind of on the left, right?

08-00:20:28

Halvorson:

Very much on the left, yeah.

08-00:20:32

Meeker:

Then, they combined with, as you said, the for-profit health insurance plans. Talk about tribal differences. Walk me through the process by which you created a sense of “us” amongst these previously competing groups of people.

08-00:20:52

Halvorson:

Well, actually, it was relatively easy to do that because I knew what the basic motivators needed to be, and knew how to do it—knew how to offset the old barriers. We actually had a negotiating meeting where we had, I think, four people from the GHA side and four people from the insurance side sitting at a table. They had tried five prior times to do the merger, and all five had failed. So, it was my turn as chair, my turn to take a run at it. What I did was I sat down with a group of people in the room, and I said, “We need to sit down and figure out how to solve these issues.” I made a list of all issues. There were thirty-four problems I had on the list. These are the thirty-four issues that had to be resolved. So, I said, “Okay, if I went around the table right now and I said, ‘Number off—blue, green, blue, green, blue, green,’” and I said, “blues go to that side of the room, greens go to that side of the room,” and then if I put some kind of a competition into the room, we would all compete, right? You would compete as a blue, compete as a green. You would each do competitive things. Is that right? They said yes, and I said, “In fact, if we had a ball involved, you’d probably throw yourself at the ball to keep it from scoring. You’d do things for your team even though we just invented that team.” They said, “Yes, absolutely.” I said, “What we’re dealing with here in these two trade associations is a lot of blue/green issues. They’re really not relevant. We are just taking that side, on this issue, because we were chosen to be blue or green. That doesn’t make it a relevant issue.” They all agree and they said, “Yeah, that makes sense.” So, I said, “Okay, let’s go through this list and let’s figure out which of these are blue/green issues. For example, one issue is: which corporate headquarters will we use afterward? Do we really care? Does anybody in this room care? We’re all board members; we’re not going to be in that work space, anyway. But each side wants their headquarters to be chosen because they think that will be symbolic in some way and will look good to the world. Everybody has their favorite—do we really care, though? Do we care in any functional way? Is that a real issue or is that a blue/green issue?” They said, “That’s a blue/green issue, so how do we resolve it?” I said, “We defer it. We’ll get the merger done. Then we’ll take a look at both headquarters. We’ll figure out which one actually works best, and we’ll go there. But making it a blue/green issue is just silly. For us to fight about that issue when none of us really care and when it has no functionality, that’s just silly.” So, then I went through the other issues, and we actually took, of the thirty-four issues, we got down to four that were actually relevant issues that we needed to resolve. Then, we took the four and we figured them out.

One of them was which CEO would be the final CEO. That’s a real issue. We named a committee to do that. We said, “Okay, we’ll do the merger, then

we'll name this committee and the CEO will be whoever the committee elects." One of the issues was that HIAA had built up this big war chest and they really didn't want to put that money into the merged pot without control. So, I basically said, "Tell you what: we'll put that pot into the merger, but we'll have a committee who provides oversight to that pot of money who will be only current members of HIAA. So, we'll still use it for the good of the industry, but the HIAA board members will determine whether or not it is, in fact, used for the good of the industry. So, the new merger organization could ask for the money. This group, HIAA, could control it. So that way, you guys get to keep control of this money forever and it will only be used for your intent, and you don't have to give up control." They said, "Okay, that works." So, we did that with each of the issues and we ended up doing the merger. I said at the time, "Now, think about this: we have external enemies. There are people out in the world who really want to hurt all of us. There are people who want to put regulations in place that will do damage to all of us. There are uninformed people out there who could do bad things, and we are going to be much, much, much more effective in dealing with those issues together than we will be alone." So, I created a sense of common enemy. We really do have mutual interests in making sure that we have the best, most viable industry in the country, and we all collectively share that, so let's put together a trade association that achieves that goal and let's stop doing these silly shooting at each other things that we're doing now, where we're not dealing with the real enemy. We're just shooting each other in the foot. So, let's focus on the real enemy, and it's not us. I very deliberately used us/them, "us." It's not us; there's a real enemy, it's not us. People negotiating the merger said, "Okay, that makes sense." So we did it.

I was the first chair of that merged organization and we then had a chair from the other organization. We set up a path so that there would be five cycles where the chair rotated. That was one of the issues. But I said, "After five, if anybody can even remember who we came from, I would be really surprised." So, I said, "We're not going to do it in perpetuity, but we'll do a couple of cycles of chair rotation." We actually got to the fourth year, and we were sitting down, doing our board thing, and one of the other board members who'd been at that table said to me, "You know what, George? When you said that at that meeting, I thought you were bullshitting, but you're right. I'm looking around the room—I can't remember which group people came from, and I'm feeling bad that we need to rotate this time because it just doesn't make any sense." I said, "We need to rotate this time because that's the deal, and we have to honor deals we make to ourselves." So, that's what we did. So, actually it wasn't hard. It was just a matter of getting people to understand what their best interests were, and to take away the silly things, the blue/green things, that they were fighting about.

08-00:27:18
Meeker:

Just the way in which you describe it, it's amazing how you go from a point at which there's a proven track record of failure, right, these organizations

wanted to merge and they failed to, to actually establishing a logical process forward that allowed people, in fact, to not deny the differences that existed, but to see them in a more rational way, that they could actually overcome them.

08-00:27:46

Halvorson:

Well, you never deny the differences. You celebrate them. You enjoy them. You say, "I'm smarter because of you and because I have different perspectives, and you can teach me." I really believe we are collectively smarter than we are individually smarter. When people see that and understand it, people act differently. I said that and I mean it.

08-00:28:09

Meeker:

To that end, as you're reading E. O. Wilson and others along these lines, writing from a sociobiological perspective, there's simultaneously another perspective that is competing intellectually for authority to explain inter-group differences and tribalism, and it does not appeal to ideas of sociobiology. It does not appeal to ideas of instinct. Rather, it looks at systems of power, social construction, of the French theorist Michel Foucault, right? He talks about the social construction of reality and the social construction of rationality, and these kinds of things. He and others along his ilk, who were influenced by him, wouldn't appeal to, or wouldn't even acknowledge, something as instinctual. I'm wondering if you engaged with this kind of work, and what you thought of it at the time.

08-00:29:20

Halvorson:

I looked at some of that kind of work and I realized they were absolutely, totally wrong. Absolutely wrong. There was no possibility that they were right. The reason there was no possibility they were right is because my day job, for decades, has let me use these tools in the real world, and they work. I'm a doer because I can actually use instinctive tools to bring people together, to get people aligned, to create energy, that type of thing, because I know that the instincts exist and because I've used them successfully. I know that anyone who says it doesn't exist has to be an academic theorist and not a real-world person. There are some really fun theories. I've read some amazing theories about the primacy of intellectual cognitive thought that isn't borne out by anything that actually happens in the real world, in patterns and behavior, but people really sometimes feel passionate about those belief systems. I felt sorry for them because they're so obviously irrelevant to the way the world actually works. So, what I think of it is, there's three levels of thought. There's three major influences on our thought processes, and one of them is the intellectual cognitive thought process. We actually can think about things, create paradigms, understand things, and we can do enlightened thinking. We can do actually value-based thinking in the intellectual part of what we do. So we can decide to stop oppressing women. We can decide to stop being racist, and we can do that on the intellectual side of what we do. We can make those decisions and act accordingly. Second level of thought is instinctive thought it is clear that we do instinctively tribalize, we instinctively

divide the world into us and them. We instinctively protect our children, and we instinctively protect our turf. We do all of those things with great energy, great consistency across the planet. So that's also a very important level of thought. We also have cultural thought. We have cultures. We set up paradigms. We set up functioning cultures. In the concept of each culture, we do particular things—we act culturally to identify what the “should” and the “oughts” are in our world. I should do this because my culture says I should do that, so therefore, I do that. The cultures that exist, basically, usually support the instincts in each group context. So, as I said earlier, we have instincts to be hierarchical, we have cultures that identify what the hierarchy looks like in that setting, and those both drive our thinking. But we do have this third level of thinking that's an intellectual level, that actually, if we do it right, transcends and guides the cultures, so that we can do the things we really want to do in the way we really want to do them. So, I basically say that we should be responsible, enlightened people, and we should do responsible, enlightened things, and we should use our instincts and we should use our cultures to do enlightened things. We shouldn't let our instincts or our cultures run our world; we should manipulate and use both our cultures and our instincts to get to the end game we want. That works. That model actually is a very functional model. I've used that to run organizations, I've used it to run trade associations, I've used it to coach other organizations. I coach a number of CEOs from other companies on how to set up their companies. I've coached people through mergers because when you get into a merger, you've got all kinds of instinctive energy levels and different identities. If you know what to do, you know how to get to a common culture, common hierarchy, in the end. If you understand the instincts that are involved, you can manage through the instincts and get to a better outcome very quickly. If you don't understand the instincts, instincts can kill you. Backlash can kill you. Culture trumps strategy, people always say. I've heard that many times. Culture eats strategy for lunch, culture whatever. That is true if you don't have as part of your strategy managing your culture.

08-00:33:59

Meeker:

How did you learn how to identify instincts? How do you teach others how to identify these instinctual differences that might be at play in a specific setting?

08-00:34:10

Halvorson:

It's easy. The truth is, we don't have a million instincts. We have the instincts I've talked to, and we have instincts to be hierarchical. We have instincts to create turf. We have instincts to be alpha. But when somebody's alpha, you are more likely to be territorial, you're more likely to expect to be obeyed. There are certain packages of thinking and emotions that come out of being alpha that we can predict because they happen with great universality across the planet. So, there's not another set of hierarchical instincts. It's just the basic set.

So, the path that I was on for my career before I moved to Kaiser—having figured these things out and having used these things in multiple settings, having created a number of coalitions on various topics using this thought process—what my life plan was at that point, was to get to age sixty, to be financially secure, no mortgage on my house, no mortgage on my cabin, so I would basically be able to go forward and work on this other set of issues. That's the path I was on and I was enjoying that path. I was doing the research, reading everything I could get my hands on from scientific journals and sociological journals. I subscribed to psychology magazines, the psychology magazines that are written for psychologists, not for laypeople. Reading all of this material, trying to get a sense of what the various labels and layers of thought processes are, and enjoying that immensely. I used that when I took over CEO at HealthPartners. That original organization had had a number of areas of internal division and splitting and some anger, and I basically brought those folks together into a high performing team. I had observed, at Blue Cross, in my early days at Blue Cross, some very dysfunctional behavior. There had been a merger between Blue Cross and Blue Shield and when the two merged entities, the people tended to hate each other. They were divided for years. There was long-term animosity. I saw those patterns of behavior, and as I thought about it and studied it, it was really clear to me why they had happened, what had been the drivers in those behaviors, and why that set of people did what they did. So, as I did mergers, I actually brought seven merged companies into HealthPartners. We did it seamlessly. We just basically brought in the Group Health Plan from Saint Cloud. We merged that into the HealthPartners. I went out and met with the people, created common values, common issues, was absolutely clear on the hierarchy immediately because people feel a lot of anxiety if they don't know what the hierarchy is or what their relative position is. So, I relieved that anxiety immediately, shared the values, put the process in place, and it was so seamless that a year later, you couldn't tell that a merger had happened. Now, there were a lot of people just let mergers happen and they let people bump around into each other, and ultimately, hope for a good outcome. So, you can do sort of a clumsy, let outcomes happen model, or you can do a model where you say, "I'm aiming for this as the end point. This is the culture, and this is where we're going to go."

08-00:38:25

Meeker:

So, rather than letting the chips fall where they may, right?

08-00:38:29

Halvorson:

Which is really a silly model, if you're a leader. Letting the chips fall where they may is a really silly model. What you need to do is before you make chips, you need to figure out where you want them to go, and then you need to put the chips where you want them.

08-00:38:43

Meeker:

So, when you engineered the merger between Group Health and MedCenters, what were some of the key cultural differences, tribal differences, between these two organizations that you felt like you needed to address head-on?

08-00:38:58

Halvorson:

One of the things I did in doing the merger between Group Health and Med Centers was to identify how we would deal with the issues of medical best practices. There were two medical groups, both very good medical groups, so what we did was created the Institute for Clinical Systems Integration, ICSI, and we had ICSI with representation from each of those organizations, and also some representation from the Mayo Clinic. Those two organizations and ICSI sat down and did care protocols completely independently of the influence and control of the health plan. So, I basically said, "I don't want, as health plan CEO, to influence or build a medical protocol. I do very much want the best medical minds in Minnesota to build those protocols, and I want to create a template and a structure for that to be done. We will support that. We'll fund it. We'll use it. But we won't impose it or direct it because you're the physicians and you need to make those decisions." People looked at it and said, "That's actually a pretty good model," and that helped a lot. If I would have tried to do arm's length sort of, "Here's how we do diabetic care," it would have been an inferior model.

08-00:40:21

Meeker:

As a non-physician?

08-00:40:27

Halvorson:

Even if the first set of protocols would have been right, it would have been an inferior model because it wouldn't have kept up, probably. What's really important is to get the buy in of the relevant people at the appropriate level, and that's back to the point earlier. You create an "us." The "us" we created there was an "us" of people who really wanted best diabetic care.

08-00:40:47

Meeker:

Did those medical groups eventually integrate fully?

08-00:40:51

Halvorson:

They have actually integrated very strongly over the years, and I think they're within months now of actually, finally finishing the merger, these medical groups.

08-00:41:03

Meeker:

So, this is a long process—this is twenty years?

08-00:41:05

Halvorson:

Twenty years. But during those twenty years, though, they have worked very closely together using common protocols, common approaches. So the alignment that was set up has been functional for a long time.

08-00:41:20

Meeker:

How do you know what is the best timing for something like this? Twenty years is a really long time to have two cultures integrate, even though they're working alongside each other for that whole period of time. Sometimes it can happen over six or twelve months, and that's perfectly fine. How do you know? Is it the strength of the cultures, independent, that need to be integrated together?

08-00:41:43

Halvorson:

They didn't need to merge. The merger wasn't necessarily the optimal end game. Merger is one of the possible end games. What was really the optimal end game was to get everyone to do this ICSI and to use protocols and to do shared processes. The fact that they had different corporate entities under that was interesting and not particularly problematic. So, the challenge in any given setting is you have to figure out what's the real thing you want to achieve, here? If it's medical best practices, then you achieve medical best practices, and then you don't get confused by corporate mergers.

08-00:42:25

Meeker:

Historically, one of the cultural, tribal differences within Kaiser Permanente, of course, has been the health plan versus the medical groups. That was certainly borne out in the 1990s within Kaiser Permanente. Obviously, you weren't there at the time. I know that the organization of HealthPartners was somewhat different because it was a staff model, correct, but was there a similar cultural difference between those who were the care providers and those who were on the health plan side at HealthPartners? If so, how did you as CEO deal with that?

08-00:43:10

Halvorson:

Any time you've got separate sets of people in any organization, you've got the potential for those separate sets of people to go separate ways, and to distrust each other or dislike each other. So, that whole agenda can happen anywhere, and there were some elements when I got to HealthPartners. What I did was I made it absolutely, totally clear that my goal was to have best patient care, to be a great place to work, great place to practice care, but to have the patients be our focus. The caregivers liked that. If they believed my goal was corporate profits, it would have been much harder, but my goal wasn't corporate profits. My goal was how do we provide the very best care for our patients with diabetes, and then how can I, as the health plan CEO, help you as the caregivers achieve that goal? It was good to [take] measurements and some approaches to move in that direction. I think the day that I left HealthPartners, if you would have asked the medical group to vote on whether or not to have me continue as a CEO of that group, I think it would have been an 80 percent positive vote. I think it would have been a good number because we were all aligned in real ways. The group liked being the best. When I had the opportunity, when I got the call from the headhunter asking whether or not I wanted to look at the Kaiser Permanente job, my first reaction was no. My first reaction was I don't want to go to KP. I had two

reasons for that reaction, and one of them was that I had my path. I knew what I was going to do at age sixty. I had everything set up for that path. I tend to create paths and follow them, and I knew what that path was. I was comfortable with that path. The other was that I knew inside KP, there had been all kinds of really significant problems. That there had been tribalism to a significant degree. I actually had had Permanente Medical Group leaders come to Minnesota to study things that we were doing and transport it back to various parts of Kaiser Permanente separately. I talked to the leaders and they had expressed, in some cases, intense anger about the health plan. I actually had the Blue Shield plan of Northern California called me at one point and said they were in discussions with some people in the Permanente Medical Group to spin off from Kaiser and to go off and be a separate medical group, and wanted to know if I wanted to support that effort. They wanted to be a consultant to them in doing that because they knew that I knew how to run an integrated group. I didn't do that.

08-00:46:36

Meeker:

That would have been the nuclear option, right?

08-00:46:39

Halvorson:

Yeah, but I knew from the fact that I had gotten that call and that that was going on that clearly, if any possibility actively existed for a spin-off, that there were clearly issues internally. There were a number of issues. I was on the board of GHAA with several Kaiser representatives. Kaiser used to have, like, four seats on that board. It was down to two seats, when I actually got to Kaiser. Two legacy seats. I had watched the four people who represented Kaiser on that board not get along. Get along on some issues, but not get along on others, and unable to vote on a number of issues over the years that were relevant to national policy because there were two sets of people on the board and they, in some cases, didn't want to go against each other. So there were issues when votes didn't happen. In fact, there were a couple of issues where the entire KP delegation didn't show up for one reason or another because they couldn't reach agreement, and I was delegated as a friend to speak the KP position at a national GHAA meeting. So, there are actually a couple of times when I actually said, "Well, let me share the Kaiser position on this point," and I did it from my HealthPartners job, not as a KP employee. So, the question is, did I know that there were challenges inside KP? The answer is yes, I did.

08-00:48:20

Meeker:

Did you understand at that point in time the nature of those challenges?

08-00:48:22

Halvorson:

Sure. I knew tribalism. I could have diagrammed it for you. There was no doubt in my mind exactly what was happening. None at all. I'd seen it in multiple settings, I knew what it was there. I knew the nature of it, I knew the names of the tribes, and there was no confusion at all about what the issues were.

08-00:48:45

Meeker:

There were also some pretty substantial external challenges in the 1990s to Kaiser as well. We had talked about the managed care crisis. It's a long conversation, but the economics of it, some non-profit plans were having deficits because of the intrusion of for-profit plans and cost-cutting into the system. So, there were external challenges to the organization as well. You must have understood those differences, too?

08-00:49:22

Halvorson:

Well, I knew those differences, but I know the model well enough to know that Kaiser can simply kick ass on all of those issues if Kaiser is internally aligned. Yes, the fact that some of the other people who are KP wannabes were going to do some problematic things was obvious, but the ability to outperform them was huge. I ran a vertically integrated care model at HealthPartners. We put an electronic medical record in place. Two of them, actually. But we put an electronic medical record in place, and so we had the information with the patients and we were integrating care. I knew what that tool could do. I also had been the planner for a hospital system for the Health Central system, networked with all the isolated hospitals, and I knew none of them could do any the work KP could do. I knew that those other hospitals didn't get along with their doctors, that the medical groups were split, that they had three sets of surgeons at any given hospital, and the surgeons hated each other. I knew they were fighting with each other. I knew how nasty and ugly and splintered that world is—was and is—in most settings. Also I know what vertical integration can do when it's fully armed and energized. So, that didn't give me any hesitation. But in terms of wanting to go to KP, I knew that those other issues existed and I know that KP had gone through a financial turnaround, and I also knew that there were a couple of internal people who had been the architects of the turnaround. It seemed to me that the internal people who were architects of the turnaround probably should have gotten the CEO job. Dale Crandall was the president at the time. He had been the architect of much of the turnaround, and it seemed to me logical that Dale Crandall having been the architect of that process would be the person that KP would select.

08-00:51:21

Meeker:

So, rather than throw your hat into the ring, you expected that they probably would have gone with an internal candidate?

08-00:51:27

Halvorson:

Well, I advised them to. I advised them, I said, "No, if you've got an internal candidate who's done a turnaround, that's a horse you should ride. So I'm not interested. I'm not going to talk to you about the job. I think you've got some internal people that you should be looking at and I'm on a different path. My path is to work five more years, and it's not to work another decade."

08-00:51:51

Meeker:

They were looking for a decade commitment, perhaps?

08-00:51:54

Halvorson:

I knew that it would take a decade to do what needed to be done, and I knew that I couldn't go into something that complex and do it in five years. I still wanted to leave in five. So, I said no, and then they called a couple of times. I said no. Then, Karen Ignagni called me, and Karen said, "This is really silly. This is really wrong." I said, "Why is this wrong?" She said, "KP is the perfect job for you." She said, "You can do all of the things you want to do with electronic records and quality improvement, process improvement, care outcomes, all of that medical research." HealthPartners, at that point, had the best medical research going on in the country. "You can just eclipse that at KP very quickly and you can do everything to scale." I said, "I really don't want to do that job," and she said, "It's just silly. If you do this work in Minnesota—even if you do it really, really well and even if you have the best care in the country, people will say, they'll discount it and say, 'That's Minnesota. Minnesota has Mayo, Minnesota has HealthPartners, we can safely ignore Minnesota. Minnesota's not going to teach the country anything.' But if you do it at KP, the whole world will learn from what you do and the impact you want to have on the quality of care can happen." So, she said, "You can't have an impact in Minnesota, with all due respect, but you can have it at KP, so you should go to KP."

08-00:53:24

Meeker:

The scale difference was substantial?

08-00:53:27

Halvorson:

Well, not that different. I mean, HealthPartners had three hospitals, Kaiser had thirty.

08-00:53:33

Meeker:

Okay, so ten times.

08-00:53:39

Halvorson:

The difference between no hospitals and one is really big. The first day you start running a hospital, that's a learning experience. The first time you run a multi-site hospital, that's a learning experience. So, having three sites is different than one, but the difference between three and thirty is not relevant. The same thing, we owned medical groups. In Minnesota we had basically 1,500 doctors in the sites that we owned, and Kaiser had 15,000. Same thing. Once you've got 1,500, it's more than one doctor, and once you've got medical groups. You have groups. We had every specialty. In Minnesota we were teaching. We had 1,000 residents in our teaching program at HealthPartners. So it's already a teaching job. I was doing great research. I managed a vertically integrated system. And we had put an electronic medical record in place. So all of the pieces were there. It was just a matter of scale, and we were actually in a couple of states. We even had a little license in Wisconsin. So we had a couple of states already. I'd spend a lot of time at the legislature on various issues in Minnesota, and I knew that I would have to do the same thing if I went to KP. Again, I just got back from Sacramento last

week. I just spent several days in Sacramento last week meeting with some of the legislative leaders about my early-childhood commission. It's the same thing. Once you're down that path, you're down that path. I was already chairing the National Insurance Association, I was chairing the national not-for-profit group. So, in terms of direction, it was the same set of directions. I knew what the issues needed to be. I knew what the challenges were. Karen said, "This is just really, really wrong. You need to talk to them." So, I said, "Okay, if the headhunter talks to you again, call him up and say, yes, I will talk to him." So, they said yes. The headhunter flew to Minnesota. I spent some time. I thought about it for a little bit and said, "Okay, I'll go meet with the board." They had gone through a good process. They'd had about thirty candidates here. I said, "What about the internal candidates?" The headhunter said, "The internal candidates have removed themselves from consideration." I said, "What about Dale?" Dale has said he did not want to be a candidate for CEO, so he withdrew from that race. So, I said, "So, Dale voluntarily withdrew?" They said yes.

Audio File 9

09-00:00:07

Meeker:

This is Meeker interviewing Halvorson on February 10, 2084. This is tape number nine. So, here we are talking a bit about your recruitment to becoming president and CEO of Kaiser Permanente. Tell me about the meeting that you had with the search committee. What were they interested in talking to you about?

09-00:00:36

Halvorson:

Well, one of the interesting things about that interview was that David Lawrence had, a year before that, given one of my books to the board. So, the board had some sense of what I believed in and what I was about. So, I started with that. It was kind of a grounding perspective that continuous improvement, process improvement. Those types of things are relevant. I sat down with the board and said, "If I become CEO of KP, here's what we'll do. This would be the sixth health plan that I would run, and what we would do would be totally supported electronically I said that we would have electronic data for all of our care. I said that we would be focused on being the best in quality. After we got to be the best in quality, we'd be the best in service, and we'd go down the path. We would be internally aligned in multiple things." One of the board members said, "Well, I want you to know that if you're the CEO, we will support you in your battles with the medical group." I said, "I want you to know that if I'm CEO, there won't be any battles with the medical group because the medical group will be on the team. We will do this as a team, and I have no concerns at all about the ability to work in alignment with the medical group." They said, "Well, you may say that now, but it's going to be really tough, and you may need the board. If you do need the board, we'll have your back." I knew from other experiences that there were issues. So, I said to the board, "We will be aligned. We'll be focused on best practices.

That will create a culture of excellence. We'll create a database culture at KP, and this will be a good path to go down, and I've done this already. I know that it can be done." So, they asked some questions, I gave answers, and it was a good meeting. I also said, "I am fanatical about diversity, and so, I will increase the diversity of Kaiser Permanente in my watch. So, if you're not comfortable with being computerized and if you're not comfortable being diverse, then you should pick one of your other candidates. But if you really like the idea of being computerized and having that support care and if you like the idea of having diversity that will be one of our strengths, then that would be my agenda." They came back and said, "That sounds good to us, let's do it," and they offered me the job.

09-00:03:39

Meeker:

How did your colleagues at HealthPartners respond to the news?

09-00:03:45

Halvorson:

Well, sad, because I had been sort of the founding CEO. The old Group Health organization had under 200,000 members, HealthPartners had roughly 1,000,000; I had been the CEO through that time. The new organization, HealthPartners as an organization, had never had a CEO other than me. I had put together a really good team, just exceptional team. Star players in every position. Great COO and great CFO, great CIO, and then we really had a high-performing team of people. So, there was a sense of synergy. I had named Mary Brainard to be my chief operating officer about four years before I left, and I named Mary to that job because I knew that I needed to do a number of external things and some things in Washington. Before that, I had been the COO and had run all of the various meetings. I named Mary to that job, and she had run insurance functions at the Blues, and she had run clinical functions at KP, and then expanded her job to be the COO. Mary is very strong. She's very competent. She's very talented. She's a really good person with great personal ethics. She's just a really good, solid person, and the board's anxiety, I think, was alleviated more than a little by the fact that I could say, "I have complete and total confidence that Mary can take this organization from where it is now and make it even better than it is now. So it's not a matter of losing me and having things deteriorate. We are so wired to go forward." Mary just won executive of the year last year for the State of Minnesota, and she's a star player at multiple levels. The board knew that.

09-00:06:02

Meeker:

So, there was a real deliberate succession planning on your part already?

09-00:06:05

Halvorson:

Very deliberate, yeah, yeah. At KP, we ended up with a very deliberate succession plan where we identified several people and developed them over a number of years to succeed me. In Minnesota, we had a narrower succession plan that was down to just one person, but we did have her clearly in training to do that job. She's bright. She's creative. She's articulate, she's charismatic when she gives a speech. Actually, at my going away party, I said to the

board, “In three months, you’ll think you’ve traded up.” Jean Janson, who was then chair of the governance committee, said, “George, it will not take that long.” [laughter]

09-00:07:04

Meeker:

I hope you took that as a compliment. [laughter]

09-00:07:07

Halvorson:

I did, and Jean’s a friend of mine, but Mary is really good. So, your question was how did people respond? The immediate response, I think it was sad and they roasted me—there’s a video of that roast that’s really funny, I mean, I actually got pretty seriously roasted as I went out the door—but people weren’t panicking because they knew that we were on good paths and that Mary was a good leader. I think people were thinking that it would be fun to see what George does at KP. So, I think there was good will, and I had an agreement of the board that I wouldn’t take more than one person from HealthPartners with me. They said, “Worst thing now would be not that you go, but that you strip the place.” Since we had really good people in a number of jobs, we had an agreement that I would not take more than one person. One of our senior people who I liked a lot had already done some interviews with KP, so I knew that he had an interest in going to KP. Actually one of my fun phone calls was to call him up and say, “Ted, I just found out who KP is going to name for their new CEO,” because he was in the interviewing process, he said, “Really, who is it?” I told him, and he was amazed. He was the only person that I took.

09-00:08:50

Meeker:

Who was that?

09-00:08:51

Halvorson:

Ted Wise, and he came into product development at KP for a few years. He’s now a chief operating person at a health plan up in Seattle, so he’s having a good time up in rain country.

09-00:09:04

Meeker:

So, what was the time period between your job offer and when you started?

09-00:09:08

Halvorson:

Well, that’s a good question. The time frame. I accepted just before the end of the year and I started on, I think it was March 4, early in March. So, I had a couple of months in between. Because Mary Brainard was already my COO in Minnesota, it was a real easy transition—I just handed the baton and got out of the way—and I had some travel. So, what I did during that timeframe was I got a list of all of the consultants that KP was using. Deloitte, et cetera. I got a list of all the consultants, and I got the names of the senior consultants on the KP projects. I had each of them come to Minnesota and brief me. So, I got an in-depth briefing on all the relevant projects, but also on all the relevant people and all of the relevant issues from really smart people who were already working with KP from an actuarial perspective. When I landed, I also

had the auditors meet with me and explain to me the strengths and weaknesses of each of the regional CFOs and the whole financial process. I basically said, "I'm expecting you to tell me everything, and I'm not going to share this information with anyone other than myself, but how is our CFO in Georgia?" So, when I landed, I'd met with the actuaries. What are the actuarial issues? So, I landed with a pretty broad perspective on who the players were and what the issues were, and I also had some of the senior people from the KP staff then fly to Minnesota and brief me. So, Artie Southam got on an airplane and flew to Minnesota, and we talked through Artie's job, Artie's role, what he was all about. So, when I actually landed at KP and went through the process, the first thing I did on the first day was not go to KP. I went to Hawaii. I went to the first clinic where the electronic medical record was being put in place, and I asked for a demo of the medical record.

09-00:11:35

Meeker: Was this Epic or not?

09-00:11:36

Halvorson: No.

09-00:11:37

Meeker: This was the IBM-based system?

09-00:11:39

Halvorson: Yeah, there was an IBM-based system before that, that people were building, and internally building. Since I had built an internal system myself and since I had purchased a system and since I'd been working with medical records for a decade, probably longer than anybody in the health plan world, for sure, I knew that getting that right was absolutely critical to our success. I knew absolutely that we had to have the medical record in order to succeed as an organization. I knew that we had done that development work and I knew that we were pilot stage implementing. We just had the first client in Hawaii. I knew all of that from the briefing. So I symbolically but also functionally went to Hawaii to look at that system. I went into the exam room. I watched them use it. I watched the interaction. I looked at the outputs of the system and I looked at the functionality and capability of the system. I saw a system that was a couple of years behind the curve relative to other systems. There had been a snapshot taken of systems a couple of years before, and they had been building their system off that snapshot. So, it definitely was not a state of the art system, and it also had some huge functionality gaps.

09-00:13:00

Meeker: For instance?

09-00:13:01

Halvorson: Couldn't bill. One of the beauties of an electronic medical record, if you get it in place, is that you can use that then to drive a bill, and it's much easier to get your bill out. That system had been built without a single billing component. So when I said to the person at the desk, "Okay, now show me the bill, I just

saw the counter. I just saw the patient being treated. Okay, now show me the ability to bill from that system,” and the person said, “Well, there isn’t one.” I said, “Well, sure there is. If you’re going to do a bill, what would the bill look like?” They said, “No, there is no bill.” I said, “Well, what’s the coding for the bill,” and they said, “We’re using non-standard coding; we couldn’t do a bill if we wanted to.” So, I went to the financial people there and I said, “How are you going to generate a bill?” They said, “Basically, we’re going to take the electronic information. We’re going to print it out, and then we’re going to have a coder do a bill.” I said, “Really? That’s interesting.” So, I went back and said, “Could you change the system to generate a bill?” They said, “Not in an easy way. There’s no way that we could generate a bill from this system as we have designed the system.” So, what I saw was an old system, slightly clunky, not the best ergonomics, that also had flawed functionality. In terms of doing the data reporting, they had chosen not to use the standard data reporting format that would give comparative data with other sites. So, I think some really good people did some really good work for a long period of time to build that system and to get it to where it was, and if that had that been the only medical record in the world at the time, it would have been the best. But it wasn’t the best that day. So, I came back from Hawaii to Oakland and I basically said, “What we’re going to do now is we’re going to have a medical record and we’re going to do a search. I want a list of the best and brightest people. I really want to know what’s the best group of people for us to have to look at the right system, and then we’re going to bring you the best consultants, and they’re going to bring us all of the right systems, and then we’re going to have this bright group of people look at what all of these people bring in, and we’re going to pick a system. Then, we’re going to use that system and ride that system. The system we have now is eligible to participate in the competition, so the new system we have now in Hawaii can be part of that process. There are a couple of things that it can’t do. So, if it’s going to be part of the process, we’re going to have to have whoever’s designing it figure out how to change it so it can do the things it needs to do to meet the specs. But I’m totally happy with that. If that system wins, then I’m very fine with that. But this is the path we’re going down.”

09-00:16:14

Meeker:

This must have been a somewhat controversial proclamation to make fairly early in your tenure.

09-00:16:21

Halvorson:

Well, I think people weren’t entirely expecting it. In fact, I think no one expected it. When I came back from Hawaii, I did get about a thirty-page report that was an assessment that an internal committee had done of the functionality of the system. They said, “George, you don’t need to look at the system. We’ve already done a functionality assessment and we all voted that this is the right system and the right path, and here’s the assessment.” So, I said, “Thank you very much, I’ll read it.” I took a look at it and it did not answer any of the issues that I had. But it did say, based on the goals that are

set for that system, it would have achieved those goals. Unfortunately, those were not the goals we needed strategically as an organization to thrive, going forward.

09-00:17:17

Meeker: What other goals were you looking at in addition to the ability to bill, for instance? There must have been more.

09-00:17:23

Halvorson: Data research. The ability to have information available in real time to caregivers at the point of care. Fully assimilated care. The system didn't have a hospital component and we were a hospital system. I think there was, to be fair, an intent to go in that direction, but it wasn't in place at that point. So, I said, "Let's create specifications. Let's figure out, what do we want this system to do?" Then, we put together a group of about seventy experts from all over the process, and almost all of them were physicians. So, it was almost entirely a physician process.

09-00:18:22

Meeker: That was by design?

09-00:18:25

Halvorson: Yes. I went out and hired Louise Liang, who had done the medical record implementation at Harvard, and she had done the medical record implementation at Puget Sound, and she had been chief operating officer of two care systems. She was a physician who was a White House fellow, who's a really solid person. She'd run a hospital in Hawaii. Louise knows operations and systems, and she was the only person on the planet who had actually led medical record rollouts in two different companies. I used to kid her that I'd done two and she'd done two, and she'd done hers at Harvard and Puget Sound, and I'd done my two in the same site. We both had the advantage of having rolled out medical records. However, the first time you do that, there is a learning curve. We had both gone through it a couple of times. So, I put Louise in charge, and then Andy Wiesenthal was the Permanente leader who had been working with the system before that. He was a leader from Colorado, a medical leader from Colorado. Andy is also a very bright, very capable person. He did a great job as well. So, Andy and Louise were given the process of looking at all of the options, setting up a process for everybody, and then, once we made our decision, we then took everyone's input and picked Epic. We then did the negotiations. We then created a collaborative build, and the collaborative build involved the same sorts of people—another seventy people—coming together for a couple of months to figure out, what do we want the system to do?

09-00:20:14

Meeker: I'm curious, I know that Northwest was already using Epic, correct?

09-00:20:17

Halvorson: Yes.

09-00:20:18

Meeker: Did that play a key role in their selection?

09-00:20:21

Halvorson: No.

09-00:20:23

Meeker: How could that be?

09-00:20:24

Halvorson: How could that be? Because they were using an earlier version of Epic. Well, when you say “play a key role,” the fact that it was running in Northwest was a good thing. Northwest had put the Epic system in, but had frozen it. So, the Epic system that I knew was a more current system than the one they had at Northwest, and taking the one from Northwest and that version of it would not have worked as a solution set. But we knew from the experience in Northwest that Epic did a really good job. They did great support, and I knew from Minnesota that they did a really good job and great support. Part of Epic’s culture is that they deliver whatever they promise they will deliver. They’re fanatical about delivery. So, if they say, “We’ll have it done on July 1,” that’s their culture. That’s their approach. That’s their strategy, and they will have it for you, July 1.

09-00:21:33

Meeker: I understand that their founder and CEO has a lot to do with that.

09-00:21:37

Halvorson: Yeah, Judy Faulkner sets a lot of the culture of that organization. Judy’s about that—she loves medical records and she doesn’t love any other kinds of systems. This is her world. This is her life. This is what she does, and she is completely and totally committed to it, but she’s a person of absolute honor. So, if you say to Judy, “I need you to do this or that,” she’ll say, “If I can’t do that, I won’t do it.” Judy is perfectly comfortable saying no, and one of the reasons some people aren’t happy with her is because of her comfort in saying no. But if she says no, it’s because she can’t, and if she says yes, she will. Knowing that, and the fact that I had actually used it in Minnesota and we’d used it before, in Portland, that actually didn’t hurt. I literally did not go to a single one of the evaluation meetings and I didn’t go to any of the site visits, and I made sure that the criteria that was set up was the real criteria that we needed to use to figure out what the system was, so that it could bill and it could do research. So, I made sure that was in the mix, but then I very deliberately kept myself out of the process because I didn’t want it to be George’s choice. I do have faith in the group process. I did believe that that group, given the right input and the right information, would make a good choice. Frankly, whatever system came out of that process I think would have been the best system out of that process because we did have some really smart consultants.

09-00:23:32

Meeker:

Well, so, this is interesting. This is obviously very early on and you had talked about the tribal differences between the health plan and medical groups—typically, within Kaiser Permanente, the investment and infrastructure like this would be the domain of the health plan, right? That’s where the investment would come from, and then the medical groups would be asked to use it and implement it. Did you recognize that you were kind of mixing this up a bit, in recognizing that it was the health plan that was making the investment, but putting the decision in which plan would be invested in, in the hands of the medical groups?

09-00:24:15

Halvorson:

Well, yeah. It was very intentional, right, because I trusted the process and I got to set the process up. I got to design the process. The inputs were in my scope, and so, if you get really good people and if they have the right inputs, they’re likely to make good decision. Frankly, I wanted the input. I wanted those people to go to the different sites. They went to the Cerner sites. They went to Epic sites. They kicked the tires. They talked to the users. They talked to the people there, and they came back with insight into the various ways the system worked in a way that I could not possibly have done myself. There’s no way that I would have even, in those settings, been able to ask the right questions or get the right feedback. So, when they got together as a process, the vote was something like sixty-five to five, or something.

09-00:25:12

Meeker:

In favor of Epic?

09-00:25:13

Halvorson:

In favor of Epic. Then, we said to Epic, “We have to get a positive contract. This contract has to work for us, and it has to have a number of guarantees in it. One of the guarantees is that while you’re doing us—because we’re so big—you’re not going to do twenty others.” We had a series of provisions to protect us in the context of that time and in going forward, and some of those were challenging negotiations, but they ended up being done. So, we ended up implementing it, and then Epic did what I thought they would do, which was to deliver the resources needed as we were implementing the system at the time and place that we needed the implementation. From the medical group perspective, the fact that there had been a collaborative process in picking the system, and then a hugely collaborative process in picking the components of the system, and then a very collaborative process for roll out was key. We rolled it out region by region, and in each region, Louise and Andy sat down with the leaders and figured out, what do we do in Colorado to make the system work in Colorado? We had very, very, very detailed day by day, piece by piece planning documents that identified what needed to be done in what order, and tracking of that. So, we knew any time we were slipping by a day. We knew where we were in the process.

09-00:26:56

Meeker:

Colorado is an interesting example. Kaiser doesn't have their own dedicated hospitals in Colorado, unlike Northern California or Portland. How did you roll out a system where there was not a dedicated hospital? How did you get the record into it?

09-00:27:17

Halvorson:

There are a couple of hospitals that are pretty much overwhelmingly KP, and that system chose Epic. The hospitals that we partner with use Epic as their system. Actually, our first use of Epic in a hospital was in Colorado. So, just partnership approach.

09-00:27:50

Meeker:

I want to get back to Epic. There's obviously a lot to talk about here, about the rollout, and about some of the issues around cost that came up that I think were ultimately resolved, obviously, but it's worth talking about it. I want to go back a little bit to your arrival at KP. A couple of people mentioned to me the first memo that you wrote to the leaders of the organization in which you talked about competitors, how to evolve the product portfolio, how to respond to market pressures, electronic medical records, and issues with a couple of leaders of the health plan. It's been described as a pivotal memo, a real statement, very wide-ranging, with a real strong point of view.

09-00:29:05

Halvorson:

Have you read it?

09-00:29:06

Meeker:

I haven't read it.

09-00:29:07

Halvorson:

Oh! You should get it.

09-00:29:09

Meeker:

I would love to see it. Maybe you can kind of walk me through one, maybe your inspiration to writing something like this, where there was a strong point of view, and then two, what was within it?

09-00:29:23

Halvorson:

Okay, yeah, I should get you the memo. I have it on file somewhere, but I'm sure KP has it on file as well, I think, David Mays might be able to find a copy of that, for that first memo. It actually didn't go just to the senior leaders—it went to every single person at KP. What I did was I said, "Here's the challenges, here's the opportunities, here's the issues, here's who we are, here's our current status, here's who's going to come after us." Very much an "us/them" sort of memo: We're us. We're the people in Kaiser Permanente. We're going to do these things. There are some competitors that want to take our customers. They want to take our members. They want to take our patients. They're bad. We need to prevail and we're going to do electronic medical records to prevail. That particular memo, a number of our competitors circulated it, actually. I heard from several other companies that their senior

leadership had gotten copies and had passed it out to their senior leadership, and a couple of them even shared it with their boards. So, it actually got a very wide distribution. I wrote it in part to sustain and support a broad distribution, assuming that minimally, the news media would get it. If the news media got it, I needed to make sure there was nothing in there that was adversely quotable, but also, I needed to make sure there were points in there that I actually did write to further the new brand that we were creating. So, there was a lot of brand positioning in that letter: we are vertically integrated, we've got these systems.

09-00:31:19

Meeker: That's a difficult balance to achieve.

09-00:31:22

Halvorson: I've been doing it for a long time. I wrote quarterly memos to all the people at HealthPartners explaining the same kinds of things. I'm a writer by nature, I explain things in writing. That's where I explain things very clearly and simply, in writing. So, I sent this letter explaining to everybody what we were going to do, and I also wrote it after I had just reorganized.

09-00:31:49

Meeker: Personnel?

09-00:31:50

Halvorson: The personnel. So, I had reorganized the senior leadership and so, I basically also explained in that letter who the new senior leaders were, why they were what they were and what the jobs were of each of the senior leaders. So, anybody who got that memo both knew what our strategies were and who was going to lead us, going forward. So, that memo announced the new people.

09-00:32:20

Meeker: So, I don't know if you want to talk about the specific instances, but maybe you can at least explain how you did organize the senior leadership and what your motivations were in the changes that you did make?

09-00:32:32

Halvorson: I did several things that were, I think, important at that point. One of the things I did was the regional presidents had never been a group. They had functioned as independent, separate chains of command. David Lawrence, when he explained it to me, said, "They are unrelated to each other in any way."

09-00:32:56

Meeker: So, those were the direct reports to him, but they never interacted with one another?

09-00:33:00

Halvorson: Well, they were, I think, direct reports to Dale, after a bit, and then I think there had been a number of other organizations. But they hadn't functioned as a group. There was no equivalent of a presidents' group. There was a medical

director group, and on the twenty-seventh floor at KP, there are pictures of each of the medical directors on the wall are in that area. I added pictures of each of the presidents. I created a wall of presidents' pictures and said, "The presidents are now the RPG, the regional president group, and the RPG is going to meet regularly and do functions together and share learning, and we're going to have the regional presidents function as a team in addition to a being in chain of command within the region." Actually, the initial meetings were a little stiff, I think.

09-00:33:54

Meeker: Of the presidents?

09-00:33:55

Halvorson: Of the presidents. There was enough local autonomy and local isolation that people didn't necessarily want shared information in some of the settings. I basically created a mechanism of having shared information and having the presidents meet regularly, and then having the presidents meet as a group, periodically, with the medical directors as a group. So, what I did was I created a three-legged stool that had the hospitals and the regions in the process in a more collected way.

09-00:34:37

Meeker: It's almost as if you created an institutional presence within the health plan side that, to a certain extent, mirrored what Jay Crosson and others had created with the Permanente Federation in the 1990s that finally brought together the heads of the medical groups into a regular coalition, whereas before, they were much more independent.

09-00:35:00

Halvorson: Yes. I followed Jay's lead and paralleled exactly. Right to the point of having the frames for the pictures look pretty much like the frames that Jay had for the medical group pictures. I put the presidents, my wall of pictures, on the path to the board room and got the presidents to function together. Then, I did some other changes. I actually had Bernard Tyson [the current President and CEO of Kaiser Foundation Health Plans and Hospitals] become the head of brand work. His initial reaction to that was, I have to say, skeptical would be a good response.

09-00:35:40

Meeker: What had been his role prior to that?

09-00:35:42

Halvorson: He'd been doing some leadership in the regions, and he ran the Washington region for a while. He had a shared leadership. His original career had been a hospital administrator in Oakland, and then he'd been promoted through a number of positions. I actually heard Bernard—my second week on the job, I went to a meeting in Oakland and people were talking about some of our positioning issues—go to the front of the room and talk about what he believed KP was and shared that with the group. It was a very powerful

presentation, and I thought, this is a man that we can use to do some of our key and essential brand work.

09-00:36:32

Meeker:

Do you recall what he said?

09-00:36:38

Halvorson:

Good values. It was basically about we need to deliver care, we need to be a team. It was basic, functional things, and it was about getting things right and having a patient focus. He did it with great passion, and so I said, "This is a man who can speak to these points." I knew we really needed a brand. We didn't have a brand. KP had no brand. KP had eight regions who each had the ability to set their own ad campaign and their own ad agenda, and they all did. There was a whole separate set of advertising initiatives going on. When I first got to KP, one of my first weeks on the job, there was a nasty article in the Los Angeles paper about something that had gone on. One of my board members down there told me about it, called me up and said, "There's a nasty article in the LA paper about KP." So, I said, "Okay, I'll get on it right away." I called in the head of communications, nationally, and I said, "I've just been informed this is going on. The LA paper's doing this article. How are we dealing with it and what's the strategy?" He said, "Well, I'm not involved." I said, "What do you mean, you're not involved?" He said, "Well, that's not something I handle out of Oakland. We don't do PR out of Oakland." I said, "Okay, who do I talk to? Where is it?" He said, well, "It's not me," basically. So, I called to Southern California and I said, "Put me on the line with the head of our communications department for Southern Cal." So, that person got on the line, and I said, "I'm reading this headline," or whatever, "what's our strategy, how are we responding to it?" That person said, "Well, I'm not involved." I said, "Aren't you the communications lead for Southern California?" The person said, "Yes, and that's actually a hospital issue, and so it's totally within the jurisdiction of the hospital." So, I said, "So, you're not dealing with it any level, strategic or responsive?" "No, that's not our scope."

09-00:39:09

Meeker:

When you say "hospital issue," you mean the specific site of that hospital?

09-00:39:11

Halvorson:

The specific site of the hospital. There was an occurrence that had gone on at one of the hospitals. So, I basically called the hospital and I said, "Give me the communications leader." I called the hospital and said, "What's going on here?" The person basically said, "Why do you want to know?" whatever, and I said, "Because I'm the chair and CEO and this is on my watch and this is on my scope, and so, I need you to tell me what you're doing and why you're doing it. I got some feedback on the issue, and I changed the direction, and the person basically said, "Do you have the authority to do that?" I said, "Yes, I do, because I'm the chair and the CEO and anything that relates to us in those areas is in my scope of practice. So, yes." That's how I got involved in that issue. So, then I called people together and said, "How does this work?" They

basically told me that we were decentralized so much that we didn't even have the ability to respond to some issues regionally, from a position perspective. That particular headline was running on the East Coast, it was national news. Washington was seeing the news, it wasn't a local thing. It wasn't just running in the local paper.

09-00:40:34

Meeker:

The fact that this employee at the hospital questioned your interest and authority on the matter speaks volumes.

09-00:40:44

Halvorson:

Oh, it's fascinating, yeah. A few years later, when I changed the Medicare rates, a couple of years after that, I was talking to one of the raters in one of the areas and I said, "I think we're going to change that rate. We're going to take it down 10 points." I got involved in that one because the rate had to be filed that day and I'd looked at all the rate files, and so then I just thought, "No, we're not going there with that." So, I changed it, and that same thing—and the person said, "What authority do you have to change this rate? Don't you have to get permission from the regional president?" I said, "No, the regional president actually reports to me. So I am changing this rate, and feel free to call the president and explain that I did that, and I'll talk to him tomorrow." One of the beauties of KP is that there's a lot of things that are decentralized, and it really is a strength because when you're focusing on the patient and you're in the area and you're in a geographic site. It's really good to have care in each site focused on that area. People invent things all the time in those areas, and when the invention is then spread to the rest of the system, that's a really good thing. Having that level of isolation on some things, however, was not optimal. So, I said to myself, "We have no brand."

09-00:42:18

Meeker:

This was before the "Thrive" campaign, correct?

09-00:42:20

Halvorson:

Yeah. Well, the "Thrive" campaign resulted from that. So, we had no brand. We had no campaign. So I basically said to Bernard, "You need to be in this job," and then we picked a world-class ad agency, and I said, "You'll have great support. You'll have really great ad agency support. You'll have great PR agency support. But we need a national brand. We need a national agenda, and we need to tie this stuff all together." Bernard went around, talked to all the regions, talked to all the people, basically got everybody aligned. I created a chain of command for all the communications people and all the regions reported to him—dual reporting. They report to the president and they also reported to Bernard—and created a national campaign. Then, the "Thrive" campaign resulted from that. I said to everybody, "We're going to have a national brand and we're going to have a national message."

09-00:43:13

Meeker: Do you remember when you first heard about the “Thrive” campaign and what your response was to it?

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Halvorson: Well, I was sitting in the room, designing it.

09-00:43:20

Meeker: Okay, well, tell me a little bit about that process.

09-00:43:24

Halvorson: I tend to be heavily involved in communication issues. If you go back and look at the Minnesota ads we did, we actually did “Thrive” ads in Minnesota before I got to KP.

09-00:43:33

Meeker: Using that same term?

09-00:43:35

Halvorson: Using “improved health,” “improving health as an agenda,” and we ran ad campaigns that were about people’s health we improved. We had annual meetings where we’d invite the media in. We had real people on those Minnesota ads who were thriving, and we invited the news media in to meet the people in the ads as part of our kickoff campaign for the ad. So, I came with the intent of creating a similar sort of agenda. Then, as I was part of the process to pick the agency, and then as we did all the ads, part of the process that picked all of the initial ads and provided input. So, there wasn’t a “Thrive” TV ad—there are all kinds of radio ads I wasn’t linked to, and there are some wonderful radio ads—but in terms of the TV ads, for the first five years, there wasn’t a “Thrive” ad that I didn’t have a relationship to.

09-00:44:51

Meeker: What were the guiding principles in those ads?

09-00:44:55

Halvorson: We want people to love us. We said we’ve got two campaigns—we’ve got one campaign to have people respect us, and we have a second campaign to have people love us. The “Respect Us” campaign was the research, publishing the research, doing the books, doing all of that, and the “Loving” campaign was we wanted the “Thrive” campaign to let people know what our basic values were because paradigms exist in the world, and people believe in paradigms. The fact is that every paradigm is driven by a core belief. When you interpret data about any particular thing, you interpret data in that core belief. So, if you believe that the number one motivation of an organization is just profitability, then every piece of data you hear about that organization, you interpret in the context of the profitability. If you believe that the core paradigm of an organization is about improving health, then when you’re reading the thing about the organization here, you interpret it for your health. So, we needed people to believe and know that we were about health, and we need to do it in a way that made people love us. So, we were funny, we were

friendly, we were happy. I gave a couple of guidelines: one, we can't ever do anything that's ever disparaging in any way, that's insulting to the member. We never make the member or the patient look bad; we always look warm and friendly, and the whole point of this is how people feel good about us, and to like us, and we get the respect for the work with the Institute of Medicine, and we get the affection for the work with "Thrive."

09-00:46:27

Meeker:

I think the genius of the "Thrive" campaign is this, and that is, like you just said, it is about health, but it's also about prevention, it's about keeping people healthy. It's not about the other side of the medical industry, which you see even more of, which is, "We're going to perform miracles because you're already sick," right? "We're here to perform miracles because you've already screwed yourself up." Thrive is entirely opposite, which is, "We don't want you to get to that point. We want you to either stay healthy or to get healthy." That is almost revolutionary, I think, in healthcare marketing, right?

09-00:47:08

Halvorson:

Yes, there wasn't much of that happening. In Minnesota, we'd actually set the Partners for Better Health Campaign, and we set goals for reducing heart attacks by 25 percent, and we did the same kinds of things and then we ran ads about them. But there weren't many other places in the country doing that. In California, nobody was doing it. So, when we did the "Thrive" campaign, that was directionally different. Again, the reason we did it was we wanted people, when they heard something about us, to have a context to interpret that information. If the context was, "These are really good people and want you to be healthy," then KP did this or did that is interpreted in that context. There were people before that that thought KP made all decisions based on money. There were some negative aspects of that, and we needed to pull those negatives out. We had to give them a different why. You have to replace the why part of the paradigm, and so we replaced the why part of the paradigm with we're good people, and the sense of humor is very deliberate. It's hard to dislike somebody who has a positive sense of humor. So the humor of all of those ads is a key part of the messaging. You'd like us—if we lived next door to you, you'd like us—is kind of part of the messaging. So, we could have done just science-based ads. We could have done other kinds of things, but we basically wanted to be liked. So, we had the "Head" campaign and the "Heart" campaign going simultaneously. So, "Thrive" was a good thing to do, and then we took "Thrive" internally, and we passed it around to all our employees.

So, let me go back and talk for a second. We've already talked about this, but I wrote that letter to all the employees to create a sense of us. I talked earlier about the work I'd done on us and them, so if somebody is an "us," you're a protective supporter, nurturing, forgiving, understanding, affectionate, if somebody's a "them," you're territorial, and you don't trust them. You are suspicious, suspend conscience, you lie to them, you firebomb them, you do

terrible things to them. Those behavior patterns happen all the time, and so we needed to become an “us,” inside Kaiser Permanente, and we had to be an “us” so that we didn’t have all the internal dissensions. That letter and others like it were designed to do that. I later wrote weekly letters, every single Friday, for five years. They were all about being us. They were about celebrating who we are and what we are because when people are functioning as an “us,” they’re stronger and more collaborative. But when I first got to KP, one of the first things I did was I took all of our executives to a retreat. We went to Half Moon Bay, a lovely site. I’d never been there before. I was really impressed.

09-00:50:26

Meeker:

When you say “executives,” is this health plan along with medical groups?

09-00:50:30

Halvorson:

The senior executives of the health plan. So, I had twenty people there, and what I did with those twenty people was I explained us/them. I explained sociobiology. We had a two-day lecture on sociobiology and electronic medical records because I needed to anchor the people on those two things. So, we did sociobiology and I said, “We are only an ‘us,’ inside KP. There is no ‘them’ inside. We’ve been fighting with medical group—that’s no longer permissible. No one can ever refer to the medical group as ‘them.’ You have to say ‘our medical group.’ You have to make it an ‘our,’ but you can’t say the medical group, ‘them,’ ‘what do they do?’” It was a change in dialogue and a change in terminology, and I said, “We’re going to be aligned.” I actually got a feedback from that retreat from a couple of people who said that I was naïve and didn’t understand real issues with the medical group, and I was being too academic. But I knew from having done this multiple places that I needed to defuse that, and so I said to the senior executives, “Anybody here who can’t become an ‘us’ inside Kaiser Permanente needs to leave. I need you to go work someplace else. I’ll help you get there, do good severance, but you can’t work here. You have to go someplace else because we have to be an ‘us’ inside KP for us to win. We have to be an ‘us’ to do the medical record. We have to do ‘us’ to do the research. We can’t do continuous improvement if there’s not trust.” So, I basically did that retreat, went through that process, shared the slides, showed them the “us/them” stuff and the pyramid, the basic alignment trigger pyramid, and a lot of things that I had been working on and had used. I’d actually done almost that same meeting at HealthPartners a year earlier with the senior leadership of HealthPartners. Actually, I had trained all the supervisors at HealthPartners in how to avoid us/them thinking in your work site. So, at KP, we ended up creating unit-based teams and building that into our contract. When I left, there were 100,000 workers in unit-based teams that were focusing on being an “us” at each work site, collectively focused on issues of care improvement.

09-00:52:58

Meeker:

What do you mean by unit-based teams?

09-00:53:00

Halvorson:

We actually created unit-based teams, wrote them into the labor contracts, where in each team, in each unit, there's a team of people who work together to achieve specific purposes. So, KP right now is the richest source of unit-based teams in the world, and we have unit-based teams on all of our sites, and the unit-based teams work together to improve throughput, to improve service levels, to improve different issues.

09-00:53:24

Meeker:

Can you maybe give me an example of one of these unit-based teams?

09-00:53:29

Halvorson:

Literally, throughput—the amount of time it takes in a waiting room. The waiting room could function as a team. How long does it take us to get patients out of the waiting room, into the exam room? It's taking us an hour; let's cut it to five minutes. The unit-based team then sits down as a team, does flowcharts, and says, "What have we done in the past? What could we do now? What changes could we make?" The unit-based teamwork actually improves morale—people like each other more—and care improves. So, we literally have 100,000 people organized into unit-based teams doing that work.

09-00:54:06

Meeker:

These are people in medical groups as well as health plan and hospitals, all together? The idea is, it sounds like, to create best practices that then are replicated throughout the system?

09-00:54:09

Halvorson:

Oh, yeah, totally. Well, it's best practices, but it's also best performance in that site. One of the points of being a team, one of the instincts we have, if there's any time we are in a team, we overlook other differences and work together. Back to the blue/green thing. There would have been two teams there, one blue, one green, but any time somebody is a team, they function better together. They like each other more, or they share better, and people naturally like teams. So, if you create teams everywhere and people on each work site function as a team, and in that team setting, they perform better and they feel better, morale goes up. I can actually show you studies that show that the morale level of the high functioning unit-based teams, when they're rating the company in terms of how much do I like working here, or would I recommend this to a friend, the sites with the unit-based teams have the highest scores.

09-00:55:15

Meeker:

So, maybe just wrap up by telling me a little bit more about this retreat. You had mentioned that there were obviously some people who were—I don't know if "cynical" is the right word—dubious of actually being able to approach things along these lines.

09-00:55:28

Halvorson:

And even some resistant.

09-00:55:30

Meeker: How do you deal with that?

09-00:55:33

Halvorson: I've done it for a long time. I've done it for a long time. Well, I'm a patient teacher, so I'll basically say, "No, you need to understand that if you treat people like that, they will naturally respond to you in a similar vein. The emotions are contagious. So if you do that, they will do that. Immediately, you'll end up with the two of you disliking each other, hating each other, doing bad things to each other." I always say, "There has to be an adult in every room, and unfortunately, it has to be you." Everybody has to be the adult in that setting, and what you end up doing is teaching the people to do it. There have been, both in Minnesota and California, times when people were initially resistant but once they got it, realized what an incredible tool kit it is, they have used it really well. One guy in Minnesota who resisted initially became a genius at it. When he retired, there was a massive party. People loved him, but he started in very much us/them and kind of cranky. So, you teach people the value, you teach people the logistical value, you teach people the operational value, and it basically feels better for you as a person if you're operating in that level. So, I basically taught that and then reinforced that. In my last meeting, as I left Kaiser Permanente, the last meeting that I had with the executive staff before I turned the reins over to Bernard, I went back and revisited all of those same points. I don't know if I kept the slide set from that one. Same points: if you allow us/them emotions to be triggered and you allow an "us" and "them" to be defined, then you end up doing the nasty things to each other that people do. If you don't allow that to happen, then you end up with collaborative, cooperative, supportive behaviors, and that's what you want.

09-00:57:52

Meeker: Well, that's probably a good spot for us to wrap up today.

Interview 5: February 12, 2014

Audio File 10

10-00:00:09

Meeker: This is Martin Meeker interviewing George Halvorson. This is February 12, 2014, and this is tape number ten. We are, again, at his home in Sausalito. So, we're going to return today to your period of time as CEO, President, and Chair of Kaiser Permanente, those three titles, correct?

10-00:00:31:

Halvorson: Right.

10-00:00:33

Meeker: There's a great deal that I want to ask you about, but I think I want to start out today by asking you about some of your agendas at the beginning of your tenure there. One is something which has been called by people who you worked with "the fishbone diagram," but you have a different name for it. I wonder if you can tell me what your name for this diagram is and why, perhaps, people on your team thought it significant?

10-00:01:09

Halvorson: One of the first things that I did after becoming chair and CEO, and also COO—I actually took four titles for a couple of years, for somewhat symbolic reasons, but I had all four for a while. One of the things I did very quickly was to develop an overall, what I call, pathway chart. Because it had multiple lines coming in and then flowing together, other people referred to it as the "fishbone chart." I created a pathway chart, and the pathway chart filled the entire wall of the boardroom. So it was ten feet tall, twenty-five feet long, and it outlined everything we needed to do for the next five years. It identified by strategic area what we needed to do. It identified what we were going to do for brand, what we were going to do for credibility, what we're going to do for systems, what we're going to do for financial status, and I put our products on that chart, put our customer service, and I identified for each of those areas what we were going to do and the order we were going to do it in.

I've used that same chart, that same pathway, for starting several other companies. So I treated it like a start-up. When I did Uganda, I used the same chart. When I did HealthPartners, I did the same chart. HealthPartners people will joke about the fishbone chart there because I find it to be a very clear way of thinking. If I put all of the issues up one big chart and identify all the pieces, then I can see how the marketing interrelates to the systems, how that interrelates to the financial, and I can identify how all the pieces fit together. Even more usefully for me, I can explain to everybody else how they fit because almost everybody thinks in silos. Everybody knows what their accountability is. Everybody knows what their little piece of the organization is, and people are very wedded to and focused on their piece.

What I do by putting everything on a big pathway chart, you show people that what we're doing in marketing actually relates to what we're doing in sales, relates to what we're doing actuarially, relates to what we're doing positionally, and that helps people understand the strategy better. Also, as people make day-to-day decisions to run their part of the organization, they make those decisions much more effectively if they understand the context they're making them in. So, it's a very complete chart. You actually can run a company from this chart and identify the fact that we can't do new products until we have new insurance claim systems in place, and that we can't do the new products until we have the regulators change the standards that we are regulated by for products, et cetera. If I put the whole thing on one big chart, then everybody knows what all the pieces are. Since I'd run a number of health plans, started a number of health plans, for me, it was pretty easy to do the chart that had all the pieces on it because I had run every kind of health plan, I'd run hospital systems. I'd run a clinical system. I'd run insurance companies. And I'd started several. So, I knew what all the pieces were.

When I started the health plan in Spain, I used the same chart. When I started a health plan in Uganda, I used the same chart. When I started in Jamaica, same chart. Same approach, and as I'm doing my new work now on inter-group issues, basically same process. Identify exactly what sequence I need to develop the products, what sequence I need to develop the credibility, when I need to do the positioning, when I need to make my contacts. So, the whole thing is not serendipitous. The whole thing is extremely intentional. One of my senior officers in Minnesota, Judy Meathe, said years ago that I was the most intentional person she'd ever met in her life. She seemed to think it was a good thing, but it's very much the way I think about things. So, when you come to a complex organization like KP that has many moving parts and many pieces, if you have an overall understanding of where you want to go, and if you understand what each of the pieces are and each of the steps are, then you're much more likely to get there.

I literally put that on the board room. Covered an entire wall. The reason I did it in that room was because that's the room that I had my senior officer meeting in. So, the national leadership team met in that room every week, and every week they'd meet in that room with that chart on the wall, and we would talk about... I did the first draft of the chart myself because I could and I knew how to do it and I was a CEO. One of the things I put on the end of the chart was that we're going to have the best care in America. When I put that on the chart, there was actually a lot of resistance. People said, "That can't possibly happen. There's no conceivable way." In fact, people said, "If you put that up there, you're going to undermine your credibility as a leader because it's such an unachievable goal, that if you say we're going to be the best in the country, then people won't believe other things you say either." I said, "Well, it's very possible to do that and it's very reasonable to do that. It's very achievable to do that. That is, in fact, what we're going to do. That's my

job, is to get us there. We're not going to send out press releases about being the best in the country until we're the best in the country."

Internally, one of the other advantages of setting the thing up year by year is that internally, I can identify very clearly year one, if we're going to get to this end goal. Here's the things we have to have, year one. Part of the end goal is to be a culture of continuous improvement. We need to continuously improve at KP. We don't want to do a lean process. People do the lean process, streamline existing processes. People who do continuous improvement, the [W. Edwards] Deming sort of approach, basically reengineer the entire process of anything you're involved in. I've been an advocate and a zealot of continuous improvement for a very long time. I preach it in my books. I talk about it, but I use it as a continuous model. The reason I do it is because it's data-based, and because once people start doing it, they fall in love with it. Once they start doing it, they become addicted to continuous improvement because they get better and then they get better and then they get better. That's very affirming for the people who are getting better, and it works pretty well as a tool kit.

So, I said, "We're going to do continuous improvement in the end, but we can't do continuous improvement in the end until we have data upfront. We can't have data until we have trust. We can't have data until we have systems. So, we have to put these pieces in year one, in order to have this progress for year two, and then we have to have that so we have year three." So, I actually showed, in a five-year plan, I said, "At this point, we're going to do sepsis, and it's going to be four years out." People said, "Why don't we do sepsis now?" I said, "We're not ready. We don't have the parts, we don't have the pieces, we can't transport it. Right now, anything that we do at any particular place that succeeds stays in that place." As a culture, the culture of Kaiser Permanente was to be very, very siloed, extremely siloed. So, things would happen at any place.

Don Berwick used to make a joke, he'd say that when he wanted to discover the best thing happening anywhere in the world in healthcare, you could find it at Kaiser Permanente, but you would only find it at one place at Kaiser Permanente, and the rest of KP would refuse to use it.

10-00:09:25

Meeker:

Many different kinds of silos, geographic silos, you had as sort of departmental silos, you probably had intellectual silos?

10-00:09:36

Halvorson:

Yeah, exactly. There were medical group/health plan silos. There were hospital silos. Until I brought all the hospitals together for a collective meeting, they had never in the history of Kaiser Permanente had a meeting where all the hospitals were together because the hospitals were embedded in each of the care sites. There were geographic silos. There were medical group

health plan silos. There were specialty silos. The oncologists in Northern California didn't interact significantly with the oncologists of Georgia or Southern California. David Lawrence told me when I got to KP, he said, "This is the biggest IPA in the country. What a lot of people don't realize is this is actually an IPA," and he said I need to be prepared to deal with that. I said, "Actually, I've been there before and I know that model." So, but if you say, "Where are we going and what's the end game?" We're going to do continuous improvement. We're going to do data-based care. Then, what do you have to do along the way to get there?

If you build a really clear pathway chart and then you identify each step and then you have all your senior officers responsible for their steps, I called it the March of the Seven Generals: I said, "We have seven armies, and each of the seven armies has to achieve their goals. The systems army has to put their work in place in order to support the other armies, and they have to do it on time and they have to do it in sequence. The other armies can't achieve their goals if that doesn't happen. As the system people are doing their part of the agenda, they need to recognize that they're doing that in the context of improving care and they're doing that in the context of creating great research. If they understand the goal of the entire process, then they're much more likely to make the individual, day to day choices, in an effective, meaningful, useful way." One of the things I learned a long time ago is that if the entire organization knows where you're going and if you have the right culture of the organization, then people who have to make day to day decisions to get through every day will make those decisions in the context of the path you were on and the culture you're part of.

But if people don't know where you're going, then people make their day to day decisions in the context of their situation and their personal history, and sometimes, there are local battles of one kind or another. Sometimes there are turf issues. Sometimes there are professional agendas. Or there's all kinds of things that happen in that situational context that are all perfectly legitimate if you are just a situational organization. If you really want to get to an endgame, if you really want to solve problems and be great, if you want to be the best in America and everything, you can't do that by having a whole bunch of one-off, situational occurrences. You have to put the pieces together in an organized way. So, there are actually two pathways. The one pathway was extremely visible and everybody in the organization, all the senior leaders, saw that. It was on the board of the room that many people met in for various meetings. The second pathway that I did, that only went to the board of directors and the senior officers, was a culture pathway.

I did the same thing on culture. I said, "Corporate culture needs to be a tool of our strategy, and for the culture to be a tool of the strategy, we have to have culture. If we're going to be a continuous improvement strategy, we have to have internal trust, we have to have data sharing, we have to have a whole series of cultural things. We have to have a sense that shared learning is a

good thing.” So, there’s a whole series of cultural components that have to be in place, and we need to put those components in place. Once we put them in place, then we can make the strategy work, and if you don’t have the culture in place, the strategy’s not going to work. When I arrived at KP, people didn’t share data. In fact, there were rules against sharing data. People could lose their job if they shared data. There were barriers between regions on data sharing. There were barriers inside departments. The barriers that existed to data sharing all emerged somewhat spontaneously from the model, and the model was a very site-specific model.

10-00:14:20

Meeker:

This brings up an interesting question, and that is that it is a challenge to get people to think in a networked way, and that their activity is related to a series of other activities that the organization needs to do. It’s kind of like an intellectual pathway, and opening up those intellectual pathways. But it’s an entirely different task to retrofit the institution, the bureaucracies, the work pathways, in order to facilitate those new intellectual pathways that people are creating.

10-00:15:00

Halvorson:

It’s collaborative, right.

10-00:15:03

Meeker:

So, for instance, the idea of data sharing. Whereas before there would have been some either cultural or even rule-based—

10-00:15:11

Halvorson:

Political, financial, legal, all kinds of issues, yeah.

10-00:15:17

Meeker:

Yeah, a situation that prevented that from happening. You wanted to end those blockages and help set up the pathways. The intellectual change is one thing, but the changing the way the actual institution works, the bureaucracy works, is an entirely different thing.

10-00:15:40

Halvorson:

It’s not as hard as you might think if you do it in order. It’s really important to get the pieces right. What our officers heard me say over and over and over again was, “Each thing in its turn, each thing in its time.” I said that over and over again. Each thing in its turn, each thing in its time. The second thing is the old Zen saying, “When the student is ready, the teacher appears.” Have you heard that saying? Do you know what that actually meant? That actually sounds like somehow the universe will provide—when you’re ready as a student, the universe will provide a teacher. In the real Zen tradition, the Zen masters would identify a student that they thought would be a wonderful student, and they would sort of hover and be ready. When the student was ready, the teacher would appear. It was actually a strategy from the teachers; it wasn’t the universe somehow providing, serendipitously, the teacher. I also taught that to our staff. I said, “We have to get the student ready for each of

these points. Then, when the student is ready, the teacher needs to appear.” There would be points when I would say to the group, “Are you ready to appear on this point? Do we have the pieces?” So, it was, again, a conscious strategic process.

But how do you get there? When you have no data and you have inconsistent data, and when you don’t have any kind of data sharing, you have to start by building data. So, one of the reasons that I said initially electronic medical record is going to be absolutely critical to what we do and foundational to what we do is because the medical record gave us the information set so that we could have uniform data everywhere. We couldn’t have survived as a company, we couldn’t have survived as a care system, without that tool. We would have been eaten up by other competitors who were coming, taking our patients, and doing a number of things with us. Our brand was suffering, our credibility was suffering, and our functionality wasn’t optimal. We weren’t winning number one HEDIS scores. We weren’t winning service scores because we didn’t have the tool kit we needed to do that. The foundation for that tool kit was a medical record. So, I knew that we needed an electronic medical record. I have done an electronic medical record twice before, so I had not only put them in, but I had used and I knew how good care can get when you have that data. So, I could sit down in a setting at KP and explain how good it was going to be when we had that data, and I could do it from a level of credibility. I can say, “If you don’t believe it, call Minnesota. Talk to my people there. You’ll find out what we did there.”

We won the Robert Wood Johnson Pursuing Perfection award the month that I left for Kaiser because we had put the medical record in place, done some of the same kinds of things, and I’d done it in a continuous improvement mode. So, I got to KP and I did the pathway chart and I did the culture chart, and I sat down with the board and I said, “We’re going to have to get from here to there on the culture, and here’s what the pieces look like.” At every annual board retreat, I sat down with the board and I went through the culture pathway. It was interesting. Some of the board members loved it and looked forward to that part of the retreat, and some board members hated it and it bored them silly and their eyes glazed over as I went through that because they kept thinking that’s sort of George being academic or theoretical or hypothetical or something. But the ones who were more practical understood that we weren’t going to get to where we needed to get unless we managed the culture part of who we were. Once you get that in place, once you get systems in place, the data in place, then what you need are some wins.

To your point, you don’t become creative everywhere and you don’t become innovative everywhere and you don’t share stuff everywhere because everybody is rooted in and anchored in their own setting, their own situation, their own processes, their own history. What you do is you find some wins and you take those wins and you transplant them. So, you take things like sepsis death rates, you take things where you can make a significant

improvement on your blood sugar management for minority patients. So, we took things that were wins, and then we celebrated those wins, shared those wins, talked to everybody about the wins, and kind of created an internal expectation that we were the kind of people who figured out really good things, who put processes in place to achieve really good things, and started changing the culture to being us defining ourselves as being that.

So, we started as defining ourselves as being all of these isolated, segregated, separate, untrusting, but what I told the officers when I had those first retreats is that when we have wins, when we have victories, and when we celebrate the victories, then everybody will line up and that will be a self-reinforcing building process. But we have to have some wins first, and once we have the wins, we have to have in place a template that lets us transplant the wins. If you create a win somewhere, if you have a great success in some site but then you have no mechanism to take it anyplace else and there's no infrastructure to land it anyplace else, then you get what Don Berwick talked about at KP—great things happening somewhere but not everywhere. When you sit down and say, “We're going to have the same tool kit everywhere, the tool kits everywhere are going to have the ability to do prompts, reminders,” and you have some successes and make people feel really good about who we are and what we've done, then people say, “What are the other things in my environment that I could do that would look like that?”

Then, we celebrated innovation. We had innovation awards. We gave innovation awards in quality. We gave innovation awards in patient safety. We gave innovation awards in community service, we gave awards and we publicized the heck out of those awards internally. We would have a dozen nominees for the quality award, the best quality, and we would then tell everybody what all twelve were because that told the people in the organization, “Jeez, this is a place that's doing a lot of cool stuff.” Then, we announced the winners and that also said that we were an organization that was doing cool stuff. Then we put in process a place that we have a second award that was the transplant award. If somebody transplanted last year's winner or the prior year's winner, they won an award for transplanting, which also created the sense that transplanting is a good thing.

10-00:22:53

Meeker:

“Transplant” meaning moving one model of care delivery to another place?

10-00:22:58

Halvorson:

Yeah, something we did in central line infection up in Portland, they could win an award in Colorado for moving that process to Colorado.

10-00:23:08

Meeker:

What were some of the actual mechanisms that allowed those transplants to happen? In a federal system, as you said, those are a very difficult thing to do.

10-00:23:18

Halvorson:

Well, there's several mechanisms. One of them was literally to kind of go over the system and share some of those things at the macro level, and to have the awards and invite all the medical directors, all the presidents, to the award ceremonies, and have that sharing. But another thing, we have the Care Management Institute. The Care Management Institute is a great internal resource that I tripled in size. In the Care Management Institute, there's a lot of very smart people who are physicians, caregivers, researchers, who look around the world for best practices but also internally look at best practices. A year ago, the Care Management Institute had six key projects to share everywhere for our Medicare patients. Because they do that for a living, they do it well. They know how to do it. They know how to interact. So, one of the six projects was on broken bones. We figured out how to cut broken bones for seniors by about 40 percent. We celebrated that in many ways. We published it, but then we also made it an internal agenda, and we had the Care Management Institute to figure how each of the regions could put in place their own diversion of that. So, we have that, we have the CMI as a transplant mechanism. When I got to KP, CMI existed, but it was siloed. It was off to the side, doing research, but it wasn't sharing anything. They actually weren't allowed, at that point in time, to go to the regions and share much. It was a really good idea, but for various reasons, it had been sort of cocooned.

10-00:25:13

Meeker:

I did want to ask about the Care Management Institute, so maybe now is a good time to talk about it. We can go back to some of these other issues, but since we're on this topic, I had the opportunity to interview Paul Wallace a number of years ago. I found both him and the work of the Care Management Institute to be really quite interesting. I'm wondering, when you arrived at Kaiser, when did you first learn about this? Is it something that you knew in advance?

10-00:25:44

Halvorson:

I knew about CMI before I got to KP, and I knew about the Kaiser research. At Minnesota, we started a research foundation at HealthPartners, and Andy Nelson ran that. He still runs it. Andy Nelson ran that, and we Minnesotans wanted to do shared research. So HealthPartners hosted a national coalition—it's actually called the HMO Research Coalition or something—and Andy chaired that for a number of years. We funded it with HealthPartners money, but KP was a member. KP joined the HealthPartners Institute, as did Harvard, as did Puget Sound, and all of the other organizations. It still exists, still functions in the chair. I knew from that organization both that KP had a dozen internal foundations and that the Care Management Institute was part of that process. So, when I landed it at KP, one of the things that I intended to do was to strengthen that part of the organization. I significantly increased the funding of it and the resourcing of it, and later made sure that we went out as a search and then brought in some really good people. Jay Crosson, who was the head of the Permanente Foundation when I got to KP, was also a strong supporter

of CMI. Jay was delighted that I was willing and eager to increase the funding and the resources and support that agenda.

10-00:27:20

Meeker: When you arrived, what was the description of the Care Management Institute? What was it supposed to do and how well was it accomplishing that?

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Halvorson: It was doing some collective research, and in some areas, it was doing some really good work. But it had no mechanisms in place to go in any consistent way. It was doing some really good work in medical research and was reading other people's journals very nicely. But in terms of a mechanism that was being used in the regions, it was sub-optimized. It was a really good idea, directionally correct, but sub-optimized.

10-00:27:58

Meeker: They were creating sort of evidence-based clinical care guidelines? That was part of what they were doing, correct?

10-00:28:04

Halvorson: That was part of what they were doing, right. Creating them and finding them, which are both really good things to do.

10-00:28:09

Meeker: But having a hard time getting people to implement them?

10-00:28:12

Halvorson: Yeah, the distribution mechanism for what they were doing was not as strong as it needed to be. Clearly, it gave us a massive advantage to have that functionality performing at a high level. So, I put some emphasis on that. When you look back at my original pathway chart, the fishbone chart, CMI was an entire line all by itself in terms of the kinds of things that it needed to do and what support we needed to give it and what outputs we wanted from it. I think as the day I left KP, it was pretty much doing the things that had been envisioned in that pathway chart back in 2003.

10-00:29:08

Meeker: Maybe we could go back to talk about the card that you developed, or is there something else you want to cover first?

10-00:29:14

Halvorson: No, that's a good point to go to. Yes. So we had the fishbone chart which explained where we were going, and then I took that to the board at each of the board retreats. We did it on scrolls, and I did it on scrolls partly just because there's a certain drama to rolling out a twenty-foot scroll. So, we did the three-foot high version of it instead of the ten-foot high version, and rolled that out. I talked things through. That was not so much to get the board involved in the pieces, but to give the board a sense of comfort that there actually was a plan, and that these were the key parts and that it was a

legitimate approach. Then, we did the short form of the pathway chart on a couple of things. One chart listed the ten things we really need to fear as an organization. These are the things that could chew us up, eat us up. These are the things that could damage us. If Medicare does this, it'll hurt us badly. If state regulators do that, it'll hurt us badly. If our competitors do this, this, and that, it'll hurt us badly. So, we identified what all of the threats were, and again, the threat chart was easy to do because I knew the threats. I'd been the threats. It all was relatively easy to do. I sat down with the board and said, "Because these threats exist, we have to do X, Y, and Z. We're going to have this as an endgame—Medicare's going to cut revenue by at least 10 percent." I actually predicted to the year that they were going to do it. "They're going to do it out here. It's a major part of what we are right now. If we don't do these three things to prepare for that, then we're going to be in big trouble when Medicare does what they do."

So, the risk chart is also one that we sat down with the board. The senior management every year would have a retreat, and we would look at risks. One of the sets of risks we look at would be nuclear winter sort of risks—what if things really go wrong? How bad could things be? What would really going wrong look like? What could people do to us that could really damage us? I'd done that in Minnesota for years. The nuclear winter exercise is very sobering.

10-00:31:31

Meeker:

What were some of the biggest fears?

10-00:31:35

Halvorson:

Competitive behavior, regulatory issues, stock market collapse. We actually had stock market collapse as a risk several years before it happened, and we talked about what would the consequences be to our reserves, our assets, our whatever. What would the consequences be to our marketplace? We talked all that through and actually, when I did that at the board, I had a couple of board members who were very senior national business leaders basically sort of say that "You're off-point on a couple of them," and those board members had the grace to, when the stock market did collapse, to say, "Wow, we actually heard it here, first, and I heard it here, a couple years back." If you do a nuclear winter sort of thing, you take a look at what are all the components of the world that could affect you, and then, which of those things could do damage? Then, I looked at it from the perspective of if I were running one of our competitors, how would I hurt KP? That was actually pretty easy to do. You could sit down and say, "If I were running one of these other companies, what would be the things that I would do that would do damage to KP?"

It was easy to put together a list of vulnerabilities because my inspiration as a coach, I don't remember who the coach was, but it was said about one coach one time, he can beat your team with his team in the morning, and he can switch and coach your team and then beat his team with your team in the afternoon. That is my role model. You have to think like that. You have to

think like that, you have to think like, “Okay, if I were that team, how would I win?” Then, we had to do things to cut off the likelihood that those people would win. Some of the things that they were going to do relative to product design, risk pool selection issues, our whole series of things that it was clear that our competitors could do to us if we didn’t have the ability to do particular things in return. Like, have our own cost-sharing benefits and some other things. I knew that they could do that damage. I knew the timeframe they were likely to do it on, and because we were looking at the nuclear winter and the worse outcomes sort of thing and I was explaining it clearly to our management staff, I ended up with people believing in it and going along with doing things they needed to do in areas that were changed, had been resisted in the past.

So, we got change in products, we got change in approaches, we got changes in systems. We got those changes in part because of the fear of a common enemy and the ability to delineate that the common enemy existed and explain who they were and what they are, and what they could do to us. It was clear to us that Blue Cross of California could have gone into half a dozen of our major groups, and underpriced and done some reselection with a high benefit package. If you’ve got a high deductible from a competitor, everybody who has cancer would stay with us and everybody who had no disease of any kind would go to the plan that had the \$50 premium advantage because of the high deductible.

10-00:34:52
Meeker:

Let’s talk about that because that’s such a key point that I would guess that there would be some pushback within the organization, given the historic nature of the prepayment, group practice system, the kind of original core values of Kaiser: the idea is that you actually wanted to provide comprehensive care package with prepayment, so therefore not a lot of upfront cost when, you know, trauma strikes. Part of this is the preventative notion, that you don’t want to dissuade people from seeking care at the right time. But if there are high deductibles, that would make people presumably think twice about seeking care. So, that begins to then impact the overall model at which Kaiser becomes efficient—that is, that KP tries to keep people healthy as opposed to getting people well once they’re already sick.

10-00:35:59
Halvorson:

Several things about that—one is that the model that works best for Kaiser Permanente is a cash flow model where people have full benefits and pay a full premium. One payment per month. That’s it. Nothing by the piece. Everything by the package. That is a far superior model. That’s a model that I extol, that’s a model I’ve preached, that’s a model I taught, that’s a model that I actually got regulation in favor of. I had a history of that, and I also had written books extolling and celebrating that model.

10-00:36:36
Meeker:

It’s the historic model of Kaiser.

10-00:36:38

Halvorson:

It's the historic model of Kaiser and it was a historic model of HealthPartners. Yeah, and I love that model. It's a really good model. One of the things that was good for my credibility inside KP was that I had written books about it. I'd been a champion for that model. I had been a leader of multiple levels for that model, and so, when I came to the table and said, "We need to do cost sharing," I came to the table with a high level of credibility. They didn't say, "Okay, here's somebody from Aetna that's coming in and wanting to change our benefit package. Here's a guy who loves this group model as much as anybody on the planet, and he's saying we need to do this in order to survive because otherwise, Blue Cross is going to steal all of our patients."

10-00:37:17

Meeker:

All of our healthy patients.

10-00:37:18

Halvorson:

Our healthy patients. I explained that with great clarity. The other thing is, if you explain things, if you make it an ideological debate, you lose. But if you sit down and talk people through the pieces of the situation, then I actually showed the risk distribution charts. Passed them out to all the senior leaders, senior medical leaders, I said, "Here's what our risk pool looks like." I had our actuaries go back and do our risk pool. They look the same everywhere, but it was good to have ours as specific data. Then, I said, "One half of 1 percent of our people are 20 percent of our expenses. Those people aren't going away." We actually had a higher concentration and had a greater percentage of people with less expense than many sites, but same exact model, same curve. I said, "Here's the math. If we keep all of those sick people and we lose this 20 percent over this end of the continuum who haven't been in for care for two years, then here's the numbers. We keep all these sick people, so we have that, and our premium needs to go to here. If our premium goes to there, guess what? Another third of those people are going to leave." I just confidently talked everybody through the model and the flow charts and graphics and said that, so, "This is the path we're on. It's the path of actuarial destruction, it's an actuarial risk death spiral," and I convinced people that it was real.

10-00:38:51

Meeker:

Was that difficult to do, to convince people it was real?

10-00:38:53

Halvorson:

You know what? I never have trouble convincing people of things that are true.

10-00:38:58

Meeker:

I just wonder about these healthy populations. Do they really actually disappear?

10-00:39:04

Halvorson:

Oh, absolutely. Oh, absolutely. They disappear very quickly, yeah. If you're a young person and there's a \$50 difference in your take-home pay and you haven't had any care needs in the last couple of years and you haven't bonded with your doctor, you're gone. Yeah, that's absolutely true. In fact, one of the things I could tell people was for a short while, when I was at Blue Cross, running marketing for Blue Cross, I actually destroyed a couple of small HMOs by going into those HMOs customers in markets in a couple of Minnesota counties. I actually put in a \$500 deductible before anybody else had one. Got the premium so low that all the healthy people joined it and all the sick people stayed with the health plan. That was a death spiral, there. So, we won it in those markets. I not only knew it theoretically, I'd done it. As the villain.

10-00:39:55

Meeker:

So, you saw it work in real life, yeah.

10-00:39:58

Halvorson:

Back to my point about if you were the coach of the other team, how would you play this? I was a coach of the other team then and I played it the other way, and it worked. I gave talks about it and then I gave talks about the health plan side when I was running the health plan. One of the newspaper reporters in the Twin Cities said, "I finally figured out the actuarial issues, and the actuarial issues are wherever George goes." [laughter] There's an actuarial reality. So, at KP, sitting down, explaining to people very clearly, and then saying, "I don't want to go there, I don't like that model," and then I said, "because if we have a \$1,000 deductible. We have to bill for that \$1,000, we have to collect that money." I said, "We'll still get the money. People stay with us. We actually don't lose revenue because we're a care system." So, the person who had been paying for that office visit with a premium will now pay for that office visit with cash. They'll still come to the office and they'll still pay. So our premium level, our total cash flow, doesn't change much as long as the risk pool doesn't change. What happens is the cash flow changes because we have to get that money in a different way. So, I said, "We have to become really good at billing. We are the worst billing system in the country. We actually were rated by several insurance company consultants at the very bottom." They would have a list of 100 insurance payers and we were at the very bottom.

10-00:41:30

Meeker:

There was a period of time that Kaiser had no billing system.

10-00:41:34

Halvorson:

Yeah, there were some sites that had no billing system, which was just fine for the time and the circumstances. But we needed to do that. So, I said, "We have to become really good at billing and we have to become really good. We have to have systems that can do this, and when WellPoint comes in and sticks our group with a \$500 deductible, we have to put ours in side by side,

so we'll still beat them by ten points because we will have our ten-point advantage and we'll be apples to apples in benefits." We did that, and right now, our deductible product is the third-largest region at Kaiser. Right now, there's 1,500,000 people who are in the deductible product. Had we not put that product in place, KP wouldn't have 9,000,000-plus people. Today it would have 7,000,000 people.

10-00:42:45

Meeker:

Have you found that that population then transfers?

10-00:42:47

Halvorson:

It would have been fewer than that. It was very real. We didn't push it, we didn't sell it, we didn't promote it. We just sold it where we had to sell it, and at that level, it went over 1,000,000 members relatively quickly because there were 1,000,000 people who wanted to pay less in premium. So, it was either do or die on that particular point. So, I said, "We change nothing internally. We don't change our membership card to identify that this is a different member. We have to be good at coaching people about the price of things because we haven't had to do that before, so we have to do that, so we have to become that. But we're not going to change our care protocols. We are absolutely not going to churn anything to gain revenue. We're not going to change the nature of who we are, the culture of who we are, the approach." I'd done the same thing in Minnesota. I'd gone through the same process in Minnesota to keep the Minnesota plan alive.

One of the things that I made absolutely clear was, from the doctors' perspective, that if they had a congestive heart failure patient—if you have a congestive heart failure patient and you're self-insured, you make a lot of money by keeping that person in the hospital for a couple of weeks, and if you're prepaid, you do well financially if you get that person to go home the next day. Some people were afraid that somehow inside KP, we would change. I said to the medical leaders, "That can only happen if you change it. You don't want to change it. You're opposed to changing it. You're committed to not changing it. So the answer very simply is don't change it and it won't happen. It cannot happen without your blessing, your approval. You have to be a co-conspirator to make that happen. Since you're not going to do that, don't worry about it. There's no way that somebody externally is going to change the practices, and since the individual doctors don't know and are not affected in any way financially by the benefit package of the patient, they're not going to change behavior at the individual doctor level." Again, I explained it to people clearly enough so that they understood what the issues were and what the pros and cons were. Also, everybody knew that I really hated the model. I'd given speeches against high deductibles and I've written pieces against it and my books say this is a bad model. So, nobody doubted whether or not I was trying somehow to sneak something past the culture. I was trying to protect the culture by keeping our patient population as it needed to be.

10-00:45:22

Meeker:

The point that you just made about there being a firewall, in essence, between the care provider and the insurance package that they get is really interesting because that then prevents the care provider from thinking in financial terms, on either side of the spectrum.

10-00:45:42

Halvorson:

Yes, which we don't want, we don't want. That's one of the things I'm fanatical about. In Minnesota, there was never a time when I ran the staff model HMO, I was the functional administrative equivalent of a medical director for seventeen years, and that was one of the biggest medical groups, second-biggest medical group in Minnesota was the group that I was the CEO of. I made sure that there was never a time when there was any relative value change in compensation. There was straight salary, I believe in that model. I am passionate about that model, and I believed that the minute you move off that model, you start creating different kinds of behaviors. Before that, when I ran the Blue Cross HMO, that was a capitated health plan. When I ran the purely capitated health plan, I saw some capitated behaviors that I really did not like.

10-00:46:37

Meeker:

Rationing?

10-00:46:38

Halvorson:

Yeah. People saying, "I'm not going to provide that care to that patient for another six months because I'm going to let the capitation pool build up, and I'll do it then, and the patient needed the care. I saw people, good people, make some really, in some cases, inappropriate decisions. I saw some people make some brilliant decisions. I saw some of the mental health caregivers do really innovative things that they could not have done on a pure fee-based process. It's a pro and con sort of thing, but you have to protect against the patient being damaged by either a surgery they don't need or not getting a surgery they need. Both of those happen if you've got the wrong model, and I write books about that. I've been making that point in speeches and books for decades. Again, because I've done that. So when I got to KP, some of the physicians and the physician leaders had read my books and knew what I believed in and knew what I'd done, and they had come to Minnesota and had been part of the research foundation, had been part of other interactions. The KP doctors knew what I believed in and talked to the Minnesota physicians.

A number of Minnesota physicians got calls from KP physicians, and the calls said, "Okay, George is coming out here, what does he believe in? What's he about? What are his values? What are his behaviors?" They told them, and they said, "We can live with that." When I first got to KP, I did an education process, I also sat down with the medical directors as a group. Jay Crosson did some really, really wonderful things for me. Really good things. One of the things he did before my first day on the job, the night before my first day on the job, he had his annual Permanente leadership retreat. Jay let me come to

that retreat, and that was a first for a leader of the health plan to be at that retreat. He let me give a talk, and I gave a talk about my values, I gave a talk about my personality. I gave a talk about who I was and kind of what I believed in. I told the group not to expect charisma, but I said, “My background, my cultural background, comes from people who live in igloos in the Arctic Circle, where it’s dark for half the year, and in that culture and that gene pool, there is no room for personality. So, don’t expect charisma. If I say, ‘that’s pretty good,’ that’s actually high praise.”

The group laughed a lot, but it changed the expectation and it was also good because David Lawrence had a lot of charisma and people were thinking about they had been in an issue where there had sometimes been charisma battles. They knew from the initial points I made that that’s not who I was or where I was going or what I needed to do or be. Then, I talked about the things that I believed in, the patient focus, and I said, “We are all one group. We are all on the side of the patient. We bring in patients together. We take care of patients together. It’s our accountability. It’s our joint accountability to do that. We need to do that really well. We’ll be betraying our trust if we don’t do that collectively and do that well, and that needs to be who we are and what we’re about.” People, I think, believed me, but also people could read my books and look at my lectures and look at my history, and there were a couple of medical directors who’d been on national boards with me who had seen me interact in those settings.

Back to Jay. So, Jay did this wonderful did this wonderful thing of inviting me to that meeting, and that at that same meeting, he let me have one on one time with each of the medical directors. So, I went into a separate room with each medical director, got to know them, and got to talk to them and have a good dialogue and share information. Also, he had a regular meeting, he had a quarterly meeting, with all of the medical directors and he brought them in to Oakland for a meeting. He gave me one hour at each of those meetings. One open private hour. That hour, and the staff left. So it was Jay, the medical directors, and me. There were no staff people from the medical group or from hospitals or health plan. That was candor time, and what I said in the first meeting was, “I will never lie to you. I will always tell you the truth, and you can ask me any question you want, and I will give you an answer. I’m hoping there are some questions that you think are too personal to ask, but even if you ask those, I will answer them. I may not like you afterward, but absolute, total candor, trust, you can ask me anything and I’ll tell you the truth.” I set that up.

I also said, “My staff will tell you the truth, and if any one of my staff lies to you, I will fire them. So, the expectation is that as of this moment, that it is a honesty relationship between medical group, hospitals, health plan, and we need to have that because we’re all in this boat together.” I said, “We’re like two people chained together at the ankle, swimming across a cold lake. There’s no way that either of us can get to the other side alive unless we swim together.” That’s the situation we’re in. I talked about the enemies. We’ve got

enemies out there, they want to do this, Leonard Schafer wants to take our healthy people. This is the world that we live in, and so we need to identify the external enemies. They believed that to be true because it was true. I said, "The only way we're going to win is we're going to do this stuff together." Jay, until the day he left that job, continued to, every time he had those meetings, I had that hour private session. I would say, "What's going on, what are you concerned about?" Somebody might say, "Well, George, we've got this issue and we got that issue," or whatever. The rule was that I wouldn't micromanage the relationship between them and their president, but if there was something that I needed, I needed to know it.

Then, I would use that time to say, "Here's what's going on externally. Here's what's going on nationally. Here's what's going on with our buyers. Here's what's going on with our board of finance, whatever," and I would give them confidential, very direct briefings. Particularly in the heart of both the Affordable Care Act in Washington and also as we're doing healthcare reform in California, I gave them briefings in that room that were insider briefings. They wouldn't have gotten from any other setting. I'd say, "Here's what's really going on and here's what the Senate finance committee is really up to. Here's what they're doing. Here's why they're doing it. Here's what we're trying to do about that." So, they had a sense, going forward, that they had some at least awareness and to some degree involvement. I think the medical group's leaders liked the fact that I was representing KP in a number of those settings. There was a high level of trust, I think, that as I was representing KP, I was doing that in a way that was about care delivery.

I keep saying externally that Kaiser Permanente is a healthcare system that owns a health plan, and the health plan is our conduit to get cash from our patients. So, what we are as a care system, we function as a care system, we do our best as a care system, and our primary functionality isn't to be an insurance company. But we have to be an insurance mechanism in order to get the premium to pay the members. I never think of us as being an insurance company. I always think of us as being a care system that happens to use this financing mechanism. People believe that to be true because it's clear that I actually believe it, and act accordingly. One of the biggest rules is you have to always act in accord with what you are saying and what you believe in. There has to be a consistency. People are always looking for any hint of inconsistency. If there is a great consistency between what you say and what you do, that's very valuable. That creates credibility and it creates interaction and it creates cooperation in a level. If I were to say one set of things and do something else, then my success level would drop significantly. I've been blessed with being able to be in jobs where I really believed in that job, and in settings where I could really promote what I believed in.

KP was very much like that. So the medical directors and I had this ongoing dialogue. A couple of the medical directors, Robbie Pearl, came in every single month for an hour to talk about macro issues, never micro issues, but

what are we doing as an organization, where are we going externally? Robbie is very strategic, so he'd come in and he'd say, "What do you think we should be doing strategically relative to this issue?" Or he'd come in and say, "You know what, I've been watching what Sutter's doing, and Sutter's doing X, Y, and Z, and I really think we should either fight that or stop that or emulate that. Robbie's a bright person who really thinks, really loves strategy, and he's a strategic wonk, sort of. The rule we have was Robbie had a president that he interacted with, and a couple of different presidents during the course of my tenure there, and the rule was that Robbie and I would never deal with any topic that he should be dealing with, with his president. I set that as a ground rule, but Robbie liked that as a ground rule, and the reason for that is because the minute I undermine my president by doing things that are really part of his job, it makes his job much more difficult—almost impossible—and it puts me in a position where I'm suddenly functioning as regional president instead of the CEO of KP, and I don't want to be regional president. So, that's worked.

10-00:58:17

Meeker:

How did you decide which topics were on the table and what topics were off the table, given what you just said?

10-00:58:23

Halvorson:

Every once in a while, a topic would hit the table and then I would say, "You know, that's really something you need to do directly with Mary Anne [Thode]." So, I would personally never bring a topic that should have been the president's topic. So, I just self-censored, and once in a while, something would come up. They'd say, "We're really having a challenge in this particular issue," and I'd say, "Thanks for telling me." But I wouldn't say, "Let me solve it," and Robbie didn't say, "Would you solve it?" He basically said, "You just need to be aware, George, that this particular thing is going on," and I'd say, "Thank you for telling me that." Same thing. Medical director in Southern California for a number of years also gave me some good feedback and coaching. I've had good relationships with the medical directors, and then a very good relationship with Jay Crosson. If we're going to end this tape, that might be a good point to start the next tape, talking about Jay and that whole set of relationships.

10-00:59:47

Meeker:

Good, let's do that, then.

Audio File 11

11-00:00:08

Meeker:

This is Meeker interviewing Halvorson on February 12, and we are now on tape eleven. Let's just continue the conversation where we left it off a moment ago, in which you were talking about your engagement with the leaders in the medical groups, and also Jay Crosson, who was the executive director of the Permanente Federation at the time of your arrival.

11-00:00:36

Halvorson:

Yes, Jay and I had a very good relationship. He was a wonderful, welcoming host when I got to KP. He came into my office and gave me really good information. One of the things that I was doing was trying to figure out who the ongoing staff should be on my leadership team. I asked Jay for insight into each of the people. He gave me wonderful insight that was actually quite good insight that I found very useful. He was very sharing. When we sat down to do things like build the overall, long-range plan and the strategic direction. He was very positive about doing that and he's a very smart man. Because he's a very intelligent person, he has input to the processes. As we were beginning the process, there were a couple of times when we were both amused by the fact that he went off to give a speech that looked like it would have been my speech, and I was in the next room giving a speech that looked like it might have been his speech under, if we had drawn lines between the payment functions and the care delivery. He met regularly with the medical directors.

We co-chaired a group called the KPPG, Kaiser Permanente leadership group. KPPG included several of the medical directors, several of the key staff people from health plan and hospitals, regional president, CFO. That group met about six times a year and had really good agendas. We'd meet for half a day, two a day, depending on the topics. We would do various topics that we needed to inform each other about. The usual approach for that, meaning many of the early meetings, I would lead with sitting down and doing kind of an update—here's where we are, here's where the process goes. Then, the chairing that we did, actually, Jay is really good at chairing meetings. So, even though we co-chaired and both sat at the head of the table, the usual process was that I would have would be to do a little bit of a tee-up in a context-setting thing, and then I would turn the meeting over to Jay. I actually wouldn't chair any other part. I would co-chair, but I wouldn't run the meeting. Jay ran those meetings and did it consistently well.

We met before the meetings and we had our staff people meet the day before the meetings to identify what should be on those agendas. To the extent that we had a desired outcome for the agendas, we would figure out in advance what those outcomes were likely to be. If it was likely to be something where the outcome wasn't optimal or wasn't likely to be agreed with, we would tee things up and then pull it off the agenda as an action item and bring it back to a future meeting. So, Jay was good to work with. He really wants KP to succeed at a very basic level. He's very, very loyal to the medical group, but he's not loyal to the medical group at the expense of the patients or the plan or the organization. He has good behavior and good demeanor. So, I found it to be a very good relationship.

[The narrator has sealed a portion of the interview.]

11-00:09:08

Meeker:

Tell me about Jack Cochrane, who succeeded Crosson when he retired as head of the Permanente Federation. How did you establish a relationship with a new person coming to this role?

11-00:09:19

Halvorson:

I actually had a good relationship with Jack when he was the medical director at Colorado. Jack did some really good work in Colorado. He was very innovative. He was very creative. He actually did the first electronic medical record at KP. When it came time to do the final system. Jack led what he called the Rolling Thunder Rollout, and he was on the ground with the troops, rolling the thing out over a couple of weeks. Jack was innovative and he believed in care protocols. His teams did some of the best work in imaging. He was catalytic and a leader in a lot of ways, and when the Permanente Federation board met to decide who they wanted to replace Jay, I actually described Jack's features and characteristics as what I thought the medical leaders should be looking for in making that selection.

11-00:10:32

Meeker:

What were those features, then, I mean without his name attached to it?

11-00:10:38

Halvorson:

Innovative, willing to be a leadership change agent, willing to focus on best practices, very willing and eager to share learning. Willingness to look at the outside world and respond to the outside world as though it's a real part of what our reality is. So, Jack came into the job and had a learning curve because it's a complex job. Where Jay had sort of risen through the ranks through multiple levels of a hierarchy. That was his first CEO job, was to run the Federation. Jack had been the CEO, but he'd never actually been anything below CEO. He'd run a department and then went right to CEO level, so he went CEO to CEO in terms of style.

11-00:11:40

Meeker:

Crosson started out as a front line physician.

11-00:11:42

Halvorson:

Front line physician. But he was the system manager of a care site and then he was the manager of a care site. But he worked his way up the chain of command inside Permanente, and he does really good work and he's a good thinker, and so he kept getting promoted. He came to that job from, like, a deputy medical director role. I don't know his history well enough to know that he'd never been the CEO, but I don't think he actually functioned in a pure CEO role until he was CEO of the Federation. Jack, on the other hand, had never done anything but Department Head and then CEO. So, Jack's initial set of responses wasn't quite as politically adept as Jay, but Jack came into the job and he did exactly what I hoped he would do, which was to be a catalyst for change, bring people together. He provided strong support for CMI and the role of CMI as a change agent. Jack and Jay both give a great speech. Jay gives speeches that win people's heads. Jack gives speeches that

win people's hearts. People hear him speak and in the end, they really feel good about Kaiser Permanente, about our values and our functionality. I have turned over a dozen speech settings to Jack. People have asked me to go off and give external speeches around the world at all kinds of sites, and I substituted Jack for me in many of those speeches, and without exception, the groups think they traded up. They feel better about KP, have a great respect for us, because of the job he does. So, he's a great external spokesperson and he's working on the inside, doing the internal things. So, he and Bernard [Tyson], actually, go back many years in terms of some of their interactions. I think that's going to probably work out well, as well.

11-00:13:57

Meeker:

Why don't we talk about the card that you developed, that you distributed to your leadership team, correct?

11-00:14:06

Halvorson:

Right. Back in 2003, the beginning of 2004, I was meeting with the board and we were putting together, for the first time in the history of Kaiser Permanente, a strategic plan. There had actually never been an overall plan because the thing had kind of risen spontaneously from the parts and pieces, and there hadn't been an overall agenda. There actually hadn't been an overall capital plan, and there hadn't been a strat plan. We put together the first strat plan, and I went to the regions and I said, "We're going to control all capital and link it to our plan." That was the leverage to get the strat plan done: we're going to control all capital and if the capital expenditure isn't covered by the strat plan, we won't spend the money. That's a very high leverage because the regions wanted to build clinics. They wanted to buy x-ray machines. They wanted to do all kinds of things. I basically said, "We're spending billions of dollars in capital and that capital is only going to be spent if it's done in the context of our overall capital plan and strategy, strategic direction." So, I put together a planning department work with each of the regions to build a plan, and I said, "The strat plan has to be signed off by the president and the medical director in each region, and we're not going to activate the entire capital plan for the entire organization until every region has signed off."

11-00:15:47

Meeker:

What was the time period for the strategic plan, and looking into the future?

11-00:15:52

Halvorson:

You mean how long did the plan run?

11-00:15:53

Meeker:

Yeah.

11-00:15:54

Halvorson:

Well, it's a five-year plan with a lot of specificity at three years and extreme specificity at one year. So, it's a one-three-five-year plan.

11-00:16:04

Meeker: Every year, then, it gets revised?

11-00:16:07

Halvorson: Yeah, and I've had people look at it externally and say the current version may be the best strategic plan they've ever seen because every single thing that we do is on the plan. It's back to my original fishbone thing. Every single thing that we do is in that plan, and it's in that plan for this year, next year, and the other year, explains why we're doing, what we're doing, and how we're doing it, and how we're funding it. So, the strat plan, any given region can pull up their strat plan and tell you what's going to be happening in this region for the next couple of years at any point in time, and the plan looks internally and externally. It's a good plan. But we had never had one. There had never been a plan at KP. So, I put together the first plan with the regions, and then I had each of the presidents and medical directors sign off on that plan. We set up a board planning retreat to look at the strat plan and say, "This is the plan that we have." I basically said to all of the regions, "Until we get the board's blessing, your capital plan is not approved." So, people did some good work. As I said, we identified two things: one was the macro agenda that I said earlier that we're going to have electronic medical records everywhere, we're going to be paperless everywhere, we're going to have these kinds of things were in the plan, and then what does the version look like in each of the regions to get to that endpoint.

So, what is Southern California going to do in that context, and get to that end point. So it was a really good plan—fun plan. The document that we had signed by all the medical directors and all of the presidents was somewhat historic because there had never been anything like that as a coalition document. The plan for Georgia didn't have to parallel the plan for Hawaii. It had to have some of the same elements in it, but we weren't trying to clone anything region to region. Georgia and Honolulu are very different settings, and so we needed a plan that was specific to Honolulu that would work for Honolulu. Before I was communications, I'd run planning for the Blues. I actually was the chair of the planning agenda nationally briefly for the Blues, and I personally taught planning processes and approaches to a number of Blues Plans. So, planning is something that I like and use as a tool kit, and I don't find it hard to convince people that it's a good thing to plan.

Then, the plan's going to come to the board of directors, and the board of directors then has to say, "Okay, I bless this plan." What criteria do they use? If you're a for-profit company, it's really clear because the criteria that you have to use, by law, is optimizing your fiduciary role, optimizing the value of the shares. Your job as a for-profit CEO is to optimize the shareholders' shares. It's a criminal offense, actually, not to do that, and so it's very clear. In the for-profit world, growth is a wonderful thing, and the more you grow, the more your stock prices go up. So, there's usually a direct relationship between growth. There's no such thing in the for-profit world as too much growth

because your stock prices will go up, and there's no such thing in that world as too much profit because the more profit you make, the better off you are, and the shareholders demand it. So, I had dealt with some really smart board members. I'd recruited some good board members, and it was a good board. But they had all been in the for-profit world. They'd been the CFO for GE, that type of thing. The CEO for Pepsi. These were people on the KP Board who had great history evaluating the strategic plans of for-profit companies. We also had other people on the board who had run an academic setting or run a university, whatever, and who had never had any experience evaluating a strategic business plan. So, what I needed was how do we evaluate this plan that we brought in, A, and then B, what actually is the plan? What are we trying to do as an organization? How are we going to go where we're going to go, and how are we going to get there?

So, what I did was I put the whole thing—evaluation process and plan targets—on a little card. I gave this card to the board every year. We would renew the same card every year. We talked about the card every year. Talked about, is this still the strategy that we need to go? Let me really quickly go through it because I love this card.

11-00:21:30

Meeker:

Can you show it up, first of all? Here, let me take this for a second, and here is the card. It's, as you can see, laminated, right? So, it can be placed in people's wallets. [Shows the laminated card for the camera.]

11-00:21:42

Halvorson:

They were laminated every year, handed out every year. People kept the cards from prior years. They didn't need to change them. The senior officers had them, but we didn't pass them out widely through the organization for reasons you'll see as I read it to you. So, we said, "Okay, board, when you look at our strategic plan that we're going to present this year and next year and the year after it, how should you evaluate it?" This is the set of criteria you should use to measure success. So, the first point, first reason, first decision criteria was called for evaluating the plan, first criteria was "Be in place a decade from now." Long-term survival. At least ten years. The point was that we're in this for the long haul. We are in the long haul for our staff, for members, for our members, for the community. For-profit companies run quarter to quarter. Whether or not they're in place a decade from now is irrelevant because it's about how much the value is generated along the way. What cash flow they generated, and if they generated optimal cash flow and disappeared in a year, that's actually good in that world. But our world, I said to our board, "Look at each of these points and say, 'If we do this part of the strat plan, will we be in place a decade from now?'" So, they said yes, that's a good criteria. The second goal is, "Growing, but growing at a reasonable or optimal rate." We're not a stock company, so we don't have to grow at the optimal, the fastest rate, the greatest rate. We need to grow at the right rate. We had grown faster than we could handle, a couple of years in our historic past. We'd been burned by

that. We'd outgrown our supply lines. We weren't able to take care of the patients when we grew too fast.

So, the right rate to grow at is the rate that fits what we can handle. We needed to grow, and I gave the board a list of ten reasons to grow. We needed to grow because if we don't grow, we're not credible with the buyers who are making their decision about who they're going to choose for their health plan. If we're shrinking, they're not going to choose us. If we're growing, they're going to think we're credible. If we're hiring people, we want to hire the best people. If we're shrinking, they're not going to come to us because they're not going to put their career here. If we're growing, they're going to invest their career. Ten reasons to grow. So growing was good, but not growing for our stock prices, growing for strategic, operational, functional, brand-enhancing reasons. Growth was a good thing to do. So, I said, "Evaluate growth, is it the right growth?" We need to grow, but is it the right growth? The third goal was, "Achieve our bottom line," which is very different than maximize profitability. I said, "If we maximize profitability, it will take away our not-for-profit status. We will have backlash in the community. People will hate us." At GE, you could do that—we can't do that here in our not-for-profit setting.

So, what we have to do is achieve our bottom line, we need to figure out what bottom line that we need each year, and then we need to achieve that bottom line. So, will this strat plan achieve our bottom line? That's what you need to look at. We have to be financially strong, and we have to create the capital that's required to support quality care and growth. So, we need enough capital so we can build a hospital, build our buildings, run our ad campaigns. We need to grow at that rate. So, each of the strat plan, you should look at. I said, "This is much harder than a for-profit company, where "maximize profits" is the right answer. We need the right profit, not the biggest profit. What's the right profit for KP at this point in our history?"

The next goal, and I said, "If the plan doesn't achieve this goal, you shouldn't support the plan," is to "Meet or exceed or quality standards and our metrics." The second part of that sentence is "Be the national quality leader." So, I said very clearly back in 2003, "You as a board should insist that we go forward and be the national quality leader in everything. That was back at a point in time when people were resisting whether or not we can do it. I said, "We need to do it. It's the right thing to do." As you look at each year's plan, I told them, you need to look at the plan and say, "Will this be a step on the path for us to be the national quality leader?" They said yes to quality as a goal.

Then, the final point is the community benefit. The question is, "Will what we do create major community benefit in care and health and medical science, and is our work modeling appropriate behavior and community learning?"

Then, the last point of that one is another leader goal: “be the world leader in database, medical, and health research.” I said, “There’s no reason for us not to be—I’ve been doing medical research for decades. I know this world inside-out. There is no reason for us not to be the world leader on medical research.” But if we don’t set our database up appropriately and if we don’t put resources appropriately and if we don’t staff our research foundations and we don’t treat that as something that’s a resource, then we won’t achieve that goal.

I said to the board, holding up this card, “Look at those issues.” So, then, how do we get there? This is the fun part.

This is what’s the strategy is to follow those goals. [Shows the reverse side of card.] The first strategy point is to implement full modern infrastructure to improve clinical and administrative performance and deliver the right care levels and the right product portfolio. So, we need to have the right products out there and we have to have the right services out there. We need electronic medical records. We need electronic claims systems. We need electronic billing systems. The whole thing has to be electronic, stem to stern. That was a breakthrough goal. I told them, “We should end up as a paperless organization so we’re going to go down the path to get there.” So the strategy is to implement that full infrastructure.

The second strategy is to build capacity and grow into it. So, if you build it and we do not, you know, grow into it, that’s not good. But you have to build it. So, then, how do you do that? There’s two ways of doing that. One is you build and acquire facilities, hospitals, and beds. So, you can either build it or acquire it, but you own it.

The second thing is to create clinical efficiency, become more efficient in what we own, to create capacity. So the business model that works best for us is actually to take our existing capacity and get more patient’s use out of it. So, the second plan is we’re going to create clinical efficiency.

We’re going to reengineer—and I said, back then, this goes back—clinical services and we’re going to focus on ergonomics and process. So, the process improve that I talked about in the strat plan, so then there’s two other strategies.

The other strategy, the second to last strategy, is a successful labor-management partnership. The LMP was in place. David Lawrence had kicked it off. It was trying to figure out what it was and where it should go. So, it didn’t have a focus, but it did have an existence. What I knew from having run labor organized settings, that you could go down a couple of paths in that setting. You could go down the path of labor war, or you could go down the path of labor peace. If you go down the path of labor war, you can be damaged badly. In a number of settings, I’ve seen hospitals taken completely

out of business and destroyed by getting into a battle, in essence, when the companies do the same thing. I've also seen settings where you have a good labor partnership and the labor partnership is mutually supportive for everyone. When I left Minnesota, the best party that was thrown for me was thrown by our labor unions. It was a really fun party because I believe in win-win. I'm perfectly comfortable with us having the highest paid nurses at Kaiser Permanente, as long as we have the best premium for our members at the same time. So, win-win.

The labor leaders needed to know that win-win was the strategy and that win-win was possible, and that when we both all focus on the patients, the win-win can be something that we'll all feel good about. I basically said to the board in 2003, "If we don't take this lovely gift that David gave us coming in, if we don't take this and turn it into something good, it's a screw up." Every labor-management partnership that had been started any place in the world had died within five years. There had never been one that lasted longer. They tried them in Switzerland. They tried them in the US in several different places. The partnerships would all collapse. So, what I said was, "We can't let this one collapse. We have to make it a priority. We have to do the right things and make it a success.

Today, ten years later, it's doing really well. We actually have a high level of labor management success, highest performance levels. When you win J.D. Powers and get rated number one in Consumer Reports for best service and best credibility, you've got a lot of front-line labor workers working with the patients and the customers to get those ratings.

So, I said that, and then the last strategy point was—and this one surprised both the management staff and the board when I put it out, initially—but the last major strategy point is "create massive external public credibility." We can't get by with minimal credibility. We can't get by with improved credibility. Some of the people said, "Massive, isn't that a little dramatic?" I said, "Right now today, when people in the news media say, 'Here's a healthcare issue, how should we think about this?' they say, 'What does Mayo Clinic think?'" I said, "We need to replace Mayo Clinic as the organization that's in that sentence. So, when people in the *New York Times* and the *Wall Street Journal* and Washington say, "How should healthcare do this?" We want them to say, "What does Kaiser Permanente think about that? How does Kaiser Permanente handle that?" I said, "We need to have so much credibility that people default to us. When they write national health insurance, they need to build it around our model because we're so credible." So, we need to do that, and I showed the board that we needed to do that work as a key part of our strategic plan.

[The narrator has sealed a portion of the interview.]

11-00:34:50

Meeker: How did the first board respond to your strategy?

11-00:34:56

Halvorson: They liked it, they liked it. Well, it feels good. I mean, what's not to feel good? Some skeptics, some people who'd been on the board for a number of years, were thinking that I was probably naïve. But to the extent that they were challenging, I was able to point back and say, "You know, I actually did this, pretty much all of this, in Minnesota. It's totally achievable. It's just different. It's a bigger scale. It's ten times bigger. But it's still the same tool kit and the same opportunity.

11-00:35:35

Meeker: Can we actually talk about the board a little bit? I imagine that in the eleven years that you were heading up the organization, the membership of the board probably turned over close to 100 percent. That means that you must have played a key role in recruiting new members to the board over that period of time. When you recruited new members, what kind of qualities were you looking for?

11-00:36:00

Halvorson: Recruiting the board, we created a grid and said, "Here's the set of characteristics we need on the board." One of my basic rules is that on any important issue where the board talks to itself in executive session when there's no management presence, on any important issue, I believe there should be at least one expert on the board in that room who can say, "Let me offer my expertise on that issue." So, I actually created that as a grid, talked to the board about it, and said, "This is my belief, this is my approach." So, Chris Cassel is on the board. Chris Cassel has led the national internal medicine structure. She's run a medical school. She's written books on Medicare, and she's a brilliant chair of the quality committee on the KP board. KP has 250 quality measures. That number far exceeds anybody on the planet in terms of quality measures because of Chris's leadership and her credibility. I recruited Chris to the board.

11-00:37:06

Meeker: Where did she come from?

11-00:37:07

Halvorson: At that time, she was running a medical school in Seattle. She later ran the National Internal Medicine Association, and right now, she's been nominated to run the research program for the feds. So, she actually is a very credible person with good values. Values are the first criteria. We have a woman on the board right now who was the chief of staff to the governor of Colorado, and she was also the chief operating officer for a major systems start-up, and she was the lawyer, earlier in her career. As chief of staff to the governor, she handled years of political issues. So, when you have a political issue relative to state politics on the board and I'm out of the room, the board can turn to her and say, "So, what do you think?" So, you want a board that is absolutely

expert. A very diverse board. The board is only 40 percent white male—so the board is minority and female in key jobs.

So, you want the talent, the expertise, and then personality. You really want a board full of people who don't need to be prima donnas who don't need to be jerks, who are mission-driven people. You want a board full of people who are there to achieve the mission of the organization and not there for any of their personal reasons. Then so you need interaction.

One of the criteria for the board was we don't have anyone on the board who didn't have, in their personal life, a significant level of community service. So, Neal Purcell, I recruited to the board. He was the national head of KPMG. So, he was the chief operating officer for that auditing firm. He had really great credentials. You couldn't find a better person for auditing credentials and running those committees, but he also had run Salvation Armies, and he'd actually been, in a couple of communities he was in, he had been the operating chair and did Salvation Army work for people who were really in need in various communities. So, we look for people who had a sense of value, adding value personally, in their lives—making a difference in the world because we want a culture and an organization where the people around the board table automatically default to doing the right thing for the right reasons, people who are also extremely bright and talented in their area. So, it's a really good board. One of the things, when we bring new people on the board, one of the feedbacks I usually get from the board members after a year is, "Wow, I've never been on a board that's this smart and this good and this collaborative," so it's a really good board.

11-00:40:25

Meeker:

And perhaps also expects a good deal of work from the members.

11-00:40:29

Halvorson:

It expects a lot of works from the members, yeah. The average board book that the board members read is 1,000 pages. Each of the board members is reading 1,000 pages before the board meetings. They're reading quality outcomes process. There's a ton of stuff. We set the board standards for best practices. We have board committees, and the board committees have really clear sense of what they're supposed to do and when they're supposed to do it. I did that back in Minnesota, as well. It's a really good process. If the audit committee knows every single thing it's supposed to audit, when it's supposed to happen, what the time frames are, what the supports are, who the resources are, then you really get a much better audit committee. In the finance committee, the same thing. Quality committee, the sure thing. So, we identified really clearly what each committee's supposed to do. We have a chair who's a star for each committee, so the finance committee has a finance star, and the quality committee has a quality star, the community benefit committee has a community benefit star.

Then, we do something that no other board has done, and that is we have the internal audit department of the company audit each committee against its goals and standards. We actually have internal auditors attend the committee meetings, but we say, "If the audit committee's supposed to do these ten things, did it, in fact, do those ten things? How well did it do them? Where are areas where the committee can do a better job?"

The governance committee of the board is made up of the people who are not chairs of any other committee. So, they can sit in judgment on the rest of the board because they're not the committee chairs from the other committees. The governance committee got the responses and the audits from the internal audit. So, we'd sit down and look at how did the finance committee do last year, and in an audited standard? So, it's a very high performing board. Really good people, but it's also very well structured and very high performing.

11-00:42:31

Meeker:

It's a unique check and balance system.

11-00:42:33

Halvorson:

Yes, yeah, and the checks and balances system, I'd done a lot of these other things before. This is the first time I had the insight to have the governance committee be made up of people who weren't chair of anything because usually, every other governance committee I've been on, I've been on governance committees for years, it's always the chairs. It's always the chairs of the committees are also the governance committee. So, we flipped it, and that was kind of a fun thing to do. It was actually a really good thing to do because now the non-chairs sat down, and part of their job every year is to look at how each committee did and evaluate the work of the committee. So, we do that through an evaluation process, but they also have the benefit of having internal audits support them in that. So, the governance committee actually governs.

11-00:42:33

Meeker:

You would meet, I guess, quarterly with the full board, correct?

11-00:43:26

Halvorson:

Six times a year with the full board. Four quarterly board meetings, two retreats. One of the retreats is a week and one of the retreats is two day. It was a week retreat with the board, and then there's a second retreat that's a two-day retreat. We put that in place because I like to do a deep dive into things. So, we set up a deep dive retreat that happens usually in October, and the board comes together for two days somewhere. We pick two topics, maximum three, sometimes one. When we're doing succession planning, for me, one of the deep-dive retreats was just about that. So, we set up a process that had a succession plan for KP. We identified half a dozen internal candidates. My goal was to make sure that when the board met, when I left, when the board met to pick my successor, that they would have half a dozen internal candidates who each could do the job. So, we set that process up, and then

identified the candidates. Then, I went through an evaluation process. The candidates did not know they were on the list. There was no process that said, "This is the list." Partly because we didn't want the candidates who were incredibly collaborative to suddenly start thinking that they should be contending with each other in some way.

We identified the people, and there's some really good people at KP, and said that these are the people. We're now going to change their jobs. So we changed the jobs. Some people, we gave them some national exposure, we brought them to the board in different ways for different exposure, and so we gave all the board members exposure to all of those people in ways that were conducive to the process. So, when I said, "Okay, here's my notice I'm giving," and I had officially agreed to give more than a year's notice when I retired—so I gave fourteen months' notice. So I gave the notice, and that immediately activated the process. The board then sat down. One of the things the board did then was they actually went outside and the search firm that was hired, the external search firm evaluated each of the internal people on that list. So, that process took place, and there were good people. The search firm said that after they met them. There were also a couple of really impressive external people who wanted the job, who came in, and applied for it. Then, the board went through those internal and external interviews, and that was a really good learning experience because the board got to hear some really smart people who were doing a good job in other job settings explain what they would do if they ran KP. So, that was a good learning process.

The search firm interviewed a half-dozen internal people and said, "If we came to you with this list of people after doing a search, we would feel we'd done our job." It was that good a list. Not to name names, but Ben Chu was on the shortlist. Ben's the chair of the American Hospital Association. Ben ran all the hospitals in New York City. Ben has run Southern California for a number of years, and they've been the best growth years Southern California has ever had. He's achieving quality standards. He's shooting out the lights. He's credible, he's bright, he's talented. When you look at all of the issues that you're looking for in a CEO, if the search firm would have gone out and said, "Okay, we've got a guy who's run a couple hospital systems, he's run a 3,000,000-member health plan. He's been a superstar there. He chairs the American Hospital Association, and he wants to come to work for KP," the board would give the search firm a gold star. So, it was a good process. I had promoted Bernard to be the president a couple of years before I left, so Bernard had the inside track on the process, but he didn't have a career lock. The board went through a process of looking at some really good internal and external people before choosing Bernard. So, to the extent that people think that I completely and totally wired that process in favor of Bernard, that would be an inaccurate perception of the role of the board. The board did really good work. One of those retreats, as I said before, was about that, and was done to set that whole process up, so that there would be a process and it would be an effective approach for the board to use.

11-00:48:58

Meeker:

A little more about the board, I find it quite interesting, and obviously, the role that it plays in the organization is profound. I'm sure that in these six times a year meeting and along with the retreats, there's a lot of acknowledging of the achievements, celebrating the achievements, as is warranted in these kinds of meetings. I suspect there's also challenging moments. I've sat on the board of a small non-profit myself, and I know that both of those happen. I'm wondering if you can maybe tell us a little bit about an example of one or two challenging moments for you, going into a board meeting where perhaps there's difficult contextual things going on or difficult things going on internally that the board really wants to know how you're going to perform in that situation?

11-00:49:59

Halvorson:

There haven't been that many. Two things: one is the board doesn't spend a lot of time celebrating. There's a little bit of it, but very little celebrating. It's kind of a Minnesota-style. You say what you've done and get over it. But the number of board celebrations on those topics, when we present the financials with the finance committee, we spend three minutes on the overall success and then zero in on whatever region is challenged. The culture is continuous improvement, and so it's not about winning, celebrating, and taking the trophy home. It's about how do we get better at this? So, audit committee is about what do we need to improve our audit? Literally, continuous improvement is the model for every board committee, and that doesn't leave a lot of celebration time. So, it's not something that's ignored, but it's also not something that's a key part of the culture.

So, the second thing relative to problematic issues, we do a lot of systems. We've invested many, many billions of dollars in systems, and the electronic medical record went extremely well. Basically came in on time and within the budget, and it hit the budget that I had told the board it would hit, which was about 30 percent over the original budget that we set for it. But that almost always happens on a major system. So, when I do my own estimates of what the cost is going to be, I take the first budget. What I said to the board at that point is, "If we can do this for under \$5 billion it's a massive asset to us. It's a massive asset to us and it's worth the money." On some of the other systems, I said, "This one's worth \$1 billion this one's worth \$2 billion." I basically say, "This is what it's worth to us strategically to get this right. Here's the dollars. Now we're going to give you a budget"—the budget's going to be way less than \$1 billion because the first time out of the chute when people do their bits and pieces, they don't know what all the pieces are and they underestimate.

So, what I said to the board because I'd done systems for thirty years, "You can count on this number as being the outside parameter. If we spend more than this, it's bad." Some of those conversations have been challenging, and some of the board members don't like and haven't liked that way of me thinking. When I say this is going to cost us \$1 billion in the end, even though

the budget, we're adjusting it right now to change the pharmacy system, is \$800 million in that first official budget. Hypothetically, I believe that, A, we need that system. We can't survive without that system. We are one of the five biggest pharmacy systems in the world in terms of the number of drugs that we prescribe. We have to have the electronics that are state of the art to do that work, and if I could write a check right now for \$1 billion and get that system, that would be money well spent and it would be worth it. Some people say, "I got it, it makes sense, \$1 billion's right." Other people, particularly people who've been in some of the for-profit companies where budget management sometimes is a different kind of science, get excited about that and say, "Well, are you saying you're not going to manage it to \$800,000,000?" I say, "What I'm telling you is I believe it's worth \$1 billion, I think when all the pieces come together it's probably going to cost us a lot closer to that. I'm not going to say that now is the official projection because the official projection, based on the best insight from these people, is here."

Because I have steered so many systems for so long, I know what the value of a system is and I know what the cost should be and I know what the processes are. I base my decisions on value. But there are people who were uncomfortable with that value-based evaluation process.

11-00:54:28

Meeker:

I can imagine how and why that happens. Taking HealthConnect, for example, so it sounds to me like what happened was the original budget was, what, \$3.2 billion, I think, or something along those lines, and maybe it gets closer to \$5 billion once it's all done. As somebody who's implemented these kinds of systems before and can see mission creep and inflation or a whole, wide variety of issues, you can say, "Listen, let's budget 3.2 for this, but don't freak out if it hits 5."

11-00:55:05

Halvorson:

Oh, I said that.

11-00:55:05

Meeker:

Is that kind of how you deal with this?

11-00:55:06

Halvorson:

I said, "We will miss any major system by 30 percent. That's just the way it works, and the most important thing is to have the system work." So, what I said was, "As we go along the way, if we get to a point where we need to parachute in enough people to build a bridge over the river, right, we're laying track right in front of this train. If that train goes into the river, we're toast. So, if I need to spend another \$100 million overnight to make sure that bridge is built across that river because that bridge is the most important thing now to KP. We've got billions and billions of dollars. The most important thing for KP is to get that bridge built and spending \$100 million is well worth the expense." There are some people who appreciate the fact that I've been doing systems successfully for decades will say, "That makes sense." There are

some other people who just have a discomfort level with... What I've seen in a number of companies is that if you manage a major systems project rigidly to the budget, and if your top priority is the budget and not the system, you fail. They all fail. Those companies fail. They don't get it done on time. They cut back on what they were doing in systems, and end up failing because they have inadequate support. If you start making decisions about whether or not you're going to build that bridge just in time on whether or not you've budgeted for that bridge, you collapse the system. And crash the train.

11-00:56:43

Meeker:

You focus on the budget rather than the project at hand.

11-00:56:47

Halvorson:

They're focusing on the budget, yeah, and they're making the budget the higher priority. I keep saying, "No, go back to this chart. Are we going to be in place ten years from now? Okay, if we spend the \$100 million, we will be in place ten years from now. If we don't, we won't." This is not hard. This is what we're going to spend the money. So, I spent the money on those projects at the level that was needed to spend on the projects, knowing that they were going to come in over budget and knowing that if we have really good systems management, which we need to have, we're going to know if we're off-track. We're going to know when we hit a bump.

[The narrator has sealed a portion of the interview.]

Audio File 12

12-00:00:07

Meeker:

This is Meeker interviewing Halvorson. We are now on tape twelve. It is February 12, 2014. Kaiser Permanente has an Office of Heritage Resources, and that says that the organization values its history, sees it really as an asset. When I did a series of interviews a number of years ago on the organization, one of the topics that Kaiser wanted me to cover was core values. There was this list of values such as prepayment, group practice, and affordability – a whole list of things that were considered the genetic code of the organization. People such as Bruce Sams, at the time, were really committed to it. He was the medical director in Northern California. So, my question is: when is history in Kaiser Permanente a real attribute? Then, maybe, when can history be a burden?

12-00:01:28

Halvorson:

History is an asset to Kaiser Permanente for a number of reasons. One, it's a good thing for us to have a sense of who we are and what our values are. I've talked about culture a number of times, but when people are making decisions in their day to day context, if people have a sense of what the culture is and what the historical legacy is, that helps guide the decision making in positive ways. It's good for people's morale to have a sense of being part of an organization that has a history and a culture and a legacy. Gives people a

sense of us, to be part of a culture and to be part of a legacy. There are some really interesting and good stories in our past that provide useful guidance to our future, so that the classic, iconic story about Sidney Garfield being at the dam and noticing that people were being lacerated with great regularity, and Dr. Garfield discovering that that's because the nails they were using were too long for a particular function. So, he had them change the size of the nail and because of that, they changed the number of lacerations.

That story gets told often, and it's a really good story to tell because it's an iconic story. It says, "We're about the patient. We're about the total process. We're not just about fixing something after the fact. We're about going upstream and intervening to change the nature of the care that's being delivered. Or, more importantly, we're going upstream to change the nature of the need for the care." So, that story, I actually gave a talk in Washington a short while ago. Got to a point in the talk where that story would make sense, and then I said, "Anybody in this room from Kaiser Permanente?" A couple of people raised their hand. I said, "Do you know the story of Sidney Garfield and the nails?" They both said yes. They got it, and I said, "I should have you tell the story," but I told it. The story is told often enough because it says, "Sidney is our founder, Sidney is our giant, Sidney didn't just look at after-the-fact heart attacks. He looked at how do you go upstream?" The nail story is a good story.

So, the history can be good for that purpose. The history is good for giving us a legacy and a sense of who we are. So, I think it's a good teaching tool and a good bonding tool. It helps us bond with ourselves. Another thing that really is positive about the history is because we're an organization with history, people in important jobs actually will periodically do important things in a good way because they're thinking of their historical record. I've heard many people talk about my role in the history, when the history of KP is written, I want it to show that I did this. So, people knowing that we have a history—a legacy and a history—care about what their position's going to be in that history. I think we benefit from that because I think some people do better, smarter, brighter, more effective things because they're positioning themselves for their description in the history of KP. So, I think our history benefits us as an inspiration for doing good things.

12-00:05:15

Meeker:

How do people in the organization, particularly key people in the organization, learn about the history of Kaiser Permanente?

12-00:05:27

Halvorson:

We have a number of publications that we send out to employees. The publications, with some regularity, include history vignettes. So, the fact that we have that department, it actually provides historical pieces. You could have a staff meeting and use the history of KP as an example of why we should do a particular thing. The fact that we were the first people to put

medical information on punch cards comes up with some regularity, and it's used as evidence that this is a good trajectory for us to be on, and in fact, it's one we've been on for a long time. So, those stories get told deliberately by people to make their points, to illustrate their points, and they also get told in the internal publications. It's one of those things that once you read one of those stories, you're likely to remember it. It's a paradigm-changing story, to know that we had rooms full of punch cards as we were trying to build the very first generations of medical records, that is a memorable thing and it makes the point that this is a good thing for us to do. It's the right context for us to be in.

12-00:06:51

Meeker:

Sometimes history can be a burden, and sometimes people experience it like that. Maybe coming from a group of people who have been oppressed or discriminated against for a long period of time, sometimes members of that group just prefer to look to the future, and not continue to relive the past. Or maybe the opposite is true—sometimes people have a really glorious past and find it hard to move into the future because they're always being compared to the greater people who preceded them. I wonder if you as CEO ever felt the history of Kaiser to be a burden?

12-00:07:41

Halvorson:

I never felt the history to be a burden, but there were some times when there were past practices or incidents that could have been a burden had they been triggered and focused on. There were some issues, challenges between parts of the organization that were problematic, that as I'm working on bringing people together and creating a future, you don't necessarily want to be focusing on the issues in the past. One of the other stories that my management staff could tell you that we used as a frequent coaching story is the dead puppy story.

12-00:08:27

Meeker:

Oh, I haven't heard the dead puppy story, but I want to hear this.

12-00:08:29

Halvorson:

You haven't heard the dead puppy story?

12-00:08:31

Meeker:

People have mentioned it to me.

12-00:08:32

Halvorson:

Did they? They did?

12-00:08:33

Meeker:

Well, they just mentioned, "Ask him about the dead puppy." [laughs] So, let's hear about the dead puppies.

12-00:08:40

Halvorson:

Basically, the dead puppy story is the mother walks into the room and sees her son sitting on the floor—a young boy. She says, "Johnny, Johnny, you're

happy, you're playing, you're eating your snacks, you're having a really good time and laughing—you must have forgotten that your puppy died.” Okay, and every once in a while somebody in a meeting will go back and, I guess, and somebody's sure that we're completely and totally resolved, we're on the right track for going forward in an aligned way, someone will go back and say something about the old issue. I'll say, “You know, that's really kind of a dead puppy.” People say, “Oh, you're right, good point,” and walk away from it. You don't want to bring up the dead puppies because you can get people out of a lot of happiness by bringing dead puppies back into the room. So, when you've made progress on a particular point, it's good not to go back and revisit the challenges. So, progress is about progress. So, people mentioned that to you?

12-00:09:56

Meeker:

Yeah, yeah. They didn't describe what it was, but it's certainly something that they took to heart.

12-00:10:06

Halvorson:

Good.

12-00:10:10

Meeker:

So, leaving the dead puppies behind, I want to talk about your letters. These were letters that you started writing, I believe, to all of KP in 2007. These are letters that were subsequently collected in a book, called *KP Inside*. First of all, why didn't you title it *Be Well*?

12-00:10:35

Halvorson:

People called it *The Be Well Letters*, actually.

12-00:10:36

Meeker:

Really?

12-00:10:37

Halvorson:

Yeah. I wrote you a Be Well letter this week. “Be Well” is what I always sign off. I always sign, “Be Well, George,” in everything I sign. A lot of people refer to Be Well, but I signed each of the letters each week as “be well,” at the end of the letter. “Be Well, George.” The letters were part of an ongoing communication approach. One of the things that I have done for a very long time, decades, is to periodically write letters to everyone in the work force that I'm part of, explaining things about us. I'm a compulsive writer. I write books, articles, whatever, so I write, and I write partly to communicate and partly to think. So, at KP, when I first got to KP, first here, I wrote a letter to everyone explaining where we were going, what the reorganization was when I first arrived at KP. I wrote a letter saying that I was completely, totally, personally committed to diversity, and that we were going to be a diverse organization, and that our diversity was going to make us great. I sent those letters to everybody, so that everybody, as kind of a context for where we're going, and also so people have the sense of what I believe in and what's true about me. That's useful, when I'm having interactions with people and

conversations with people, if they have a sense of what the approaches are and what the values are. So, I did that for a very long time, and as I said, did it in Minnesota when I was in those settings.

At KP, I did a number of things that celebrated things that we had done. I told the board, “When we have enough things in the hopper so that we can celebrate number ones, so that we cannot celebrate being in the top quartile or not celebrate being in the top third, but when we have enough things that we can celebrate number ones, then I’m going to make it part of the culture that number one is who we are and what we do and what our expectations are of ourselves. Being the best at things.” I also wanted to communicate to people why it’s good to be innovative, why it’s good to be creative, why it’s good to be patient-focused. So, I decided to write a letter every week to all our employees, and each week, the letter celebrated something. Every week was a celebration letter. So I celebrated our ratings. I celebrated our pressure ulcer outcomes. I celebrated when we had innovation awards. I celebrated all of the nominees for the innovation award, and then I celebrated the winners of the award. I wrote about the winners and the nominees, and I wrote very short letters, and very brief and to the point. I identified the fact that we are creative, we’re innovative, we care about the patients, we’re focused on other people, we are excellent. The response to those letters was very positive.

I had people tell me that they waited every Friday for the letter. One woman told me that she was in depression therapy at home, and she insisted that they send her that letter every Friday. I had a couple of families tell me that they read them at their Sunday dinner, that they would take them home and read them. A number of departments would have a staff meeting on Friday and read the letter at their staff meeting as an indication of something that we’re doing. Our recruiters actually used them with a number of people and gave them to folks that they were trying to recruit, saying, “Here’s a package of six letters from our CEO.” Particularly if the letters relate to anything that they are part of, their specialty or their area. I celebrated and I made the letters very clear that we are doing our systems to support care. Our systems people—many systems people—came up to me and said, “I really loved the fact that you linked us to saving lives and that you linked us to the data flow. I feel really good about being here because of that.” So, it was our overall employee satisfaction levels climbed. You can’t say necessarily as a result of, but I can say that the numbers before and after the letters were much better after the letters started.

I also used the letters for something else that was sort of fascinating and useful. I’ve got a list of a couple hundred people that I interact with in the outside world, and I sent different letters to different people. So, when we had a hospital win, Rich Umpdenstock, who is the CEO of the American Hospital Association, would get that letter. I would send a letter to Sister Mary Keenan who runs the Catholic Hospitals of America, would get that letter. I would send the letter to those people with a little note saying, “This is one that you

might enjoy.” The letters have great credibility for that purpose because it’s not a press release. It’s not something that we’re bragging about, it’s not an external thing. It’s a letter that I have clearly written to our staff, so it must be true, and it’s like people getting to eavesdrop on somebody else’s communications. So, I created that eavesdropping scenario for outside people. So, Rich Umpdenstock would read the letter and he’d say, “Wow, this is cool, this is great, really good that KP’s doing this stuff.” On three or four of the letters, he’d say, “Can I share this with our executive committee? Can I share this with our staff?” I would say, “Sure, share it with your staff,” and he would pass it on to his staff.”

Okay, if the leadership staff of the American Hospital Association gets a letter about the incredible job that Kaiser Permanente has done on pressure ulcers, that’s clearly good for the brand of Kaiser Permanente with the people who run the hospitals of America. When I left, I retired, AHA gave me a wonderful lifetime achievement award. I don’t think that I would have gotten that award had those letters not been circulated in the way they were. It was clear that we’d done all the things that we had done in the hospital world. That would have been totally off the radar screen outside of KP. No one would have known. They would have known that we had the leapfrog wins, but they wouldn’t have known that we had the central line infection wins. That is invisible, externally.

I sent many politicians the letters, and I would say, “The reason you should be in favor of healthcare reform is because you need everybody in America to be doing this. You need everybody to have this data.” A lot of the research, when I said, “We’ve discovered this incredibly powerful information about stroke patients and the different death rates based on the treatments they got,” I sent that probably to two or three hundred people, saying, “This is why it is so vitally, critically important for this country to have data about care and this kind of longitudinal data.” That particular thing ended up being the centerpiece for a meeting in London, of systems people in London. It ended up going around the world as an example. So, the letters were more than KP. KP was an important part of the process, but they were also very, very useful as a way of taking wins that we had. Every major consulting house—Booz, Accenture, McKinsey, all those folks—all the Senior Health people received at least one letter a month, with a cover note from me. I wrote a separate cover note on each one, I didn’t just forward the letter. I wrote at least 100, sometimes 200 letters every week to those folks, and sent them those letters. So, the people at Booz knew and shared. I said, “Share these with your folks,” and if we’ve done something on being totally paperless, it proves it can be done.

Gary Alquist is a really smart person, health leader for Booz. When Gary gets the letters and sees five or six things that we’re doing that are really world class and he shares them with the Booz team, and the Booz team then interacts

with 100 hospitals in America, and they can mention to those hospitals that KP did this or it's possible to do this, that's very useful.

12-00:21:25

Meeker:

One of the things that I find most remarkable about this is that it is a compendium of innovation. There's so many little points that I imagine in such a large organization, people wouldn't have heard about otherwise.

12-00:21:45

Halvorson:

Oh, absolutely. Very few people would have heard about almost any of the things that were in those letters.

12-00:21:53

Meeker:

How did you hear about them?

12-00:21:57

Halvorson:

That's a really good question. Couple of things. One is I'm constantly looking, I scan all the time. I talk to a lot of people. I read our internal things. I look at our planning materials. So, I'm always looking. Every time we win a diversity award, the diversity people send it to me. Every time we win a systems award—we won many systems awards. We won the Uptime awards. We were the best place to work in IT for minority employees. I didn't discover that directly. The head of IT read the system magazine that gave us that award and then sent it to me. So, what I had was a feeder system. Once the process got started, the feeder system was pretty robust. I actually had many more things to write about than I would have otherwise. Then, every time I went to a meeting, if I'd go to one of our systems meetings and listen to all the vendors and go to the process, it was rare that I wouldn't walk out of that meeting with one or two ideas for a future letter.

So, I'm constantly in search mode, and I usually had a running list of about four to six topics that I was going to write about. So, the number of times I got down to a systems day without a letter, it wasn't zero because a couple of times I got down to distribution day and I discovered that what I intended to write about that week wasn't going to work. That I'd misunderstood. I thought we'd done something and we actually hadn't done it. One of the things that the process involved was I would finish the letters usually about Wednesday of the week, sometimes Tuesday. I would send the letters then to our quality department, and I would send the letters to our research department, and they would send the letters to our legal department, and to our policy department, and our external communications, the media people. So, I'd get five responses back, and they would say, "This is all good, no problem," or I might get a quote from the policy people saying, "You should be aware before you say this about Medicare that there is a bill coming up, or there is something," and so I would get a warning or a heads-up.

I'm absolutely insistent when I write something that the numbers are real. I'm kind of fanatical about that because I write a lot and I really need people to

believe what I write. So, if I write a book on healthcare disparities and I mentioned twenty disparities, I need to be sure that all twenty disparities are in fact disparities, and they can be sourced. So, each of the numbers that's in those letters is sourced. Everyone is footnoted. There's not a number that I use that doesn't have a source in the footnote, and so I have an infrastructure in place to do that. Once in a while, I get to a point, a couple of times, that the letter that I was going to write that week couldn't be done. So, there were a couple of times I scrambled on very short notice to come up with a letter. It was typically not a problem.

12-00:25:37

Meeker:

Sometimes, you're dealing with some hard issues, too. One in particular that I just remember reading had to do with the recall of replacement hips by Johnson & Johnson. In the end, the story was that because of the electronic tracking of the people who received those hips, it was easy to find the people who received, perhaps, defective hips. Within Kaiser, it was very easy to do compared to the rest of the world. But at the same time, it also meant acknowledging that sometimes bad things happen to good people, that some people maybe would have had to go through yet another hip replacement surgery because the one they received was defective.

12-00:26:25

Halvorson:

Well, I actually said that, yeah.

12-00:26:28

Meeker:

It's interesting. That's real world stuff, I guess. Did you ever get pushback to say, "Can we tell this story in a way that we don't talk about"—

12-00:26:42

Halvorson:

No. Partly because we're on a continuous improvement path. I mean, we're looking for, we're celebrating, if we find a bad hip, we're saying, "Hooray, we have the database to find this bad hip. Let's fix it." So, the people who found it would rather have it recognized than hide it. There is zero pressure at all. The cancer studies I did it, I wrote a couple—three different—letters on our cancer care and talked about how our detection rate was this and our cure rate was that. The cure rate was not 100 percent, and the detection rate wasn't 100 percent. But we had a better cancer cure rate and better cancer detection rate on most cancers than just about anybody. There are some really good sites out there, but we're really way up there on both of those. But we still have people die. So, if our breast cancer five-year survival rate is 95 percent, that's still five people dying.

12-00:27:51

Meeker:

Well, you also bring up the subject of palliative care, which is kind of, I think, off-limits for a lot of health plans and hospitals.

12-00:27:55

Halvorson:

Yes, I wrote about palliative care. Yeah.

12-00:28:01

Meeker:

What was your inspiration to do that piece?

12-00:28:05

Halvorson:

Well, I actually had a couple of family members go through palliative care. We started a hospice in Minnesota, it was called Hospice of the Lakes, for HealthPartners. The letters that I got from the people who went through the hospice and their families were incredible. I knew immediately if I got a letter from somebody who said, "I am a Hospice of the Lakes patient," or, "my husband or wife," that the rest of the letter was going to be, "Thank you for doing that, thank you for being there for me, thank you for the process." So, I knew I had a strong predisposition toward thinking it's a good thing. Then, when I got to KP and looked at our hospice program there, I had the same feedback. The people who were getting the hospice care that were very happy with it. Then, when I wrote that particular letter, an uncle of mine had just died and had gone through a hospice process back in Minnesota. Not my old hospice, but a good hospice in Minnesota. The family had been deeply, deeply, deeply grateful for it, and so, one of the things I wanted to communicate internally was that for the right person, this is a really good thing. This is something that we should feel good about.

So, I think I personalized that letter quite a bit, or I did a couple of hospice letters, and I don't remember if the one that's in the book is about that. I personalized it and talked about my family experience with hospice as part of the experience of it. One of the things, I did write about family in a number of things. I wrote about my premature grandson. I wrote about a relative dying of cancer. I even wrote about my own heart surgery. That letter, I didn't make it about my own heart surgery as much as I made it about the nurses. I've been in this business for a long time, and I've always known that nurses are respected, but I didn't know until I went through my own heart surgery how deeply wonderful the nursing can be when you really need nursing and it's there for you. I was in the middle of the night and I had tubes down my throat, I couldn't talk, I hated it. The whole tube thing is really an ugly experience. I was in a lot of pain, and I had a couple of nurses that night who came to the bed, sat and kind of held my hand, said, "George, you're doing great, you're doing wonderfully, this will be fine in the morning and we'll get these tubes out tomorrow." The warmth and the support I got in the middle of the night I will treasure forever. It was a male nurse and a female nurse who came in and did that, and they said, "You're doing really well. You're doing great. You're through this thing."

I had my lungs collapsing and the reason that the tubes were in was because I was going through some lung collapse and that's not a really good thing. The reassurance I got, and then the encouragement I got as I was getting up and walking and going around the little area, "You're doing great," and, "Wow, you made seven steps, that's really good." So, I wrote a letter about that, and frankly, I think that letter might be the single best thing I've ever written. I

don't know if that's true, and the reason I think it feels like that is because it was such an important experience to me to have that support at that time, that I kind of flash back on it when I read the letters. I don't know if it's as well written as I think it is, or if it's just that I really like making that point.

12-00:32:16

Meeker:

Put your heart into it.

12-00:32:18

Halvorson:

Yeah, totally. I'm still at this moment feeling grateful to those nurses for being there in the middle of the night, when I'd just gone through major bypass surgery and I was really in a challenging time, in a lot of pain. That is not a fun set of surgeries.

12-00:32:39

Meeker:

Another point in this book, this compendium of letters documents, is the unique case of Kaiser Permanente being such a massive organization, undoubtedly a big bureaucracy, yet also it being a center of innovation. So, this brings up the paradox of how do you institutionalize innovation? I think that some of these letters hint at that, but I'm wondering if you have an overall sense about how it is that you institutionalize innovation in a big organization?

12-00:33:16

Halvorson:

Well, partly you need people who believe in innovation in key jobs. I can preach innovation from the CEO job and that's a positive thing and it sets kind of a tone, but then when I also have a CIO, our IT person is a fan of innovation. He loves innovation and sets up innovation seminars and innovation opportunities, and sets up funds for innovation and hires people who also believe in innovation. Then, all of a sudden, you get layers and layers of innovation. So, I talked to him and said, "Phil, we really need to be innovative here, this is a really critically important because we're going to have all this data, all this systems, all this resources, all this interaction with patients, and we really need to take the lead in innovation." He had no healthcare background at all, but he had some background in some banking innovation. He started engaging, and I said, "The doctors are going to be your very, very best friends." I sit down and talk to the physicians and say, "What can you do to help them make their job better or their world better? You've got this great resource to use." He started doing that and he fell in love with it and got his team to fall in love with it. One of the things that KP does is bring in the best systems developers, all the people that are doing all these apps, a couple of times a year have app festivals. They bring in their new apps to KP, to pitch them to KP, to see if KP's going to want to use some of those apps. Some of them do get used.

Instead of resisting the new apps or saying, "If it's not invented here, we're not going to do it," we actually created a process to bring people in to pitch their best thoughts to it. One of the things that I had done for years is I have my senior executives go to trade associations like the American Hospital

Association, or AHIP, the insurance association. When they go to those meetings, I insist they go to the exhibit floor. If you go to the Hospital Association meeting, if you go to HIMS, I don't even care if you go to the speeches because the speeches are typically about the past. The speeches are people celebrating what they did, last year, two years ago, victory laps for people who did something cool. The exhibit floor is the future. Exhibit floor is all the vendors who are bringing in stuff, that is, they're trying to sell because they think care is moving in that direction. So, you see that at AHA, you see that at AHIP, you see the future, and you really see it at HIMS. If you go to the exhibit floor and they've got 2,000 exhibitors in the future.

One of the things I make an assignment to my people, go to the meeting, and then once they're there, they go to the exhibit floor and then they spend hours on the exhibit floor, looking at everything that's there. People come back incredibly well informed because you see what these people are doing, what the future is, and where they're going. It's very, very different than merely going to the speeches to hear what they did in the past, or reading an article somewhere. The energy and the synergy you get from 500 exhibitors is very different than what you get from reading an article. So, I used to assign officers to go to those meetings and then go to the exhibit floor. I told them, wherever the meeting is, "Fly to Vegas, I don't care if you go to any single speech, but you've got to spend at least one afternoon on the exhibit floor and bring back stuff. They have hand-outs. They'll have hand-outs. So grab some hand-outs. Bring back some hand-outs, and then I expect you to give me one or two really cool hand-outs you picked up somewhere." So they get a little bit of a work assignment on it. It also helps me know whether or not they actually got to the exhibit floor.

That makes a big difference because if you are just sitting in a tower in Oakland, you don't know that the world's changing. It's not changing in the walls of that tower. But if you go to Chicago and go to the AHA meeting and you see 500 vendors who have new ways of tracking the data and new ways of compiling the data, new ways of providing linkages and feedback, new care protocols, when you look at that, then you know the world's changing. You know it's changing fast and you know it's changing, and so you're smarter. So, then, come back inside KP, back to your point, those leaders that come back inside KP, instead of resisting innovation at KP, when somebody comes up with a new idea, they say, "Hey, this is our version." You get a different response and feedback from the leadership groups. You need leaders who believe in innovation to make that process work, and then you need to fund it.

We actually have millions of dollars at KP that go to fund research and innovation in all kinds of projects, and there are many projects that get funded out of those innovation funds. I de-productized, I don't know if I mentioned it to you, but one of the probably most important things I did, actually, was de-productize innovation. I de-productized innovation. In a lot of organizations, a lot of settings, you invent something which is good, and you invent it usually

because it's useful. So, a person can invent something that's a better way of doing it, and then having invented it, use it, and then having used it, the approach that's used in a lot of places is to patent it. Okay, so when you go to the patent step, you stop the innovation. You stop the progress. You take that innovation, you put a patent on it, and you have to go through the patent filing process. You have to go through the patent filing process. Then you go through a process of figuring out, how do you sell this to somebody? In the process of selling it to somebody, you say, "Okay, you're the inventor—do you get 10 percent or 20 percent of the proceeds? Does the organization get 30 percent?" There's a split. Universities go through that in great detail. Universities have all kinds of very strict rules and guidelines about protocols for how you divide up an invention and the proceeds for an invention.

I did some of those, took some really good ideas and moved them down the patent trail, and what I discovered was that pretty much killed innovation because people then started fighting about their percentage. People started squabbling about how to position it. Then, people say, "You're not selling this hard enough. This is such a brilliant idea." So, all of a sudden, instead of having this be something that's a wonderful, innovative, morale-enhancing thing, it becomes something that collapses morale. Causes people who used to like each other not to like each other, and creates all kinds of internal problems. So, what I did a number of years ago at KP was by CEO fiat, de-productized everything. I said, "Everything we invent, we give away. We gift it to the world. We gift it to ourselves, internally, and we gift it to the world, and we will no longer take anything down the patent approach."

Some people said, "You know what? These things could be worth millions." You're absolutely right, and we're a \$50 billion company. Millions is irrelevant. A \$50 billion company, we can't have this company hamstrung because I've got people in a hospital or clinic fighting about the percentage of something that's worth \$1 million. What I need to do is use that thing in a way that benefits KP for many patients and many millions of dollars. So, de-productizing was actually an important policy and functional and operational decision. We had an explosion of creativity after de-productizing. People invented like crazy because they knew they would get support for the invention and they'd get celebrated. They knew that they didn't have to fight with other people about the invention. If you and I invented something together, I wouldn't have to worry about whether or not your collaboration was going to cut into my ownership. Collaborate and say, "You know what? That's a really cool idea. Why don't you put that on helping my thing." So, it created a different synergy.

12-00:42:53
Meeker:

Creates like a massive lab or something.

12-00:42:56

Halvorson:

Yeah. Actually, a guy who's the head of one of the largest pharmacy systems in the world came to KP a year ago, and I had him and his staff, a couple of key staff, spend a day meeting with us, looking to or talking to our people, whatever. Then, I had dinner with them at Scott's at the end of the day and I said, "What do you think?" He said, "You are the largest learning collaborative in the world." He said, "I had no idea." He said, "I expected to come into this place and see this bunch of rigid bureaucrats who were all getting dictates out of Oakland who were going off and doing these things." He said, "I was curious about who much be inventing this stuff in Oakland." No, but he said, "I really expected to see this kind of a top-down thing," and he said, "What I didn't expect to see was all of these levels and layers of intellectual collaboration going on with people who were really having a good time doing it." He said, "I have to go back and think about this. This is really not what I expected, but it's really a lovely thing so you should feel good about this." I said, "I do." The intent was to get to that point and have that kind of a learning process going on. The minute you start dividing the pieces up and splitting the profits, you really do cripple that process.

We invented some really good ways of taking care of HIV patients. Our death rate is half the national average. We have the best, lowest HIV death rate in the world. So, what did we do with those care protocols? You may not remember. We went to Washington, held a press conference, and gave them to the world. Secretary stood next to us. We had a press conference and shared it, then we made the protocols available to everybody, and all of the people involved in those protocols felt wonderful. People inside KP who heard that we had done it felt wonderful. Everybody felt good about it, and we actually made a difference outside of KP. We are continuously improving that inside of KP, so our protocols are better now than they were a year ago, when we shared them with the world. If we had patented that, we would have locked it into place in that version of it, and we wouldn't have gotten better. We probably wouldn't have sold it to anybody anyway because who could we sell it to? So, when you're thinking about our history, de-productizing our inventions was actually a useful part of our creativity agenda.

12-00:45:32

Meeker:

I think that we should stop there for today, okay?

12-00:45:34

Halvorson:

Sure, yeah.

Interview 6: March 13, 2014

Audio File 13

13-00:00:11

Meeker:

Today is March 13, 2014. This is Martin Meeker interviewing George Halvorson. This is tape number thirteen, this is interview session number six, and we are again at his home in Sausalito. We have a lot to accomplish today, and I'd like to get started by talking about an issue that has come up in bits and pieces here, but I think I'd like to devote a little bit of time to it. That is the Kaiser Permanente Labor-Management Partnership [LMP]. I know that the history of labor and Kaiser is an interesting and very intimate relationship, going back to the 1940s, 1950s, actually even going back before Kaiser Permanente was established in the 1930s, with Henry J. Kaiser and his projects, particularly at the Grand Coulee Dam: he wanted to bring healthcare to the workers there, and this is something that the labor unions who were working on that project were particularly interested in.

13-00:01:28

Halvorson:

Henry was very pro-union. He made a number of public statements in support of unions and their role, and a number of other industrialists at the time were not happy with those.

13-00:01:46

Meeker:

Then, to fast-forward a couple of years after that, in the late 1940s, there was some question of whether this healthcare system that really got going in World War II was actually going to survive the end of the war. According to the historical record, labor unions in California played a major role.

13-00:02:06

Halvorson:

Dock workers in particular, yeah.

13-00:02:10

Meeker:

The longshoremen and some other unions played a key role in being some of the first major member groups that would join what eventually became known as Kaiser Permanente. Through its long history, there have been certainly local incidents of labor strife. I know in my interview with Jay Crosson, he talked about a strike. I think, that happened in the 1980s that he had to deal with at the local site, I think when he was at Hayward. So, strikes certainly happened, and then fast-forward to the 1990s, when David Lawrence was President and CEO. He forged what then became known as the labor-management partnership, which is seen by many as a model for the kind of partnerships that could be pursued. One of the major features of this was that it pledged that Kaiser, as a company, if you will, would open the books, financial books, to labor, to make the negotiation process for contracts more transparent. So, let's then talk about the state of the labor-management partnership when you arrived on the scene, I guess, 2002, right?

13-00:03:38
Halvorson:

Yes.

13-00:03:38
Meeker:

How did you find it?

13-00:03:44
Halvorson:

When I wrote this little document that we handed out to the board back in 2003 [the laminated 'card' discussed in previous interviews], I basically said that one of the critical elements of success would need to be to have a successful labor-management partnership. I listed that in the top half-dozen things that we needed to do as an organization to do well and survive, so I gave it a very high priority. In Minnesota, in my prior job, we'd had seven labor unions. I worked closely with them in that partnership mode, and we did interest-based bargaining there, and interest-based bargaining is the model where each side figures out what the other side needs as well as what they need, and then you put all of the issues on the table together. When both parties understand what the other parties need, the likelihood of coming up with a solution is significantly increased because if you're guessing about what the other people want, or if you're speculating or if you're, in the worst case, if you're creating horror stories about what the other side wants—

13-00:04:55
Meeker:

Or even not considering what the other side wants, you're only considering what you want.

13-00:04:59
Halvorson:

Or not considering the other side at all, and going into the negotiations totally for one side, then the likelihood of confrontation is pretty high. When people get into the confrontation mode, they go into us-them thinking, and you get the same kinds of thinking that you get any time those instincts are activated. You get people hating each other, disliking each other, doing damage to each other, and feeling that the other side is the devil and the demon, and you really end up with some very, again, worst case situations, end up with some very emotional situations where people do damage to each other, and lose-lose situations. I've seen some situations like that where things have gone very badly for organizations. I personally have been working in union settings now for three decades, and my own approach to that has been, let's figure out how we can win together. This is a world where we can both win. Win-Win is the right model, so what's a win for the labor union and what's a win for the health plan, and how do we bring those together in a collaborative win-win?

KP had just started down that path, and actually, when I came to KP, John Sweeney, who was the head of the AFL-CIO for the country sent out a press release when Kaiser announced my selection, and he said it was a brilliant selection. He said this because Kaiser had just picked one of the most labor-friendly CEOs in American healthcare. I actually had the head of the AFL-CIO union from Minnesota on my board at the Minnesota plan. Bill Peterson

is the Secretary-Treasurer of the union, and I had the head of the mechanics union on the board. So, I actually had union members on my board, and some of the best goodbye parties were thrown by the unions, as I left the state. So, I came to KP with a sense that you can either go down the path of confrontation or you can sit down together as reasonable people and figure out how to get to a reasonable endpoint. The number two person in the KP LMP at that time, Betty Bernardzik, had been the leader of the HealthPartners unions. Just coincidentally, she'd come to Washington and then come to KP, and I didn't even know Betty had come to KP until I got to KP. The fact that the number two person in that Partnership was somebody that I had done a lot of work with at a very good level—

13-00:07:42

Meeker:

Was she on the KP side or on the labor side?

13-00:07:44

Halvorson:

Labor side. In Minnesota, she headed the nurses' union, and the nurses' union in Minnesota was an AFL-CIO union, and she went national, and then they assigned her to the partnership. I lost track of her for a couple of years there. Somebody here said, "Here's the team of the partnership, and the number two person is Betty Bernardzik," and I said, "I think you're pronouncing that wrong." [laughter] So, I started in a positive position with the unions because they knew I'd done partnership things before, they knew I liked partnership mode, they knew that I liked win-win outcomes. John Sweeney asked me to teach at the National Labor College. We did things together, I coached some of their people at the national level, and on the SEIU side, the other major side, I also had a good relationship with Andy Stern before that happened, before I got to KP, and he and I had been on the same side, not in the labor setting, but on the same side on a couple of health policy issues. So, he also has a positive relationship. So when I got to Kaiser Permanente, I also met with Andy and we continued to have a good relationship.

My positioning to both union leaders was, "we're going to be the most unionized healthcare site in America; let's also make that the best healthcare site in America, and then you can say that union-made healthcare is the best care in the world." So, union-made healthcare should be the best care in the world. I still send, or did until relatively recently, notes to the national labor leaders reminding them each time we had a major victory, union-made healthcare won again. There's no reason for us not to be on the same side. If you don't, however, work together, and if you end up going to war with each other, then it's really easy to end up in a state of conflict and it's really easy to get angry and it's really easy to do inappropriate and damaging things to each other. So, it's a very slippery slope.

So, when I got to KP and the partnership was in place, my senses were really going to build on that. So, I actually went out and hired the person who had run the partnership and had set it up actually, I don't know the circumstances

of her leaving, but she had gone just before I got there, and the labor leaders were very unhappy that she was gone. So, I actually met with her, spent some time with her, and decided I wanted to work with her, so I brought her back. So, I sort of un-retired her.

13-00:10:39

Meeker: Who was that?

13-00:10:40

Halvorson: Leslie Margolin. So, I brought Leslie back and put Leslie back in charge of the partnership [LMP] as a token of good faith that I really, it was important to me that we make this whole process work, and that was a good thing to do. She actually did some really good work to make it work. So, then we renewed the partnership, and then we knew that we had to figure this out and get good at it because no one had successfully, anywhere in the world, done a long-term labor partnership.

13-00:11:15

Meeker: So, it was renewed in 2005, correct? There was a new agreement?

13-00:11:18

Halvorson: Yes.

13-00:11:20

Meeker: What was unique about the 2005 agreement? What were some of the innovations that it built on since it was established in 1997?

13-00:11:33

Halvorson: Yeah, don't know the dates, but what we did was we figured out ways of being aligned on key issues at a greater level. So, we worked from the overall strategy of improving quality, improving service, and having the most affordable plan. Another thing about my history, in Minnesota, I had no trouble with us being the best payer for nurses and doctors, as long as we had the lowest premium. So, if we had fewer heart attacks and we ended up with less expense but we paid our nurses more than anyone else paid their nurses, that's a good model. It's easy to hire nurses, morale is high, and the whole point is that the product in the end, that we're selling, is affordable. I made the same point at KP, and basically said as long as we can aim toward having the final result be affordable, the most affordable plan, then I'm comfortable with us being a good payer. People knew that to be true, so they weren't wondering, "Does George really mean this?"

13-00:12:48

Meeker: I wonder how labor responded to that because I would guess that part of it would be, well, that's not our problem, right? We're happy to be the best paid, but we can't do anything about having the lowest premiums.

13-00:13:05

Halvorson: We then said, "And we need to do this in a team-based way. We need to reorganize some care delivery, we have to make processes better, we need to

do process reengineering,” and part of that agreement was that we agreed to do process reengineering, and without being confined by the job boundaries, and even in some cases, the union boundaries. That’s always a challenge, but we wrote that into that agreement, that we would look at the overall process and then figure out the jobs from the process, and then make sure the union workers were protected in that process. We agreed, too, and one of Leslie’s biggest achievements was to agree to looking at process reengineering as part of the deal. When we got to the renewal after that, then we added unit-based teams to the process. So, we said, “We want our frontline workers to be in teams, we want our frontline workers to function with each other as teams, in all the care settings and the administrative settings.” When the workers function as teams, then the workers can reengineer care in each site, and can improve care, can cut down the wait times, cut down the error rates, that type of thing.

13-00:14:25

Meeker:

How are these teams different than what had been in place before?

13-00:14:29

Halvorson:

There were no teams, basically. You had a work site. You had a supervisor. it wasn’t a team setting. You had a chain of command, and a chain of command is different from a team. So, we want from a chain of command to a team, and we basically said in the team model, “we need to figure out how to make this operation better.” We had to develop some really good training for the supervisors because many of the supervisors were very comfortable with the chain of command approach, and less comfortable with a model that involved being a team leader and team coordinator. When you get into the team mode, you want the input from everyone and you want everyone’s insight, and we are collectively smarter than we are individually smart. I believed that for many years, and it’s true.

So, when we get to the work sites, the other thing that happens is humans, we’re instinctively wired to be a number of things—territorial, hierarchical, to divide the world into us and them, and do things differently if somebody’s an us and a them. There’s a whole series of instinctive behaviors that we have that are relevant, and one of the instinctive behaviors we have that’s very relevant is to function as teams. When people function in a team setting, then they overlook prior differences and focus on the context of the team and the work of the team. So, if you can get people into a team setting, morale goes up, performance goes up, and they interact differently with each other than they did when they weren’t a team, when they were siloed. So, absenteeism goes down and morale goes up, performance goes up, when people get into team mode. You have to have people functioning as teams to do that.

So, we actually wrote team behavior into the contract, and we actually put a thing called the value compass, that you should get a copy of. The value compass is a compass that basically has the patient in the middle, and then

says, “We’re going to have best care, most affordable care, we’re going to be the best place to work.” It basically says that there are some basic functionality things that we’re going to do that we’re going to be the best in the world, and the whole thing’s going to be focused on the patient. Then, we empowered each of the teams to go to the value compass for guidance. So, when you get a team at the front line of an emergency room, they sit down with the patient as the focus, as a team, how are we going to get the best service? How are we going to get the best quality? And how are we going to do this in the most affordable way? All of those pieces are in the agenda—and how are we going to make this a great place to work in the process? How do we make this a respectful place to work, so that each one practices in the scope of their contract, or their licensure? People like doing that work.

When people discover that it’s real and they trust it, then they get involved with doing it. The day that I left Kaiser Permanente, we had 110,000 people on teams. The teams were functioning well, and we track whether or not the teams are high-functioning. We have an entire support infrastructure that supports those teams. So, if a team needs support, they can call people who’ll come to the site and help them think their team issues through, or reinforce their team. We have a training program for the supervisors to teach them to supervise in a team setting. So, we took the partnership as a template and expanded it into team behavior. That was very successful, and the reason that we won JD Powers and Consumer Reports, was because we had all those front-line workers on teams, working together, getting to good outcomes.

13-00:18:17

Meeker:

What you’re talking about is a transition from the hierarchical, siloed approach to the team-based approach, this is an example of the process reengineering, correct? So, as somebody who hasn’t ever worked in healthcare, I’m wondering if you can give a brief description of what a team would look like, how they would function?

13-00:18:41

Halvorson:

Well, there’s multiple levels of teams in KP. At one level of team behavior, there are all of the oncologists inside KP who now function as an intellectual, thought-sharing team. So, the oncologists collectively share information. KP has the lowest cancer death rates on most cancers of any place because all these really smart people are working together as a team. So, there’s the intellectual team, at that level. We’ve got the Care Management Institute, which is set up to function to support teams, and to bring information in, to bring science in. So, we have a team at that level. Then, at the work sites, we have worksite teams that are focused on the patients at that work site. So, the emergency room at any given hospital would have team focused on the patients who flow through that emergency room, and then the teams would work in, how do we minimize the damage? How do we reduce the wait times? How do we improve the accuracy levels on the work in this site?

The teams do that thinking themselves, with some coaching and some support and some data flow. Then, when somebody does it really well, the teams are an infrastructure that we can share information with. If you don't have the team, you don't have the infrastructure to move knowledge around. So, it also creates a fabric. It creates an infrastructure that you can move learning around in. If you don't have that infrastructure, you can't move learning around. So, example, pressure ulcers: pressure ulcers at Kaiser Permanente, the rest of the country has 5-10 percent of the patients have pressure ulcers, some sites up to 15, and we started at about 4 percent of our patients have pressure ulcers. We set up teams at every pressure ulcer site to figure out, what can we do to improve care, how can we reduce the number of ulcers, take them down? We took them from 4 down to 3, and we took it from 3 down to 2, and we actually took it from 2 to 1. The last year, we had half a dozen hospitals that didn't have one single pressure ulcer for an entire year. I mean, it's stunning. Nobody in America, nobody in the world believes that number, and it's so amazing.

But how'd they get there? The teams on every site are doing the teamwork needed for each patient, but there was a sharing from team to team, so one place would figure something out and it would be a really good learning, and because everybody was on board with how do we reduce the number of pressure ulcers, then other sides would say, "That was a good idea. Let's take that." So, we created sharing processes and we created opportunities for the best sites to share with other sites, and then another site would figure out something and make it better, and somebody else would make it better. So, it was a continuous improvement and support mode, done in the context of those teams. The care is very patient-specific. Each patient is right there with their own care team, and that care team has to work for that patient, or that patient won't benefit. So, it has to drill down to that team, and it's a combination of culture and team.

What we did was we created a culture of excellence, and the culture of excellence is that those teams expect not to have a pressure ulcer. If you go to other hospitals, not all other hospitals, but if you go to many, many other hospitals, patient will have a pressure ulcer and people will say, "Oh, darn. I hate those. Those are really bad. Let's take care of that patient." They take care of the patient. It's kind of an "Oh, darn," situation, or it's a, "Jeez, I wish that didn't happen," situation. At KP, a pressure ulcer happens and people say, "How did we fail? How did we screw up? How did we let that patient down?" It becomes a culture of commitment to the patient that's so powerful and so strong about protecting the patient that the care team, feels like they've let the site down if they have an ulcer. People mourn. Other care sites, people say, "Oh, darn." At KP, there's a mourning process that people go through if a patient has an ulcer because the culture feels like it's let that patient down. So, you have to use a combination of process, continuous improvement, teams, and culture. When you put all those pieces together, it's incredibly powerful.

[The narrator has sealed a portion of the interview.]

13-00:30:46

Meeker:

The labor-management partnership has been described as a model: did you have other healthcare organizations coming to you to ask how you and Kaiser Permanente tried to manage this partnership successfully?

13-00:31:07

Halvorson:

Yes, yeah. Quite a few.

13-00:31:10

Meeker:

Can you talk about any examples, and how maybe that played out?

13-00:31:14

Halvorson:

I probably can't talk about examples, but a number of organizations sent senior management, their entire senior management teams—ten people, eight people—to come to California and sit down and get briefings for a couple of days on what we did, why we did it, how it worked. There were a number of settings elsewhere in the country, New York, Boston, a number of places, where people were trying to figure out how to do similar things. We sent both management and union people to those settings to coach people, to help them think things through and figure out what the pieces needed to be. So, I think we did have an impact on some other sites in a positive way. That should be up for those sites to disclose that, if they choose that.

13-00:32:10

Meeker:

You had mentioned healthcare reform, and this is something that I really would like to cover in as much depth as you're willing to talk about today, because obviously it's something that people have been trying to accomplish in the United States, I guess since FDR. Certainly since Truman and Johnson and Nixon and Carter, and just about every other President. Yet, it finally happens at the beginning of 2010. In addition to political leaders making efforts at healthcare reform over the years, you yourself have been an advocate of healthcare reform since at least the 1980s.

There's a lot of specific questions I can ask, but maybe the first question to ask is, again, you arrive at Kaiser in 2002, this is a year or so after 9/11, George W. Bush's presidency, he will go on to win quite handily again in 2004. Congress is Republican in both houses. Medicare Part D, I believe, had already been passed, or was on the verge of being passed, so there was some movement on the healthcare front, but no discussion at that point in time of a major overhaul along the lines of what Bill Clinton had attempted in the early 1990s. What was your thought about the possibility of a large-scale healthcare reform, when you first arrived at Kaiser?

13-00:34:07

Halvorson:

If you go back to the Minnesota days, in Minnesota, I served for eight years on various Minnesota Healthcare Commissions, to reform healthcare in Minnesota. At the end of that timeframe, the commission made a

recommendation to the legislature, a bill about healthcare reform. That bill didn't pass. So, what I did was I convened a bunch of healthcare leaders and a bunch of health plan leaders, and we wrote a new bill using some of the best features of the commission work. The bill that we wrote was the bill that became MinnesotaCare, and the bill that we wrote basically made any uninsured person in Minnesota who'd been turned down by two or more companies could join this risk pool. It was a subsidized risk pool. They could join this risk pool without any proof of insurance. So, we recommended the MinnesotaCare. I led the press conference that teed up that offering.

It was built on the work that had been done by the Healthcare Commission, but it was a different bill, and it was based on using a market model for healthcare. All health plans in the state were eligible to participate in MinnesotaCare, and what we did was we volunteered to tax healthcare in Minnesota to raise the money to pay for the uninsured. That was actually my idea, and I persuaded the other health plans and people to do that, on the argument that if we take money as a sales tax on healthcare and re-channel it into healthcare, and as a result of that, we get everybody insured, we're just recycling our own money. It doesn't really cost us anything because it's a sales tax and it's an add-on, and we can insure everybody with the cash flow that we can fund.

We did that, and we actually got in Minnesota the number of uninsured down to under Hawaii, and Hawaii has mandated universal coverage. So, Minnesota was down to, I think, 6 percent, Hawaii was at 7, rest of the country was 10-30, depending. So, we actually succeeded in Minnesota by bringing this coalition together to put together a plan that was open, mandated, subsidized plan. I was very pleased with that. I actually helped explain to some people in Washington why that model worked. When I got to California, it was clear that we were not going to be doing anything national, but it did make sense to put together a California plan. So, we got together with, and KP convened, Blue Shield, Blue Cross, HealthNet was a major player—Jay Gellert is head of HealthNet—and we put together a coalition to create a similar plan for California.

13-00:37:20

Meeker:

Is this the plan that you presented in *Health Affairs*, I think in about 2006 or 2007?

13-00:37:24

Halvorson:

We presented an early version of that in *Health Affairs*, yes, and that was kind of based off the Minnesota plan. Jay Crosson and I co-wrote that *Health Affairs* article, and we identified what healthcare reform should look like for California, based on it. So, then we put together a coalition, and we went to the hospital association, medical association, whole number of other associations, and we actually got a lot of support for what I thought was a pretty reasonable plan.

13-00:37:52

Meeker: So, this plan, can you describe it a little bit?

13-00:37:58

Halvorson: Everybody gets insurance, guaranteed-issue insurance, and health plans are the vehicle, and it's a subsidized premium.

13-00:38:06

Meeker: It includes individual and employer mandates as well?

13-00:38:10

Halvorson: Yes, individual and employer mandates. Total individual mandates. I've written eight healthcare reform books now, and I've recommended mandates in four of those books, and I've chaired the International Federation of Health Plans. I know how the health plans work in 40 other countries. I spend a lot of time with those countries, I know how they do it. All of the countries in Europe use a mandate. None of them use government programs. If you go to the Netherlands or you go to Switzerland or you go to Austria or you go to Germany, there is no government program. There's no Medicare and Medicaid equivalent; they're all funds, they're all sickness funds, insurance funds. I know the people who run those funds.

The exceptions to that are the Scandinavian countries, who own their entire system—and employ the doctors, they own the hospitals, own the system—and Great Britain, who has universal insurance. Everybody gets your own private doctor for primary care, and then you get into the government system for specialty and hospital care. In Great Britain, all the primary care doctors are capitated. Again, in Great Britain, everyone was in the system. But if you go to the Netherlands, the reason that the Netherlands can sell private insurance and have it be affordable is that every person in the Netherlands is mandated to buy that coverage. You can get it through your employer. You can get it directly. If you are low-income, you get a subsidy, and if you're old, you get a subsidy. There is no Medicare program in those countries. You're still buying the same coverage. You're just getting a subsidy based on your income and your age. So, I knew the model really well. I knew that it worked.

13-00:39:59

Meeker: When you start to advocate for the mandate, where did you get these ideas? Was it from your interaction with the European countries and the way in which they financed healthcare?

13-00:40:09

Halvorson: Yes, from that, and also, I know what the risk pool issues are. I mean, it's absolutely clear that if you've got a population and you're going to put them at risk, if you sell life insurance only to dead people, your premium has to be really high. [laughter] That's pretty basic. If you sell fire insurance only to burning houses, then your fire insurance premium has to be pretty high. So, if you sell health insurance only to sick people, then your premium has to be pretty high. I know that, and it's easy to teach. I just taught it, and people get

it. I knew that from experience. When we did the villages in Uganda, we enrolled the villages, we'd go in, we'd figure out the population of the village, 2,000 people, and then we would not kick the plan off until three-fourths of the people had voluntarily agreed to pay premium. Once we got the risk pool to its efficient size, we didn't need 100 percent, but we need 75 percent, so once we got 75 percent, we'd have a big party and celebrate and start the health plan. So, that's just basic actuarial science.

13-00:41:14

Meeker:

The healthy subsidizing the sick.

13-00:41:16

Halvorson:

The healthy subsidizing the sick, yeah. The people who aren't dead paying premiums to pay for deaths. You have to have someone paying in so that someone can pay out, and all care is purchased with someone else's money. So, you need to basically have a source of other people's money to pay for your care. That's why the mandate, I strongly recommended a national mandate, my advice to both the Clintons, way back when, but also to the most recent round, was that the mandate be an absolute mandate. They put in a soft mandate. Soft is better than none, but it could prove to be too soft, in the end. The challenge is you have to have people insured to function as an insurer.

13-00:42:09

Meeker:

Can I ask you to pause right there? I will get in to some more of the details on the Affordable Care Act, but since you just brought it up, can you describe the difference between a soft and an absolute mandate?

13-00:42:22

Halvorson:

Well, Switzerland has an absolute mandate. If you are Swiss, it's like social security here. If you work in this country, you get Social Security. A percentage of your paycheck goes out to pay for it. In Switzerland, you have to have a percentage of your paycheck go out and pay for your health coverage. You get to pick the plan. There are thirty different plans. They compete. They have all kinds of bells and whistles and fun things, but you as an individual must pick a plan. You have no choice. If you move to a new geography, part of the moving in paperwork is for you to list your new plan in the new site. So, in Switzerland, there's an absolute mandate. If you have that, then every single person is in the risk pool, and that brings down the premium quite a lot. Ten percent of the people are 80 percent of the cost: if only that 10 percent are enrolled, the premium has to be eight times higher.

So, if you have everyone in: if you get the 50 percent of the people who are basically zero cost not in, the premium for the other people has to double. When you get those people in, the premium cuts in half. So, it's pretty basic. It's arithmetic; it's not actuarial science. It's arithmetic. Yeah, you basically have to do the math. So, what I recommended was mandates, and in California, we put together a plan and we created a coalition. We brought all these parties together and we had some really good people working hard, and

we almost got it passed. We came within one vote in the Senate of getting that bill into law. The governor was ready to sign it. We worked with the governor's staff to help design it. So, we almost got that. In Minnesota, we got that bill passed—the MinnesotaCare passed with a Republican governor. We almost got the California bill in place with a Republican governor.

13-00:44:24

Meeker: You think Schwarzenegger would have signed it?

13-00:44:25

Halvorson: Oh, yeah. Yeah, he was not only ready to sign it, he was actually lobbying people to do it. It would have been really interesting for him to have been the first governor to have universal coverage in the state.

13-00:44:36

Meeker: Well, this was similar to what Romney had done in Massachusetts was it not?

13-00:44:40

Halvorson: Not dissimilar, yes.

13-00:44:44

Meeker: What were some of the key differences? Could you pick those out at this point?

13-00:44:48

Halvorson: Yeah, one of the key differences was the Romney plan had universal coverage, but didn't have any mechanisms at all for making care better or higher quality or lower cost. So, they only put in the insurance side, they completely ignored the care side. What we did in California was what we did in Minnesota, which was bring in both sides. We basically said, "You're going to fund this through care systems, and people are going to choose care systems and get their care from care systems." In Massachusetts, they basically said, "Go anywhere." The Massachusetts plan, the unaffordability of that is based on people going to hospitals that cost three to four times as much as the hospital next door for the same care. The Minnesota model channeled people; California model would have channeled people. Because it was ready to channel people, the health plans and the hospitals were willing to support that.

13-00:45:50

Meeker: When you say, "channel people," can you describe what you mean?

13-00:45:53

Halvorson: You'd choose, just like Switzerland, you would choose a plan. You, as a Californian, would need to be enrolled. You could be enrolled through your employer and that'd be fine, that's lovely, or you could directly enroll. If you directly enrolled, you'd have guaranteed issue, and then you could choose from the approved plans in the process. Not that dissimilar from the Affordable Care Act, at that level. We came really close, and I actually went to Davos. I was chairing the health governors at Davos at that point, and we

had the annual meeting in Switzerland. I got on an airplane the night before the vote, and I met with the senior leader in the Senate and said, “Do we have the votes?” He said, “We’re in. Get on your plane, go away, relax.” I got to my hotel room in Davos and got the note that we hadn’t won. It was really sad because we came so close, and it was a good bill.

13-00:46:57

Meeker:

Do you know what the vote was? Who the individual was who didn’t come through?

13-00:47:05

Halvorson:

I’ve heard all the stories, but no point in going back and dealing with that.

13-00:47:16

Meeker:

You seem to be less interested in the politics side of these things. Every time that we’ve brought it up, I guess the sausage-making side of coming up with this legislation, seems less interesting to you.

13-00:47:34

Halvorson:

I met yesterday with five committee leaders and the *pro tem* in the California legislature to work on these children’s issues, and working with the governor staff on these issues. I’m actually involved in the sausage-making, but the most important thing to me is not the sausage-making; the most important thing is the sausage, I guess. So, what I’m trying to get passed here and now is legislation that will help children in those first three years of life. What I was trying to get passed then was legislation to have everybody in California have coverage.

13-00:48:17

Meeker:

Did you ever get a sense—we don’t have to name names—if there was an issue or what stumbling block got in the way of it actually passing? Was there a problem with the bill or constituents or something along those lines?

13-00:48:32

Halvorson:

I think there were some political issues, some political cards were played at an unexpected level. I think even the people who are total experts were surprised, and it was kind of a give-and-take, and the outcome wasn’t exactly as we predicted, and a couple of people leaned in different directions. I think in one case, there was knowledge about why, and I think the other case, it’s speculation. But again, unless I would need to deal with that person on a relevant issue at some point in the future, so what? That’s what happened then, and that’s gone, and I’m not going to dwell on it. I feel bad about it, though.

13-00:49:25

Meeker:

What year was this? Was it 2007?

13-00:49:29

Halvorson:

I don’t remember, actually, which year, now. But it’s easy to discover—Schwarzenegger was governor, and it was the healthcare reform bill.

13-00:49:39

Meeker:

In advance, I think of Obamacare becoming a real possibility on the horizon.

13-00:49:49

Halvorson:

That was also used in some ways as a model. At that point in time, the thought was, if the federal government's not going to do this, the states can. We might as well march and have a march of the states and have every state do that. So, that was our agenda, and then Obama got elected President and decided to go down that path. So, number of folks who had been trying to get it in place before, trying to do it then.

13-00:50:20

Meeker:

Actually, I just have one more question about the California initiative. This was from reading the *Health Affairs* article that came out in 2007 that you wrote with Jay Crosson and, I think, Steve Zarkin [at the time, Chief Counsel of Kaiser Foundation Health Plan and Hospitals] also was an author on it. That is that there are some distinctions within it about how different populations will receive care, and that there was a focus on primary care for the low-income uninsured, and then there was a focus on catastrophic care for the moderate/upper-income uninsured?

13-00:51:03

Halvorson:

Yeah, that particular article was catalytic, but it wasn't the model that was in the final bill. That model, that would have gotten us to relatively low-cost universal coverage very quickly. It was designed in part to kind of shake people's thinking up because people were saying, "We can't get there. No possible way we'd get there." We said, "Yeah, we can get there and do it affordably, if we do this and we do that." If we create that 90 percent of the people need primary care, let's make it a primary care model. Actually, in Minnesota, before we did MinnesotaCare, my health plan started a primary care model. We basically went to single mothers in a state of transition who were going to school. We gave them free coverage, and we gave them free coverage based on 90 percent of the primary care thing, and if they got to a point in the back end where the coverage was going to be more expensive than that, we signed up some safety net hospitals who would take them.

So, we actually used that model, and we signed up thousands of women who wouldn't have otherwise been able to go to school and have care, and they had basic coverage for their kids. Then, some of that benefit package was used as the model for MinnesotaCare, and it wasn't needed after we got MinnesotaCare in place. Doing that kind of thinking, how do we get people covered, and the Affordable Care Act actually ended up doing it the other end. The affordable care act ended up putting in what were, that model was pay for everything upfront and then do cost-share in the back. The Affordable Care Act is to have deductibles upfront, and then more comprehensive coverage in the back end.

13-00:53:00

Meeker: What do you think of that?

13-00:53:03

Halvorson: I like the other model better, actually.

13-00:53:07

Meeker: It's interesting, the way in which you talk about the creation of this legislation, and this conversation starter article in *Health Affairs*, that it's a very different approach than, say, for instance, kind of what happened in the Clinton era, with Ira Magaziner, in what people described as a secretive legislation creation process. Then, it's all presented as a done affair, people either thumbs up or thumbs down. Here, there's an opening salvo, right? There's an idea or a series of ideas that are put out there, but it seems like that's what they were—it doesn't a set program that you either have to sign on to or you don't sign on to.

13-00:53:56

Halvorson: Yeah, all we said was we want universal coverage; now let's figure out what to do. At the beginning of the process, my first year at KP, I went to the state convention of community clinics, and all the community clinics of California were at this convention. I basically said, "Kaiser Permanente's going to be in favor of universal coverage; we need a model that includes you. We need your support for this model and we're going to figure out how to put this model together, and we'll come back and ask for your stuff." But it's just criminal we've got people in California who don't have insurance. They all said, "Yes, that's a really good idea." Then, we went to the hospital association, I went to other groups as well, and kind of got a coalition. One of the things I've learned, when I went to the Minnesota legislature with MinnesotaCare and when we had all of those key parties at the table, then the legislature could safely say yes. If you go in as a partisan with one perspective and you don't have the community clinics on board, for example, so we had the community clinics saying, "This is a really good idea. We can support this, this is good for us, there's a place in this model for us. We get to continue to do what we do, then you get a much better outcome." So, doing it with transparency and inclusion is a really good model.

Audio File 14

14-00:00:08

Meeker: This is Meeker interviewing Halvorson, tape fourteen. This is session six, still. So, you had mentioned vis-à-vis the California initiative for healthcare reform around 2006-2007 that when you started speaking publicly about it, when you started speaking with key stakeholders about it, that this was something that Kaiser Permanente was going to advocate. When you arrived in 2002, did the board of Kaiser Permanente or the organization have any established position on healthcare reform leading to universal coverage?

14-00:01:04

Halvorson:

KP, I think, has always been in favor of universal coverage. I think there was probably never a time in the history when there wasn't a sense that it would be best for the country if everybody was covered. Henry Kaiser basically said the single most important invention that he was inventing was the health plan, and it would be best for the country if everybody benefited, if everybody had the health plan. So, that universal coverage would be KP covers everyone, but that's legit and that is a model. So, I don't think there was ever a time when KP was opposed to universal coverage. It wasn't being articulated as a separate agenda at the point in time I came onboard, but I had one of the things that was very clear, is that the board of directors had read at least one of my books. And knew, when I came on board, that I was an advocate for universal coverage and healthcare reform, major systems reform, major changes in processes, and so my position on that was starkly clear. They knew what they were getting when they made that choice.

They chose, as they said, they were hiring an author to be CEO, and they were hiring an author to be CEO with the understanding that there was a belief system that came with that. It was also very, very useful for me with the medical directors because the medical directors also read my books. There was a sense that they could trust me because I clearly wanted the same kinds of things that was in the tradition of both medical groups and Kaiser Permanente overall, that I wanted better care, I wanted universal coverage, I wanted team care. All the things that were in those agendas were in my books as things I advocated, and not only advocated, but had done, to some degree, successfully in sites I was in.

So, it wasn't just a matter of me being off on a theoretical, academic sort of thing. It was, here's someone who's actually been running. I was the CEO of a medical group for seventeen years, and because Minnesota law allowed a non-doctor to be the CEO of the medical group. In California, I couldn't do that, but in Minnesota, I could do that. So, I knew those issues, I knew those challenges, and I knew what the opportunities were in a very direct and experiential level. So, in terms of did Kaiser have a perspective on it, my sense was that the prior perspective on being in favor of universal coverage was reinforced by the fact that the board chose someone who was a known advocate for universal coverage to be the new chair.

14-00:04:25

Meeker:

So, vis-à-vis the particular initiative that you advocated in California and you played a key role in getting moved to the legislative phase, to what extent did you have to engage with your board of directors to confirm that this particular plan was something that they were comfortable with you endorsing or advocating?

14-00:04:51

Halvorson:

Not at all. Total confidence that I had good judgment and I wasn't going to do anything that was not going to be good for Kaiser Permanente. So, at the

board level, we had celebrated the fact that I was pushing for a reform, but did not have any discussions about the specific elements of that. Updates, I mean, the policy people had given up the, “Here’s what we’re pushing,” so it wasn’t a secret. There were no debates or discussions about could we improve this model in some way?

14-00:05:30

Meeker:

Let’s move more to the national scene. Can you describe, from a more forest rather than the trees perspective, the national mood circa 2008-2009? Perhaps contrast that where we were in ’93-’94. What were some of the main things that were different that led to a different outcome?

14-00:06:12

Halvorson:

You mean why did this bill get passed when the other didn’t?

14-00:06:15

Meeker:

Yeah, sure.

14-00:06:22

Halvorson:

When the Clintons went down that path, there was an incredible learning curve happening. It had never been done before, this kind of agenda. These issues had never been put in front of the American public, there had never been health policy discussions at the national level of any kind, and certainly not health financing. The passage of Medicare and Medicaid might have been exceptions to that, but they were very targeted for, let’s basically take Blue Cross coverage and give it to all seniors, which was sort of a pretty linear and direct approach. It wasn’t about changing care or changing markets. It was basically just extending coverage. So, the Clinton era brought in issues and challenges and policy points, and should we have a single payer, should we have multiple plans, should we have a market model? All kinds of variations were out to the table. The people who were designing it were well intentioned, but they were learning on the fly as well.

So, they didn’t really have a clear vision. They didn’t come into that agenda with, “Here’s where we want to end up, how do we persuade people to get there?” They also didn’t end up with a, “Here’s what we think we want to do, let’s go through a learning process to enhance that or improve that. So, they basically were sort of stumbling a bit along the way, doing it in a relatively short timeframe, and getting a lot of input from a lot of people, pieces of it, and I was one of the people who flew to Washington a number of times and went to the building attached to the White House and briefed people on various kinds of issues. It was when I first had a chance to be in a meeting with the First Lady, was at that point, as part of that process, one of twenty people in the room, offering thoughts on how this whole thing might work better.

So, it wasn’t, a cohesive, nailed-down approach, that let’s take it and sell. It was more recently, when we passed the Affordable Care Act, a lot of thinking

had happened over the years, a lot of hearings had been held, a lot of learning had happened, and there was a sense that there were some models that might work. The Massachusetts model actually was very influential because it did create a market model. The nice thing about that was it wasn't a single-payer, it did create a market model that had some opportunities for different people to get coverage without having to go to Medicare for all. But even in this most recent one, the whole package wasn't nailed down before the President was elected. So, smart people had to get together and figure out, how do these pieces work? I advised in that process.

One of my books, *Healthcare Will Not Reform Itself* (2009), recommends a bill that looks pretty much like the bill that passed, in terms of mandates and choices and subsidies, and it's about an 80 percent overlap between those recommendations and what was in the bill. Twenty percent that wasn't overlapped was the book recommended an absolute mandate, and what we got was a partial mandate. At that point in time, more learning had gone on and more hearings had gone on, people in Congress knew that team care made sense, that chronic care was 75 percent of the cost of care. When you look at the bill itself, what people miss, is that there are eighty-two care "shalls" in the bill. There's actually eighty-two provisions in the bill that directly direct delivery of care in some way. I actually have a slide presentation that I sometimes show people, and I go through the care "shalls" and people are astounded.

14-00:10:47

Meeker:

The care?

14-00:10:48

Halvorson:

Care "shalls." "Thou shall do this, thou shall do that," it's the "shalls." About 25 percent of the bill is insurance "shalls," and 75 percent of the bill is actually care "shalls." So, "Thou shall report hospital infections." That didn't happen, that didn't exist before. That's huge. The connectivity issues for computer systems. Those issues didn't exist. So, when you look at the bill, there's all kinds of provisions in the bill that are about supporting team care, that have been below the radar screen of the debate. The part of the bill that's been on the radar screen has been the part that deals with the mandates, insurance mandates, and the exchanges, and that's actually a very small part of the country. Only 7 percent of the people in this country have individual insurance. So, the exchanges are relevant to that population—it's not relevant to the rest.

14-00:11:50

Meeker:

So, I'm really interested in where some of these ideas come from, as a historian. So, there's not only the book that you just mentioned, *Healthcare Will Not Reform Itself*, but there's a whole series of other books on healthcare reform that you had written and published over the years, there's also the Commonwealth Fund's Commission on the High Performance Healthcare System.

14-00:12:14

Halvorson: Which I served on for a decade.

14-00:12:15

Meeker: Which you served on for a decade, and that was formed in July 2005.

14-00:12:25

Halvorson: There was a commission before that. There was actually a group before that that was an advisory group to the commonwealth. Most of us moved over to the commission.

14-00:12:32

Meeker: Well, in 2005, this is just a year into George W. Bush's second term, so this is still a few years before healthcare reform really becomes a reality on a national scale. Maybe you could pretend to be an intellectual historian for a few minutes and give me an idea of where some of these ideas were coming from. Is this a natural evolution over a series of years, an accumulation of different ideas, so that when you write *Healthcare Will Not Reform Itself* and you propose a bill, it is an accumulation of many years? Or can you identify specific places where some of these pivotal ideas came to?

14-00:13:29

Halvorson: Well, the whole process goes back to running the vertically integrated care system, and before that, running a network health plan that was capitated. So, I saw care providers who were capitated as groups of providers delivering care in ways that were different from the ways they delivered care when they were paid entirely by the piece. So, I actually saw care change and much for the better, if not all for the better, with the difference in model. I'd been watching that for decades. I've been CEO of one health plan or another for almost thirty-seven years, if you go back to the original Blue Cross health plan time, and different models were different learning experiences for me. Then, putting a health plan in Jamaica, I learned putting health plans in Uganda, I helped a health plan get started in Nigeria. That was a good thing.

I have been experimenting with variations on the model for a long time, and I've had a conviction for many, many years that it's just absurd that we spend more money on healthcare than any country in the world and leave any portion of our population uninsured. We spend way too much money on healthcare to have people be uninsured, and that just makes me a little crazy when you see the damage done to people by being uninsured. That's also clearly bad. So, I've been trying to advocate in various ways to increase the number of people who are insured, and I really believe that the best models of doing that are to get people into the best care. I believe the best care is team care, coordinated care, database care, science-based care.

So, the combination of wanting everyone insured, and wanting everyone to get good care, ends up creating the model that I end up advocating for, which ends up being a choice model where people get to choose between care

systems. If you go back and read my *Huffington Post* pieces that I wrote during the healthcare reform, there's still a few, if you pull up my *Huffington* file ever?

14-00:15:52

Meeker: Yes.

14-00:15:53

Halvorson: Did you look at the healthcare pieces that were in there?

14-00:15:55

Meeker: I've read some of them, not all of them.

14-00:15:57

Halvorson: Read the final two before, but one of them was on risk pools if we didn't get the risk pool party of it right. One of them basically said, "Mother Nature discriminates, practices age discrimination," and it talks about some of those issues, as well. So, I've believed for a long time in universal coverage and packages of care, are sort of the models that I advocate for, point in that direction.

14-00:16:32

Meeker: Can you tell me a bit about your work with the Commonwealth Fund on the Commission for High Performance Health System? Again, this was established as such in July 2005, but you had just mentioned there was a predecessor committee you worked on before this. How did you first get involved there?

14-00:16:52

Halvorson: Well, I first got involved, I don't remember the name of the predecessor committee, but there was an advisory committee on health insurance in America, or something. I was on that committee. Kathleen Sebelius was actually on that committee as the insurance commissioner from her state. She was offering some thoughts on healthcare insurance issues, but the Commonwealth Fund, Harvard had an advisory group at that same time. Anyway, Jerry, a physician at Harvard, had created an advisory group on healthcare reform and he convened the group regularly and he sent out really good information pieces, good thought pieces, on various healthcare reform issues.

So, those of us on his group, we got the advantage of that. Being on the Commonwealth Group, I got to go to their meetings about four times a year, and they had really good speakers. Really smart people who would come in and coach us on various issues. So, I really enjoyed that process, and we developed a number of recommendations. One of the things we developed was the National Healthcare Report Card. That healthcare report card that comes out every year from Commonwealth, that lists all the performance by states on all the various measures of care? Originated with that group—that

was something that we discussed, debated, and agreed to ask Commonwealth to sponsor.

That created a template in the same way we created HEDIS, to be a model for health plans. The Commonwealth Fund was persuaded to do something that was similar, relative to entire geographies, using the best available data. So, that report is often cited when it comes out because it shows performance by state in various areas of public health issues and care issues. Again, what we got to do as a result of being on the commission was work with those issues and think about those kinds of things, with some very smart people who liked doing that work. So, I found the Commonwealth Fund to be a really good use of my time, to go and meet with those people and think about those issues.

14-00:19:36

Meeker:

The reports that were issued by this particular commission were highly influential to people who ended up drafting the legislation. Can you tell me how some of these reports were written? I know that you were listed as author on some of them. What was the process by which these actually came to fruition?

14-00:20:07

Halvorson:

We'd pick a topic. The staff would do lovely research, send us materials about the topic, and then we would go to the meeting room and three or four of the commissioners would be designated as the primary speakers on that topic. They would offer some thoughts, and then the rest of us would discuss and debate. They were actually quite good debates, and it was rare that we had a meeting that I wasn't one of the speakers on one of the topics, one of the designated speakers, because my perspective I had of running a health plan, health system. So, also the fact that I had to prepare to speak on those topics was really good for my own thinking and keeping up process. We had good open discussions on those topics—some of them heated. There were a number of conversations where we had not personally angry, but voices raised. "It would be a criminal event if we did this for the country," type of debate. So, it was very vigorous on some topics in open debate.

14-00:21:32

Meeker:

Can you give any examples of some of those topics that were more heated than others?

14-00:21:38

Halvorson:

Medicare funding, some of the issues of mandates on different kinds of coverage. Some of the debates were political and some of the debates were functional and operational. I was not the only health system person on the group, so we'd sit down with someone from Intermountain or Geisinger offering thoughts, or there were times when we had discussions about what systematic team-based care could look like, where the organizations in the country that were best at doing it were sitting at the table in a safe setting, talking about what worked and what didn't work.

14-00:22:21

Meeker:

Did politics ever come in to these commission meetings? Because these would have obviously been happening at the same time that there were the—

14-00:22:29

Halvorson:

Well, what do you mean by “politics?”

14-00:22:31

Meeker:

I guess I’m thinking this would have happened at the same time that the political primaries happen, and then the general election, and with understanding that whoever was elected President would probably be the most powerful individual on determining the fate of healthcare reform and legislation. So, you know, I imagine in the room there were people of all political stripes—even people on the same side of the aisle, there would have been the Clinton people and there would have been the Obama people, right? Did any of that color the debate or the conversation?

14-00:23:12

Halvorson:

Never, never, never. The things like the Clinton/Obama, not at all. The issues that Clinton/Obama debated, yes, and the mandate, the role of the mandate, whether or not the mandate was important was a topic that was discussed, but it was not discussed in the context of Clinton or Obama. I can’t remember the name of the President was often mentioned, whoever that was, and that was relevant. The fact that we were going to have a new President and we wanted to be prepared with some good information for the new Congress and the new President was important, but there was nothing at those meetings that was political, and no one asked for any political support for anyone. Now, there were people in the room who were political allies, who could easily in the hallway have been saying, “Can you come to a rally in Massachusetts next Monday?” I mean, that might have caught on. But not one piece of it at the meeting. It would have been out of order.

14-00:24:26

Meeker:

In April of 2008—so, this would have been at the height of the primary season, just to date it—there was a World Healthcare Congress meeting. I’ve read this described as one of the most important and most informed discussions on healthcare in a pretty long time. I know that you attended this. I think that maybe you had mentioned somewhere, but I came across this particular meeting. Is this something that you remember as being transformative in any way, in the coalescing around certain ideas that would later make its way into legislation?

14-00:25:10

Halvorson:

I think I spoke at that. It was more coalescing to the point that I was trying to persuade people that systems-based care improvement needed to be part of the agenda, choice needed to be part of the agenda. So, it wasn’t so much transformative for me as an attempt by me to be transformative for other people.

14-00:25:41

Meeker:

Then, you had mentioned that you were at the White House several times, but I've come across a reference to a meeting in May 2009. This was described by Obama, quote, as "a historic day, a watershed event." Do you remember that particular meeting, and maybe why the President would have described it in such extraordinary terms?

14-00:26:09

Halvorson:

What was the date?

14-00:26:11

Meeker:

May 2009? So, the law was passed, I guess, in January 2010, so this would have been several months before that. Why would Obama have described it as "a historic day, a watershed event?"

14-00:26:47

Halvorson:

Well, that particular meeting, we brought the heads of every major healthcare trade association to the White House. So, we had the head of the AMA, the AHA. We had AHIP. We had PHARMA. We had the manufacturers, the healthcare manufacturing people. What we did was we brought the entire industry there as a support group, in saying that we needed to build healthcare reform in this country around making care better, and we could do that and we could use this as an opportunity to make care significantly better, and here's what that would look like. Then, we had each of the groups, PHARMA spoke and said, "We can do these six things to make PHARMA care better." The AMA said, "There's twelve areas that we can do care improvement in back surgery to a number of things, and we could do that."

So, what we did was we had all of these people come to the table to offer to make care better for the country, and basically said, "If you make care better for the country, we can support your bill. If it's not just about insurance issues—if it's about care issues. We had AHIP there. I wasn't chair of AHIP at that time. We had AHIP there and we had SEIU there at the table as well, representing labor. So, we had healthcare and labor workers. I was actually the chair of that group, and so, you know, we had been working for months. A couple of us, Dennis Rivera from SEIU and myself, Jeff Sachs, a couple of us had been convening all of those people in a series of meetings to get everyone to pledge that we could make care better for America. It was like the agenda we did in Minnesota, for MinnesotaCare. It was like what we did in California, for CaliforniaCare.

We brought the relevant parties to the table, and said, "If you do these things, we will go forward." The White House said, "Yes, we'll do these things," so they held a press conference. There's a picture; my wife was at an airport that morning and I was sworn to secrecy, actually, the date of that meeting. The White House had asked us to be totally secret about the fact that we're having that meeting that day. So, I just told her I had to go to Washington to go to an important meeting, and I'd fill her in more, later. She and my son were at an

airport, and the TV screen came on, and there was the President announcing this thing, and the person standing right behind the President was me. She said she was saying to the waiter, “That’s my husband. That’s my husband!” It was a good proposal, and it was a really solid approach. Unfortunately, it wasn’t the one that was used because we made commitments to do some really incredibly important things collectively, to work together, hospitals, PHARMA, and it was really a wonderful agenda. We published it and we all signed it, and I was the only signatory to it that wasn’t the current chair of a trade association. I was the convener of the group. The Congressional Budget Office wouldn’t score any of the gains. They basically said, “These are all speculative. We’re not going to score them. We give you zero credit against the bill for going down this path and doing this work.”

14-00:31:01

Meeker:

So, it just looked like inflation as opposed to savings?

14-00:31:08

Halvorson:

No, they believe it was savings. They just couldn’t score the savings. They actually believed, yeah, if we cut the number of heart attacks in half—but they said, “How do we know if half is the right number? How do we know what the real number will be? How do we actually turn this into a trajectory?” I had worked really hard at many meetings in Washington with the key leaders of all of those trade associations to get that group together and to get them to go to the White House and make this proposal, and have the whole thing be about healthcare reform. I personally feel terrible that I didn’t figure out in advance that the CBO would be the proposal killer there, because if I had known that and realized, I probably would have done a couple pieces and parts of it differently. But it was a really good group. It was the right direction. It was the right time. The President was very positive about it. He was really excited about it, and it was clearly the right thing to do. Then, it fell apart because when they wouldn’t score it, and then they started going after everybody separately on different issues. Then the coalition kind of fell apart. So, I did a coalition in Minnesota that worked, I did one in California that almost worked. I love doing coalitions. Did one in Washington that almost got to where we needed to get.

14-00:32:37

Meeker:

Did this ad-hoc group go under a name?

14-00:32:39

Halvorson:

No.

14-00:32:43

Meeker:

What would you have called it?

14-00:32:46

Halvorson:

It was the health industry. The whole industry. It was the most senior health industry leadership group. We had every major element there, and we had the chair for each element—so we had the guy who ran one of the biggest

pharmaceutical companies in the world, was also the chair of PHARMA. So, we didn't send in the CEOs and staff leaders for of the trade associations. We sent in the chairs of each of these organizations. So, Jay Gellert, at that point in time, was the chair of AHIP. So, Jay was sitting next to me, and I got to come in and sit down on the table, the President sat opposite, and the President looked at me and he said, "Welcome. What are you here to tell me?" I had practiced for days: "Mr. President, we are here to present," and I said, "Hello, Mr. President," and then I couldn't remember my next line. [laughter] I stumbled a bit, and then I finally got back on track, and it was fine. That's one of the few times when I have had a complete mind-blanking.

14-00:33:59

Meeker:

This was your first one-on-one with or face-to-face, I guess, with President Obama?

14-00:34:04

Halvorson:

Yes. I had spent a lot of time with his staff people, but this was the first one with the President.

14-00:34:11

Meeker:

Even though this proposal did not come to fruition as it was articulated, was the, in D.C. terminology, "optics"—

14-00:34:26

Halvorson:

Optics were incredibly important. The optics were extremely important because these had all been "nos". These industry associations had all been "nos." This was actually an historic moment because these had all been people voting no, we're not going to do this, we're not going to do this, we're going to be opposed to it. Or, we're pending our decision. So, before we went into that room and did that, there was not a yes from those trade associations for healthcare reform in this term. So, for the President, that was a really important meeting because all of a sudden, he had yeses, and it was yeses for a different agenda than the one he ended up with.

Then, some of his staff people—Rahm Emanuel—relatively quickly abandoned that agenda and went to something that CBO could score. Some other people were really unhappy because there was a sense that this was a magnificent coalition, and he certainly should have kept it together and not just gone off and abandoned it in favor of a scoreable thing. I think Rahm Emmanuel really, frankly, blew it, and I think that he had the makings of a really solid coalition there that was pointing in the right direction, and he should have figured out how to keep that coalition together and intact and also get the scoring, as opposed to letting the coalition fall apart, and in some cases, forcing it apart.

14-00:36:00

Meeker:

Can you maybe summarize for us what was within that proposal? What were some of the nuts and bolts?

14-00:36:07

Halvorson: It was literally making care better. Team care, process-based care, PHARMA, doing some things relative to chronic conditions in the country, to make chronic condition care more affordable and better. Hospitals agreeing to look at dozens of areas of hospital performance. The things I write about in my books are the kinds of things that were sort of committed to by those organizations at that point in time, and it was a really lovely set of things. I'm still sad that that agenda and that momentum didn't get continued.

14-00:36:49

Meeker: Did much of that agenda make it into what you describe as the 80 percent of "shalls" in the ultimate act?

14-00:36:58

Halvorson: Yes, a number of those pieces ended up in the shalls. Yeah, so they didn't totally disappear—people who were at that table, who believed in those pieces of the proposal, did manage to get many of them into parts of the bill. They just ended up being in there more isolated and not as a package. So, it didn't all disappear, but the commitment, by far, to do some things, to make care systematically better for those patients, isn't in the bill anywhere. That's sad because there was an opportunity there.

14-00:37:48

Meeker: I'd like to talk a little bit about the bill. Actually, let me back up. Did you play any direct role at all in the drafting of the legislation?

14-00:38:07

Halvorson: I helped some.

14-00:38:10

Meeker: Can you describe how that worked out? Maybe thinking about a high school audience, whose understanding of legislation is related to those, you know, "I'm only a bill/I'm only a bill, going to Capitol Hill," kind of, or maybe even high school civics, right? Can you maybe talk about where you plugged in and what kind of contributions you made to the actual drafting of that?

14-00:38:39

Halvorson: Well, it's a bigger issue. I met with the various people who support the Congress.

14-00:38:54

Meeker: Staff members?

14-00:38:55

Halvorson: Staff members, yeah. I met with individuals on the staff. I supplied people with writings, materials, information, feedback on various points. I also spent time in rooms with members of Congress and people who were their health aides. I spent time with the Senate Finance Committee Republican support staff, the Senate Finance Committee Democrat support staff, in closed rooms, talking. Not closed in the sense of secret, but in private conversations, where

I'd say, "Here's the key issues, here's the things you need to understand." Because I've done what I've done for so long, I'm sometimes able to explain things in simple terms, that are very useful to people who aren't practitioners in those areas. So, I'm able to help them think through some of the issues. There were a couple of senators I met with who were fairly senior senators, and I definitely worked with members of their staff at a very direct level. I also worked with people from the White House, who were involved in some of the drafting and some of the thinking.

Also, we provided, one of the things that we did that was really important was we provided some really, really smart people from Kaiser Permanente who know systems better than anybody on the planet, or know care improvement better than anyone on the planet, to the process. So, if they needed to tap into somebody who really, really knew hospital safety or hospital safety systems, they could say, "You know what? We really need somebody today who we can trust, who can tell us what's true about this and what's important about this."

So, we parachuted people in who were trusted advisors, and we told the people we parachuted in, "Always give the best advice for the country. Don't worry about KP. If they ask you a question about something, give the best advice for the country; KP will do fine. If the country does the right thing, we'll do great, but don't think about, as you're sitting there, answering that question, how do we spin this in some KP way?" I said, "Don't ever, ever worry about that." That's really empowering for people. People love that because they really like going in and being able to give best advice for the country, and because of that, there was a high trust level. So, there were pieces of language that I think were influenced by that candor and that insight and that expertise.

14-00:41:47

Meeker:

So, when you look at the completed legislation, are there any particular portions of it that you can look at and say, "Gee, I think I had a real hand in that getting into the bill and it being articulated in that particular kind of way?"

14-00:42:10

Halvorson:

[Take a look at the *Health Care Will Not Reform Itself* book. Ideas in that book are in the bill.] There were different parts of the bill where, for example, I had a chance to meet with people like Harry Reid and talk about some issues relevant to the bill—I met with a number of leaders—often with a couple of very senior labor leaders who ran national labor unions. We had a chance to sit down to discuss some key issues. I actually did a national rally on the White House lawn, standing next to Senator Reid. That was kind of fun. I did sit down with him and some other key leaders coach them on some things, but other people were coaching those people on the same things. So, if the language ended up a particular way, I can't say there was anything that if I

wouldn't have been there, that particular thing wouldn't be there. But there were a number of things that I suspect that I helped steer, a little. So, that's good.

14-00:43:13

Meeker: Are there any in particular that you'd like to document?

14-00:43:15

Halvorson: No. Look at the books—basically, I argued in favor of exchanges, we really need exchanges, and I argued for data-rich exchanges. Kind of an Orbitz for health sort of exchange model. I argued for universal coverage. I argued for health plans being chosen. I argued strongly for hospital safety being part of the agenda. I argued for team care being supported in the process. I argued for meaningful use being a requirement for use of electronic medical records, so people need to use it in a meaningful way. So, a lot of the things that are there, I was at least one of the advocates for. Some people thought that I was useful.

14-00:44:09

Meeker: What are your thoughts on the legislation and how it will successfully or perhaps not successfully control inflation in the healthcare sector?

14-00:44:23

Halvorson: Before you get to that, one of my regrets was that the Senate passed a version of the bill, and the House was working on a version of the bill, and there were significant differences. There were a number of areas where the House version of the bill was better than the Senate version, and there were a number of areas where the Senate version was better than the House version. Some of that was intentional because some of the things had to be put into the Senate bill to get it passed in the Senate, and so the goal was to get the whole thing to conference committee, and then have the conference committee able to take the best parts of both bills and turn that into a single, final bill.

So, there was significant advising going on relative to pieces of the House bill that proved to be completely irrelevant and moot because once the Senate race, once the Kennedy seat was no longer a Democrat, the sixty-vote majority went away. When the sixty-vote majority went away, the only bill Congress could pass at that point was the exact Senate bill, intact. An example of that was the mandates in the accountable care organization part of the bill, which is a really important part of the bill because we really need the ACOs. We really need ACOs to function in this country. We need to have ACO-equivalent organizations, so they need to work well. The House version of the ACO bill was more robust and was more practicality-based, and the Senate version was kind of rudimentary.

The Senate version had an idiosyncratic rule that no one could be told that they were in an ACO. That was because one senator needed that for that senator's vote, knowing that it was going to go away in conference committee, but had some political issue back home that needed that to be in the bill. So,

that piece of language was written into the bill not because it was the right thing for the bill, but because it was needed to get that one vote and make that one supportive senator happy with somebody back home. So, that was written into the bill, and then all of a sudden, the Kennedy seat is gone and the only way the bill could be passed is with that provision in it. So, the law actually says you can't tell anyone that they're in an ACO. Now, they've gotten around that because there's a pilot, what they're able to do is create pilot ACOs and have the pilot ACOs have different sets of rules. That's the kind of thing that happened. The bill would have been a better bill if we could have gone through the conference process, and gotten the best insight on a number of other points. So, that is unfortunate.

14-00:47:38

Meeker:

Is cost controls one of those issues?

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Halvorson:

Well, some additional ways of looking. The ACO part in particular, the whole issue of how do you deal with medical homes, accountable care organizations, and then how do you get people to be supported by team care in a way that will actually bring down the cost of care and improve the quality of care? The Senate version of that was pretty lean. It would have been much better to have a more robust version of that.

14-00:48:11

Meeker:

I know that you've been critical that cost-cutting didn't go far enough in this. Are there any other examples of ways in which, in the legislative process, some of those controls were not written into the legislation in a way in which you wished they had been?

14-00:48:31

Halvorson:

Well, we need to have the cash flow. In my most recent book, it's called *Do Not Let Healthcare Bankrupt America* (2013), I write about the fact, in that book, that we need to go upstream in the cash flow for care and change the flow. When you go upstream in the flow of cash, there's only four parties. There's individual people who can make almost no relevant changes to the cash flow of care, and you've got employers, who can make some but not a lot because the employers don't have enough critical mass in any given geography to quickly make any major difference. Employers can have a huge impact through their health plans. Then, you have health plans, who have large leverage, some flexibility, and the opportunity to make a number of changes. Then, you've got the government, who basically is half of the cash flow of healthcare, who could make some significant changes. And so what I argue in that book is that both the government and the health plans need to step up and make some changes in the way cash flows, and they both should buy care by the package and not by the piece.

When you buy it by the package, then you can reengineer care and you can make care better in systematic ways. When you sell it by the piece, you can't

reengineer care because every time they reengineer care, you lose a piece, and you lose a bill, a billable event. So, the direction we need to go as a country is to have care purchased by the package, and we would be better off if the affordable care act did that more effectively than it does. But it's not too late; we can still fix Medicare and we can still fix Medicaid, and change the way we buy care in this country. When we do that, we're going to get better care and it's going to cost less. If we don't do that, then we're going to continue to have really expensive care that is not optimal for many people.

14-00:50:37

Meeker:

But we'll probably need a whole new political leadership in order to make this.

14-00:50:41

Halvorson:

Well, the political environment in Washington right now is really non-productive. I mean, it's almost impossible for anyone to suggest anything because every suggestion is politicized. Either party makes any suggestion, then it immediately goes into politicized mode. Politicized mode means it's frozen, and you can't make much progress when everything's frozen. So, we need to get past this somehow, but I don't know how we're going to get past it. Having said that, some of these things can be done by Medicare changing the way they purchase now and being smarter, and I think some of the Medicare solution sets could be aimed at creating equivalent of accountable care plans. The Medicare Advantage part of that agenda needs to be strongly supported by Medicare because the long-term game has to be to get everyone into something like Medicare Advantage.

14-00:51:46

Meeker:

Which is the capitated portion.

14-00:51:48

Halvorson:

Which is the capitated version of Medicare. Because once you get people in Medicare Advantage, you can control the overall amount by controlling the capitation. So, the best model for the country would be to have just about everybody in that model, and then have the control from the back end. I'm actually not current for the last number of months on what's happening with that approach, but my sense is that's not what they're doing now, that they're not moving in the direction of making that the more robust part of that agenda.

14-00:52:26

Meeker:

Did you have a public position on the public option? I know that it was supported by Rivera, of the SEIU, not supported by Karen Ignagni of AHIP, both people with whom you were closely aligned. Did you have an opinion on the public option?

14-00:52:49

Halvorson:

Well, I actually wrote about that in a couple of books. I wrote about the public option, basically, I said if we go to the Medicare, if we use Medicare to administer all healthcare for the country, which is what the public option, then

the reason that that scores with a lower number is because they used the Medicare fee schedule. That's the only reason it scores lower. Medicare actually doesn't exist. There is no Medicare infrastructure. Medicare is entirely run by Blue Cross plans.

14-00:53:25

Meeker:

It's not like a VA system.

14-00:53:26

Halvorson:

It's not like a VA system—there is no Medicare infrastructure. There's not one single government employee who gets a Medicare paycheck who actually personally pays a Medicare claim. Medicare is completely outsourced now, so the public option would have just outsourced it all to a Blue Cross plan. If they would have used it, done what they were talking about, they would have let Blue Cross plans, who were outsourcers for Medicare, use that fee schedule with everybody in the market. That actually would have brought down the cost of care, but it would have been a very dysfunctional market model, and you didn't need to go there to get that advantage.

14-00:54:06

Meeker:

Did you happen to follow something that was reported quite a bit in the media—and it wasn't just the media, it was more the healthcare media, I think—there's these annual rankings of the most influential people in healthcare. It's interesting because you jump in this list from seventy-eight, in 2008, to twelve on the list. That's pretty high because I think the first three people were the President, Sebelius, and—

14-00:54:40

Halvorson:

I thought I was six in the last one. But who notices?

14-00:54:42

Meeker:

You might have been six on the last one, right. What was your personal response to this? Did you think that these listings are real world useful tools that you could perhaps leverage, or are they kind of like Golden Globe awards, that nobody really pays attention to?

14-00:55:18

Halvorson:

There's not a lot of direct leverage that comes from that listing. I can't imagine—I think I was number six last year—a group that I could go into where they would necessarily change the outcome of the process by saying that. On the other hand, it's kind of fun when people introduce me, to have that be part of the introduction. What I find it useful for, though, is I read the list every year, and I've actually been on it every year since it was formed, but I read the list and I check to see what other people's ratings are, and also, how many of them I know. What percentage of people do I know on this list? Then, to some degree, since I know them, how do I think of them relative to that ranking? So, that's part of the personal part of it. Usually, I know a high percentage of the people on the list. I usually have a relationship with most of them. Two years ago, I pulled up my iPhone when that list came out, and I

had eleven of the top twelve in my one-to-one email list. The one I didn't have was President Obama. I do have his scheduler, but I didn't have the President directly. I had everyone else on that list, I had on my email list. So it was kind of fun.

14-00:57:07

Meeker:

Just an observation, interested, when I was looking at it over a series of years, how much it actually changed, how much it actually changes. You look at rankings, for instance, of history departments in the United States, and it's been the same for the last forty years, right, the top five, they don't really change. But this list changes quite regularly. Why do you suppose that is?

14-00:57:34

Halvorson:

Well, different topics. When healthcare IT is really important, then healthcare IT people—Bill Gates went to the top of the list a couple of years ago when we were just starting looking at EMRs. I don't even know if he's on the list this last year, but he was at the top for a while. When we're looking at healthcare quality, Berwick was at the top of the list. Whatever the current fad is, if you will, whatever the current area of interest is, tends to have more people from that area of the industry reflect on the list that year. So, you can really get a sense when the issue was who's in Washington doing lobbying, the year that I was on it at twelve, everybody above me was a government official. So, that particular year was obviously a government year, but there are other years when the top of the list is totally industry. So, there is a migration from here to here.

Every once in a while, it looks like somebody did a campaign. Every once in a while, somebody will show up from a small hospital in Central Mississippi or something, in the top fifty, and will disappear in the next year. I have to suspect that either—but again, I don't know. That person could have done something so impressive in Mississippi that everybody in that state just had to vote for him or her that year on that. I don't know how many votes it takes to get in the top numbers, so every once in a while, there's one of those really odd names and I look at it and say, "How did that get there?" But most of the time, they're people who are active people who are part of the process, who are showing up for meetings, and giving their speeches and writing their books.

Audio File 15

15-00:00:11

Meeker:

This is Meeker interviewing Halvorson on March 13, 2014. This is tape fifteen, now. I actually just have one question left about healthcare reform, and that is, what can you tell me about Kaiser's preparation for the implementation of the Affordable Care Act? What were some of the biggest, or what have been some of the biggest opportunities as well as challenges, as people begin to sign up?

15-00:00:46

Halvorson: Took a huge amount of work to be ready for the bill. There were many changes in the insurance laws, there were changes in product lines, some reporting changes. We had to have a team of a couple hundred people working nonstop to be ready for the implementation. So, a lot of work, a lot of effort, some expense, so it was a real challenge. We had some really good people doing really good work, collaboratively, but it was a lot of work.

15-00:01:17

Meeker: So, I imagine you would have had policy people, you would have had probably physicians.

15-00:01:22

Halvorson: Operational people, data. We had different information flows, different benefit packages, different billing processes, and to be ready in every state for the exchanges and change the individual products in each of the states. About 10 percent of our members are in individual markets that spread through all states. So, we had to do changes everywhere.

15-00:01:50

Meeker: And opportunities?

15-00:01:52

Halvorson: There should be opportunities. It all depends on how well the whole process works out, but if it does work out well, KP should do well.

15-00:02:01

Meeker: What does that mean?

15-00:02:03

Halvorson: If there are serious numbers of people enrolled, KP should get its fair share of that enrollment. KP should do well in those exchanges.

15-00:02:13

Meeker: Are there any competitive challenges that you see as a result of this act?

15-00:02:20

Halvorson: Well, one of the things that the bill creates the opportunity for is new competitors to spring up in markets. We saw a little bit of that in Sacramento. There are some new players who are coming to that part of the market as new players, to enroll those people, and that's probably good for the market overall. It's not particularly threatening to KP. The new players don't have any kind of a price base or a price history, so the prices that they put into the market initially are peer inventions. There's no track record that justifies those prices, and since their invention, some of them are quite low. Time will basically prove or disprove the validity of those prices, and what I think we'll see will be a lot of those prices will go up significantly. But we'll see. In terms of threat to KP, I think those people add interest to the market, but I don't think they create a threat.

15-00:3:34

Meeker:

So, you think that looking 10 years in the future, down the road, that there's probably not going to be a substantial change to the way in which Kaiser Permanente does business as a result of the Affordable Care Act?

15-00:03:50

Halvorson:

Well, there could be. We don't know. If the exchanges do incredibly well—and right now, they're limping along a little bit—a couple of years from now, and if larger portions of the market become exchange-eligible, then the exchange part of the market could be the most important part of the market, or the fastest-growing part of the market. KP in that setting will need to be a really good competitor in that market. There's no reason to fear that KP should not be a good competitor. If it's a reasonable market and if the market is based on delivering the right product, the right quality, right price, I think KP should do well.

15-00:04:42

Meeker:

What do you think KP needs to do in order to be a strong competitor within the exchange market?

15-00:04:48

Halvorson:

Do a good job delivering care and have a good price. I think KP has an incredible opportunity, going forward, to win on product because KP can do more electronic connectivity than anyone because KP has all of the information about all of the patients all the time, and can deliver care electronically, can do e-visits at a level nobody else can do. Right now, 40 percent of the dermatology visits in Northern California are done electronically.

15-00:05:19

Meeker:

Through photographs?

15-00:05:21

Halvorson:

Through live viewing of the issue. So, the ability to do that kind of care and to do it in the context of a team, with the primary care doctor and a specialist working together with a patient, is hard to recreate in other, more splintered settings. So, KP should win in the connectivity market, and KP is investing a lot of money and expertise in being really good at delivering that care.

15-00:05:58

Meeker:

That's actually a really good segue to talk about KP HealthConnect. In previous sessions, we talked about the selection of Epic and the initial investment, and what you hoped to get out of the system. Let's fast-forward to the point in time that the rollout begins. Can you tell me a little bit about the rollout, how you think it went?

15-00:06:26

Halvorson:

I think the rollout went really well. As I said, I actually did an electronic medical record in Minnesota. Many years ago, we built our own patient profile system, electronic medical record, and I was involved in making the

investment and even doing a little bit of the initial design of that system, and then we rolled out. We bought a commercial system in Minnesota and replaced our homegrown system with a commercial system. We did a rollout of that system, and it worked really well. When I got to KP and discovered that KP was building a homegrown system, I went to Hawaii on my first day on the job, and looked at that system. So, the very first day that I was on the KP payroll, I was actually in Hawaii, in one of our clinics, looking at the electronic medical record that we were building. I looked at the screens, looked at the process, because I had done two before and I knew what they looked like and what they're supposed to do. So, I looked to see if this one could do those things, and whether or not it was the right system. I discovered that there were several glaring deficiencies in that system.

15-00:07:48

Meeker:

Do you remember what some of those were?

15-00:07:49

Halvorson:

Yeah, a huge, glaring deficiency was it couldn't generate a bill. Literally could not generate a bill. It was set up to be isolated and not be able to produce a bill. So, I said, "Show me the billing part of the system," and they said, "It doesn't exist," and I said, "When will it exist?" and they said, "Never." I said, "Never?" They said, "No. If we need a bill, we will print out a hard copy of that patient encounter, we'll give it to a biller, and the biller will then code it and turn it into a bill, and then we'll have a billing system. I said, "That's got to be the least effective way of using electronic data I've ever heard of, is that really the design?" They said, "Yes, that's the design. We have chosen that design and it's part of our structure." So, I flew back to California from Hawaii and I said, "Explain that to me. Why are we going to have a medical record that's electronic and then not be able to do an electronic bill?" They said, "Because we think that such a small portion of our business in the future is going to require a bill that we didn't need to develop that capability."

I said, "No, we're going to have many customers, millions of customers, that are going to have new product lines with cost sharing in them, and we're going to have to develop a bill for every one of those millions of customers. So, a system that can't generate a bill is not functional." So, what I did at that point was I said, "We're going to go out and shop, and we're going to look at every medical record in the country, and we will include in our current system. We're going to develop specifications, and our current system can bid. The current system we're developing, can be a bidder against that process. So, it's not an automatic no, but it's not automatic yes. But it's going to have to be able to bill to win because we're not going to put together a system that is an electronic system that does paper billing. There are very few things in my life when I've been completely and totally surprised by our development, and that was one. Actually, I would have bet any amount of money that that was not the design of that system. But I went to Hawaii, and I

did it somewhat symbolically, to make the point that the single most important thing we're doing right now is getting this medical record right, and so, the first thing I'm going to do as the new CEO is go to Hawaii, go to our care site, go to our hospital, and look at whether or not that system can do what it needs to do to be our future.

I came back, realizing that it couldn't, and so, then I started a process of going through the selection to figure out which medical record we wanted. Since I had been very directly involved in a couple before, it wasn't starting in a hole. I had already done this. I think there were very few people in the country that had rolled out two medical records at that point in the history of healthcare, but I had the advantage of having that background. So, we put together the specifications and we went through the process, and we allowed everyone who was in the market at that point to bid. We had a dozen initial bidders, took it down to six, took it down to two, went through the process. We ended up picking the system that we picked, and I did part of the specifications for that because I had done that before and knew how to do electronic medical record systems and specifications.

So, we then picked Epic to be our vendor. What I said to the company at that time and what I said to the board is, the goal isn't just to put in an EMR. That's just a subset of the goal. The real goal is to be paperless, to have everything inside KP paperless. That's the macro goal. That's the gold standard. That's the ultimate goal. This is the IT vision. We're going to be a paperless system, we're going to have no paper anywhere inside KP, no paper in our hospitals, no paper in our labs. We're going to have completely electronic, and we're going to have every single thing connected to every single other thing as our systems endgame. So, when somebody has a lab test, the lab test flows right to the medical record, they go right to the doctor, go right to the patient, and it does all of that electronically. You don't have to print anything out and you don't have to input things from one system into another, the systems connect.

So, I started with that design, and that was actually a design that I picked up from Uganda because in Minnesota, we'd done the electronic health record, and we'd done that relatively well, both the one we developed ourselves and the one we were using. In Minnesota, we were relatively paperless, but when I went to Uganda and started health plans in Uganda, and realized that we had to administer those plans for 10 percent of the total premium, and the total premium was a dollar a month. We had to figure out how to administer for a dime. So, when you're figuring out how to administer for a dime, you have to be very elegant. You have to have a really simple system, and you have to have everything resembling paper disappear. You can't have a bill, you can't have a paper file, you can't have—

15-00:13:15

Halvorson:

—anything. Can't have postage. You literally can't have postage. The only thing we had resembling paper was we produced one photograph of each family each year, and I actually took many of those photographs. You'd get the families together, shoot the photograph, family photograph. Then, we put that on a laminated basically six by eight piece of film, and all of the family information and the benefit packages on the back, and the family photos on the front. The families use that, then, as an ID when they went to the clinic or the hospital. That was just a few cents. We could do that for almost nothing because you could get the lamination for nothing, and taking the photograph was pretty cheap. So, that was our system.

So, I came back, but I said, "Health Partners is really proud that we're running on 10 percent administrative cost, but 10 percent of administrative cost is \$10 a month, and these guys were doing it now for a dime." So, what do we need to do? So, at Health Partners, we started the process of thinking, "How do we go entirely electronic?" So, when I got to KP, I already had that background, and I knew and I told the board. The board didn't understand that for a couple of years. I kept saying it, but it doesn't register. People don't believe that you're going to be paperless. People do now, but in those days, paper dominated everything. But I said, "We're going to design all of these pieces," and as we put the medical record in and we spent \$4 billion on doing that, part of that \$4 billion was to connect it to everything.

So, it wasn't just we put \$4 billion in a standalone EMR. It was \$4 billion and included that EMR, the lab system fed the EMR, and the radiology system fed the EMR, and the pharmacy fed the EMR. So, we put together a completely integrated process, and that was totally deliberate and basically part of the systems vision that we did, and it worked. Right now, KP has a completely, totally paperless system. It's the most paperless health system. HIMS has 5,000 hospitals that they rate, and they rated fifty of them as being the most paperless hospitals in America, and thirty-seven of them were the KP hospitals.

15-00:15:41

Meeker:

HIMS is?

15-00:15:45

Halvorson:

HIMS is Health Information Management Society. Their annual meeting is huge. They have about 20,000 people show up for it. HIMS is a very credible organization, and they have an annual rating of the most paperless systems. We won the system of the year award a couple of years ago, but we win a key recognition every year. We win the most paperless hospitals. At one point, when they had a dozen of them, we were ten of a dozen. All of the KP hospitals are now paperless. So, relative to the electronic medical record, it wasn't just an electronic medical record. It was an electronic medical record as an electronic input to the entire rest of this care system that has evolved to include care prompts. Then, we set up linkages for the members to the system,

so members can do e-scheduling. Members can get their lab results, 20 million members a year get lab results electronically. So, we set the whole system up for the members to be as electronic as possible as well.

15-00:16:50

Meeker: So, to clarify, HealthConnect is the electronic medical record component of this larger paperless system?

15-00:16:56

Halvorson: Yeah, larger total KP system.

15-00:17:00

Meeker: Do you recall the first time that you interacted with or were shown a fully functioning KP HealthConnect portal?

15-00:17:11

Halvorson: Well, I'd seen it before I got to KP. I'd been using electronic medical records in Minnesota. I actually knew the PPS system portals, and I knew the Epic portals. So, when I got to Hawaii and I looked at what those portals were, I realized that they weren't bad, but they were not particularly good, either. So, it wasn't like suddenly I saw a medical record for the first time. I designed medical records, implemented medical records, so when I saw one at KP, it wasn't like an aha experience.

15-00:17:56

Meeker: So, I guess the rollout started in sort of 2007-2008 period, roughly? I know it has happened sequentially over a long period of time, but from what I understand now, the rollout is more or less complete. How have you seen that rollout impact Kaiser Permanente as an organization, and maybe what you see as the most important transition, transformation?

15-00:18:36

Halvorson: That system supports care delivery at multiple levels. It supports research. We're doing the best research in the country right now. I think there are 1,200 or 1,300 medical journal articles published in the last year by KP, many of them based on that system. Care delivery itself is better. When you look at HEDIS, the health quality scores, I think KP had twenty-nine scores last year between Medicare and commercial, twenty-nine scores, where the number one score in the country was KP. Before we put the system in place, we had almost no first place scores. We tended to score down in the middle of the HEDIS. Our consumer reports scores were in the middle of the ratings, and variation, the last couple of years we've been number one in *Consumer Reports*. We are ranked as having the best service, best outcomes, and highest ratings of any major plan in the country by a long shot. We won JD Power's for best service in each of the markets that we're in. Again, that was system-supported. We couldn't have done that without the system.

So, we won JD Power. We won Satmetrix. Medicare rated all of the health plans in the country. The 550 health plans, Medicare rated, and they rated

them based on fifty-five measures of quality of service. They took the fifty-five measures and they rated plans from one star to five stars, and only eleven plans in the country got five stars. Eight of them were KP, and the ninth was my old Minnesota plan. So, I actually ended up with, out of eleven, almost a clean sweep. So, I know the systems work, the systems work really well. They improve performance. They improve outcomes. They bring cost down. They deliver better care. They do great research. We get payback in terms of if you count the full \$4 billion and you go back and look at what it would cost us to run the health system if we didn't have these systems in place, it's at least \$2 billion a year's savings. The system pays for itself, basically, every two years.

The other thing that's true is without that billing system, we couldn't have done the new products. We had to have some cost-sharing products for the part of the market that needed cost sharing. We couldn't have done them with the old system at all, and so we had to put new systems in place to do that. Right now, a million and a half KP members have cost-sharing. So that's a million and a half system dependent members. Instead of having nine million members, KP would have seven and a half million members right now. That would put KP in both financial trouble and operational trouble. KP would be very rocky without those members because KP is a very volume-based organization, and the financial reality depends on volume.

We own clinics, we own hospitals, and so you have to have volume to fill the clinics and the hospitals, and losing a million and a half fewer members wouldn't be good. Those members wouldn't be there if we didn't have those products, and those products wouldn't be there if we didn't have those systems. That was another problem that the state regulators initially wouldn't let us do those products, so I personally had to go to Sacramento and meet with the regulators and personally persuade them that it was legitimate for us to be able to do a cost-sharing product, and to persuade them that if we didn't have one, we were going to be in big trouble, and they were going to end up regulating a dying organization.

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Meeker:

What was their objection?

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Halvorson:

It wasn't what they expected from that. KP is always full benefits, we don't expect you to do a \$500 deductible, so we're not going to allow you to do a \$500 deductible. One of the things that I had to commit to, to get them to do that, was that we would track, we'd take the people with the \$500 deductibles and we would track their care outcomes over a couple of years, and show that we weren't somehow, with those people, ending up with much worse care. So, we had to do some reports back to the state to show them against that population. That was part of the deal. I had to sit down and negotiate a deal with them to get us to allow them to do that. So, it basically did that, but they

were not letting those products be approved until I sat down and did the direct negotiation.

15-00:23:29

Meeker: Is there anything more you'd like to add about KP HealthConnect or the broader movement to go to a paperless system?

15-00:23:36

Halvorson: This tees up the ability for KP to succeed in the future because it will now allow for direct connectivity at the individual level with patients. So, the ability to do e-visits, e-follow-up, e-tracking, e-interaction, is all contingent upon having that database. KP should have that database in a more robust way than anyone else in healthcare now because it's both a member system and a patient system. Everybody else who just has patients only has part of the data, and everybody else who just has insurance only has part of the data. If you have both, which we do, then you have a more robust set of data. If you basically enable access to that data by computerizing it, then it gives you a huge advantage. So, KP has a massive logistical advantage going forward because we did that work and we did it in that way.

15-00:24:33

Meeker: Have you tracked an uptick in the number of non-urban members for KP?

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Halvorson: No.

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Meeker: Haven't tracked it?

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Halvorson: Haven't tracked it.

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Meeker: I wonder if that will be something next on the horizon.

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Halvorson: Could be, that's an opportunity.

15-00:24:52

Meeker: Let's talk a little bit about diversity and cultural competency, and the way in which this was a key issue for you during your term as CEO. I know that we've already talked about it to a certain extent. I'm actually, to be honest, not entirely sure how I should cut into this particular area because there are so many issues here. Those issues include diversity and employment across the spectrum, so everyone from people who are working at the Ordway Building [Kaiser corporate headquarters in Oakland] to front-line healthcare workers, to interpretation and translation services, to cultural competency of training of healthcare workers, dealing with people from a whole wide variety of their cultural backgrounds, to dealing with issues such as disparities. Maybe we should start with disparities because I know you wrote a recent book on

healthcare disparities. When you arrived at KP in 2002, did you get a sense that disparities, particularly around race and ethnicity within KP, were similar to the disparities you'd find in the United States overall?

15-00:26:21

Halvorson:

I think I might go back and approach that whole topic from a slightly different perspective, but my sense on the disparities is that we would find some disparities at KP, and I did not expect them to be the same as the rest of the country faced. The reason for that is because KP has one benefit package, one set of care providers, one set of care protocols. So, even though we had quite a bit of diversity, I believed there would be disparity. I believed that because I'd seen it before. In Minnesota, we used to track our diabetic care by race and ethnicity, and saw some significant differences. So, when I got to KP, one of the things that I insisted on was that the medical record include race and diversity information, ethnicity. So, we did. We added 100 and some categories of races, and we do some summary work with that, and we put that in to the medical record.

A couple of people inside Kaiser Permanente—Ron Copeland, who's our current diversity leader, was just extremely important to that agenda. Dr. Copeland was a medical director in Ohio. He was also chair of the diversity committee, and he was my partner in getting that information there. Bernard Tyson was also a key co-leader. So the three of us basically were kind of the trio that made sure that that information was there. It turned out to be vitally important because the Institute of Medicine did a really powerful study back in 2003 that showed the disparities in the country, and they were huge. They were really ugly, nasty disparities. Really bad care being delivered based on race and ethnicity in a prejudicial way. So, they recommended, they said, "If we're going to fix this, what we need to do to fix it is we have to have data, we have to have science, we have to have best practices, we have to track how care is going for various groups."

They actually identified a series of really important steps that they believed were needed for the entire country to fix that issue. We did that. We actually did those exact steps, and we could do them because we had the electronic medical record and the database. So, we actually took the steps that were identified in the IOM [Institute of Medicine] study, and we incorporated them into our care models. So, we tracked care by race and ethnicity. We identified care protocols. We identified best practices. We identified appropriate interactions. Something like HIV, we have the best HIV death rates in the country, and we are the only place where HIV death rates are the same for black and white. Everybody else has significantly higher, including the VA, significantly higher death rates for black patients. We have all the data, and what we did was we did individual coaching, we did individual follow-up. We targeted that disparity and we changed care relative to that disparity. We actually had an impact.

So, we not only have the lowest death rate on everybody; we also have the same low death rate for African American patients. We couldn't have done that without the data. Couldn't have done that without the systems. We couldn't have done that without the focus. We couldn't have done that without continuous improvement potential. So, when I got to KP, I was already working on issues of race and disparity, again, in Minnesota. I had done some work with the American Indians, had done some work with some Hmong population in town, was on the board of the community clinics in Saint Paul, and I was working on a number of issues. When I got to KP, I knew that we needed to be really good at all those issues, and all the royalties from my books, by the way, go to the community clinics of Oakland.

I met with the people from the clinics when I first got here, said, "I'm going to be writing some books. Would you guys like the royalties?" They said yes, and so I've been doing that ever since. Those clinics are doing a magnificent job of taking care of a highly diverse population. I knew that when I got to KP. So, when I got to KP, as an organization, we were 49 percent minority, and our senior officers were fairly white, and we had a relatively Caucasian leadership group. Not entirely, but fairly heavily. One of my beliefs for a long time has been that if you have a diverse leadership group, you're more likely to have a highly competent, diverse group that does a really good job.

So, what I said, I wrote a letter to all of our employees in our first couple of months on the job, and said that I believe that diversity should be one of our greatest strengths, and I totally believe and support diversity. We're going to be a diverse organization going forward, and we're going to look at issues like disparities, and this is going to be a major part of our agenda. We were basically half minority at that point, and the day I left, we were 59 percent minority in our employee count. When you look at our officers, we had eight presidents when I left, two of them were white males. When you look at our CFO is a woman, Bernard Tyson, who succeeds me as CEO, is African American. We have three group presidents, one's African American, one's a white woman, and one's Chinese American. So, we have a very diverse senior leadership group.

The point of this is KP functions as a meritocracy. So if you look up the chain of command from anywhere, you will see someone who looks like you. One of the things, when I talked to CEOs of major companies, one of the things I tell them is when they're telling me that they are committed to diversity, I say, "If you were to join a new company today, if you personally come in as a middle manager at a new company, and if you were to pull the annual report and you see the C-suite of the annual report—the CFO, the CMO, the CEO, the COO—and if every single one of those people was a black woman, how would you feel about your likelihood of getting ahead in that company?" They usually say, "Is that what it looks like?" I said, "Yeah, that's what it looks like. Look at your annual report. Imagine what you would feel if you looked

in a new company and saw every single person was a black woman. How would you feel about personally getting ahead?"

So, at KP, if you look up the chain of command, you don't see all of anything. It is incredibly diverse at the senior level. It's a meritocracy, and these are really competent people. The group presidents, all three of them, are just incredibly competent people, and everybody knows they're incredibly competent people. So, that sends a message, and one of the other reasons why we have the ability to perform at such a high level is because of that. When you look at our growth as a system, the majority of our growth, since I've been at KP, has been in minority members. So, the majority of KP growth has been in our minority population. Northern California, we've had a really strong growth in the Asian American population. If you look at KP, we've got a high level of Asian American nurses, we've got a high level of Asian American physicians.

When you look at our membership growth, Asian American is a major part of our growth, so it's an asset to us. Our diversity makes us more creative. It makes us more responsive to the patients, and because we come together as the people of Kaiser Permanente, because we come together as people who are unified by the belief system of Kaiser Permanente, that basically causes people to interact in a team way and to meet the needs of all the patients in a positive way. So we don't have anyone coming into the system who feels like they're being excluded or somehow being treated differently in a negative way because of who they are. That has been important to me as an agenda. It's been important to me as a strategy. It's been important to me as part of the culture, to get that right.

It's been very useful to be able to point out that when we did track the care outcomes by race and ethnicity. We discovered that we actually did have differences inside KP, so on something like asthma care, there was a significant difference. For diabetic care, significant difference. What we did was we narrowed the gaps by focusing on what was causing the gaps. The way we gathered the data, because it's a medical record, I could actually tell you what the difference was by race and ethnicity on diabetic care by each care site. Difference between Sacramento and Honolulu, and the difference between Honolulu and San Diego. We basically separated that data by relevant care site, and then tracked performance against that, and saw differences. The Hawaii performance was significantly difference than the Colorado performance, based on different ethnic groups, which part of the continuum each group was on. Which makes sense because some of the issues are local and cultural.

15-00:36:29

Meeker:

From the vantage point of 2013-2014, are there any horizons that you see that Kaiser still needs to cross in relation to issues around diversity, in particular?

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Halvorson:

Diversity. I think KP's doing really well. I think KP's doing really well. I think it's hard to be more diverse than KP, and I think there's some really good things going on. I think some of the language things continue to be a challenge, but that's just a logistical challenge. That's not an operational challenge. In terms of care delivery, inside KP, there's an annual disparities summit, and all of that data is looked at by really smart doctors and caregivers who are trying to figure out. If we've taken a gap from twelve points down to three, what do we do about the three? I'm very comfortable with the direction that KP's on.

15-00:37:36

Meeker:

I'd like to actually talk about a couple of challenges, opportunities, and these are sort of discrete items during your period as CEO. One of them that I believe you've referred to once or twice during the course of the interview, but I want to ask you about it directly, and that is the heart attack that you experienced. This was 2006, somewhere about there. Obviously, it happened, and how did you respond to it? It's not an easy thing to overcome, and you need to put your health first and foremost, obviously, above your work. So, how did it impact your tenure as CEO, looking back on it now?

15-00:38:35

Halvorson:

Well, I was completely surprised, although my grandfather had had a heart attack, maternal grandfather, had a heart attack at 59 and died, and my father had a heart attack at 59 and died. I was a couple of months into being 59, and I had a fairly serious heart attack. So, there was a pattern to it that was interesting. I actually had the heart attack in Minnesota, and I was back for Easter. I was going to go spend Easter with my mother in Northern Minnesota, and I was feeling so low, actually, that I just decided to stay in the Twin Cities. I had actually commuted for about five years because when I unexpectedly got a divorce, I got weekend custody of the kids. So I actually went back every weekend. So, I was in Minnesota a lot anyway. This was actually Easter weekend, and I was back to go up north to Easter Sunday with my mother.

I had the heart attack, and one of the last things that I had done in Minnesota before leaving was Health Partners had a hospital, a major tertiary hospital in downtown Saint Paul, and we had just completely redone the emergency room and done a massive renovation of the emergency room processes. One of the things we'd done in the emergency room renovation is we had changed the way people with heart attacks and strokes were triaged at the front door. We changed the approach so that if somebody came in and it looked like they were having a heart attack or a stroke, they would go immediately to immediate treatment, and they would put the paperwork off, and do the paperwork on the fly, but we wouldn't make the person go through all the stuff.

So, my wife and I were going to have dinner with my grandkids, actually, and I had the chest pains. Then it went to the other chest. Then it went to both arms. My jaw went numb and my face went numb and I thought, "Okay, this is probably a heart attack. This is multiple levels of symptoms." So, basically I had her drive me to that hospital, and we called ahead. I was hoping desperately that they hadn't changed the heart attack triage process, and I hoped that as soon as I got there, I would go right in. I'd been gone from that hospital team for several years by then. We got to the front door, I walked in and I said, "I think I'm having a heart attack," and the receptionist said, "Oh, go to this room right here," and it was all there. The process was there. I got immediate care. I had less than 7 percent heart damage because I got immediate care, and it was pretty significant. Would have been a bad situation if there had been any delays in my care.

They basically did the right things in the blood. They put in the right catheters, and then I got a really great heart surgeon who actually did a bypass. Quadruple bypass, actually, so I got a quadruple bypass immediately on the site. That particular surgeon had done a lot of heart transplants. He's a really superb surgeon. So, I was actually in a hospital that I had built, in a care setting that I loved, having that surgery. It went right in. So, I actually didn't get back to California for my care, actually. I had my care done in that hospital, in that site. Then, I went through the recovery there, and I had a number person two at KP, was Katherine Lancaster, the Chief Financial Officer. When I left town I said, "When I'm out of town, the person in charge is Kathy.

So, we just let Kathy step up and she took over and ran KP while I was out for a heart attack. Then, we had Kim Kaiser, who was chair of the governance committee of the board, and Tom Chapman, who was chair of the executive committee of the board, flew to Minnesota and met with my doctors. They are both wonderful and caring people. We agreed that I would go through a couple months of rehab time, where I wouldn't work. I told them it would kill me if I couldn't work at all, and so they said, "After three weeks, you can work an hour a day. You can do one hour a day of work."

15-00:43:48

Meeker:

Stressful for not working, right?

15-00:43:51

Halvorson:

Well, that's actually how I wrote the Uganda book. I had to do something, and I'd outlined the book in my last trip to Uganda. So, it wasn't a brand-new idea, but I hadn't written that book. I knew that I had some time, so I actually spent that time writing that book, and that was a really fun book to write. So, if you read that book on Uganda, it wouldn't have happened if I wouldn't have had the heart attack.

15-00:44:22

Meeker:

It's a good book, it's a good read.

15-00:44:26

Halvorson: Thank you. I had outlined several of the chapters before the heart attack. So, I spent that time in Minnesota. Rehabbed, walked around, got back, and then came back to KP in the fall, and actually haven't had a health issue since. It's been a good surgery.

15-00:44:47

Meeker: Heart attacks are often related, to a certain extent, to stress, right? There's other things going on, but did you ever consider retiring, at that point?

15-00:44:57

Halvorson: No. The stress of retiring would have been much greater. [laughter]

15-00:45:02

Meeker: You're not one of those kinds of guys that would go out and enjoy several rounds of golf each day?

15-00:45:09

Halvorson: No, no. I love my job. What I'm doing right now, I'm chairing the First 5 commission. We just held a press conference yesterday, and we're working on new legislation on that, working on new agendas for getting kids up to speed. I think that's probably the most important single issue in America right now, is the fact that kids 0-3 are not getting the brain exercise stimulation they need. So, I'm working on that issue. I'm also starting my institute for inter-group understanding, and I'm writing three books on that. That stuff behind you is all various drafts of those books. So, I'm working on those issues. I'm working on a website and I need to work. I love to work. The things that I'm doing, I really like doing, and I feel like I absolutely loved my KP job. It was a great job, and I've often said it was the best job in healthcare. But it was time for me to do my own thing. I have never regretted for a microsecond retiring. I announced my retirement and retired.

I've not ever had a day where I said, "Jeez, I really wish I was back there doing that job, now." It was time. I really wanted to do this other work. Actually, I wanted to do this work. My schedule was to flip over and set up the institute ten years after I got to KP, and I told the board that. I said, "I'll work here ten years." I had set that up on my Minnesota trajectory, I'd worked out the finances, and I was doing my research and my planning to do that other job. The board basically asked me to stay on for one more year, so I extended beyond ten to eleven, and a little bit beyond eleven. Then, they said, "Would you extend for another several years?" and I said, "No. I need to do this other work while I'm young enough to do it."

If I wait 'til I'm too old and tired to do it, I'm going to never, ever, ever forgive myself for doing that. I love this job, but the other thing I said was, I told the board, "There's about ten things I have to do here, and I need to get all ten done. I need to get the medical record in place. We need the new HR system in place. We need the new finance system in place. We need to get the

number one in quality.” So, I identified all the things we needed to do, and I said, “When those things are done, it’s time to turn it over and let somebody else do it.”

Also, the timing on the retirement is perfect because January 1 of this year, when I had my first day of retirement, was when the Affordable Care Act kicked in to full gear, and KP should have a CEO on board who’d been steering just before that and who’s ready to go on from there, not somebody who was in his last year. This is the wrong year to be a last year CEO, and it’s really the right year to be a first year CEO. So, in terms of timing, I said to the board, “This is the perfect time. I will steer up through the preparation time, but at the end of the preparation time, it’s time to turn the baton over.” So, that was my timing, so I needed to do this new set of things. I did stay one year longer, but it was a good decision.

15-00:48:41

Meeker:

And the ramp-up to the Affordable Care Act was one reason the board asked you to extend another year?

15-00:48:46

Halvorson:

Yes.

[The narrator has sealed a portion of the interview.]

Audio File 16

16-00:00:08

Meeker:

This is Meeker interviewing Halvorson. This is tape sixteen, on March 13, 2014. A few more questions, specific questions, and then I’m going to really ask you to reflect on the broader issues. You may end up having one sentence, or you may end up having a little bit more to say. It’s entirely up to you. One of the things I did want to ask you about, and this is something I personally don’t know a whole lot about but I find to be really interesting, that is the Sidney Garfield Center for Innovation. I know there are different places of innovation within large organizations, and this seems to be an interesting place of innovation within Kaiser Permanente. Can you tell me in general what this is and how it came to be?

16-00:01:14

Halvorson:

We deeply value innovation. The world’s changing all the time, technology’s changing, science is changing, processes are changing, so inside KP, we really, really value innovation. So, we have innovation awards. We have quality awards, we have care improvement awards. We have care improvement awards. We have patient safety awards. We have innovation conferences. We bring people together to talk about doing things innovatively. We actually have a fund of money—any doctor that has any idea—or nurse, but mostly doctors—who has a good idea about how to change a particular system or process can throw the number or throw the idea into a pot, and a

number of those, quite a few of them, are chosen every year to do little innovation pilots. We're doing all that because we really want to encourage innovation.

In my weekly letters to all employees, I celebrated a lot of the innovations that happened, and I celebrated them so all of the employees could read about the fact that innovation is a good thing, and we value it, respect it, and appreciate it. One of the things that I did to encourage innovation was I de-productized innovation a couple of years ago. That was a really important thing to do because if you have innovation and you end up patenting everything, then that slows innovation down immensely, and it really keeps innovation from going to multiple levels of improvement. You end up with people who have a good idea contending with each other about what percentage of the royalties they should get from that idea. Most of the ideas aren't commercial anyway, and so, you end up with a lot of noncommercial ideas and a lot of internal challenging and fighting.

So, one of the things I did as CEO was just said, "We are not patenting, we are de-productizing this process, and we're just going to go forward." There are some exceptions to that, but not a lot. So, we encourage innovation and push innovation. One of the places that we innovate is the Garfield Center. So, we set the Garfield Center up and invested money to create the equivalent of hospital rooms, clinics, and even patients' bedrooms and living rooms, and then we do technological and process-based experimentation and design work, there. It's actually people come from all over the world to take a look at what we've done because we're trying to figure out what's the care delivery of the future, what's a hospital of the future, what should the clinical future look like? When we do things like electronic medical records, how do we get the record from room to room?

We tested and modeled various kinds of carts, there, to have people going from different carts. Some carts went up and down, and some had power in them and some didn't. But we had a site that we could use to test those kinds of things and make sure that we were going with the best model. We do follow-up and retest things. The thing's set up—it looks like a Hollywood film studio. There are cameras, there are recording devices, and if you look up at the ceiling, you can see both lights and the camera equipment up there so we can track flow. It's basically set up to be a process improvement tool, and it's also a bit of an icon because the fact we have it makes it really clear to people that innovation is part of our DNA, that it's an important part of who we are. So, it has a symbolic presence as well as a functional presence.

16-00:04:54
Meeker:

So, when you go into a Kaiser Permanente examining room now, as I just did when I got sick last week, a couple of weeks ago—

16-00:05:03

Halvorson: Glad you're better, yeah.

16-00:05:04

Meeker: Yeah, much better. They have these little carts that have the computer monitor, that have a hard drive, and have some writing space, but they're not off-the-shelf from Ikea. They're very specifically made and designed for use in a clinical care setting. Is that something that would have been developed at the Garfield Center?

16-00:05:33

Halvorson: That would have at least been tested at Garfield. Different models. What we usually do because we have such volume, a while ago on those kinds of carts, we actually ended up with two finalists at Garfield on those carts. Each of them had slightly different features, so we went to both manufacturers and said, "Can you modify your cart to also have this feature?" They said yes, and so we ended up actually getting a new cart, a better cart, out of the process because we designed it. There's some companies like Siemens, on their imaging equipment, will come to us and ask us what they want us to design on how the equipment should be set up. I talked to the head of Siemens a while ago who said they just love having us as a laboratory because we not only end up being a customer, but we also give them insight in a very practical level about what things should look like.

We don't charge for that service to people because what we get out of it is a better scanner. So, what we want to do is a continuous improvement model on our processes, and yes, the thing that you saw, there's a high likelihood that at least some of the component parts were done at Garfield. Then, when it gets out into the field and it gets used for a while, then we have feedback loops that also say, "Okay, what can we do better about this, what do we like about these processes," and there was this piece of equipment no one could change about it, and then our purchasing people go through both purchasing redesign and purchasing volume negotiations.

16-00:07:16

Meeker: I imagine that the move to de-productize was probably received well within a lot of people within the organization.

16-00:07:27

Halvorson: It was.

16-00:07:28

Meeker: But I also imagine that it would have been a difficult decision because the idea of potentially coming up with a product that could be an income generator would be a budget justification for something like the Garfield Center, where these things might have been developed. Was that an issue? Did it make it more difficult to justify the investment budget in a place like the Garfield Center?

16-00:07:55

Halvorson:

No. One of the reasons for that is that it's really hard to sell things. When we do productize, patent something, and then we have to go out and find a market, we have to find a distribution, we're a \$55 billion company, and so, if we patent something that's going to make us half a million dollars, that's not even a rounding error in terms of the overall revenue stream. But if I lose or if we lost the productivity in the next generation of innovation on something that we need in our daily use because somebody's holding off on the patent, that's really dysfunctional. It's dysfunctional and we don't get enough money out of it. If we were a \$10 million company, a patent that could make half a million would be relevant, but a \$55 billion company, that revenue stream is too problematic, too uncertain, and too tiny to slow down innovation. If we want to be an organization whose genius is continuous innovation, then you've got to get out of the way of continuous innovation with things like people trying to figure out what their fair share of the royalties should be.

16-00:09:15

Meeker:

One issue that I don't know has ever really been discussed that much in this long-running Kaiser Permanente Oral History Project is this question of innovation, but geographically situated within the San Francisco Bay Area. Have you noticed, coming from Minnesota, right, there's a tech industry there, but it's nothing compared to what is happening in the San Francisco Bay Area. In your term as CEO, have you noticed much interaction between the Bay Area tech industry and Kaiser Permanente?

16-00:09:56

Halvorson:

Oh, yeah.

16-00:09:57

Meeker:

In what ways, maybe?

16-00:09:58

Halvorson:

All of the major companies that do business here spend time with us, thinking through what they do. We spend time with Microsoft. We spend Apple time, we had iPads to play with before they were commercial. We actually work with all of the developers to help them think through what they should be doing for next generation, and we asked them to show us what they're doing, next-generation. There's a very robust interaction. If you talk to the CEOs of any of the Bay Area tech companies, they will probably say that they enjoy having us as a resource in the area, as well as a customer.

16-00:10:45

Meeker:

So, do some of those new products, software packages, get brought into the Garfield Center and tested out sometimes?

16-00:10:53

Halvorson:

Yeah, some do. We also have vendor forums, where we ask anyone who's developing new IT to bring in their new IT and show it to us, and so we have some smart people who get together periodically and look at whether or not

the new pieces make sense. We don't want to have a really wonderful new thing happen and pass us by. We change some of the processes we have and some of the approaches we have based on looking at that technology.

16-00:11:29

Meeker:

You played certainly a pivotal role in the implementation of HealthConnect, and then, as you talked about, the move toward the paperless organization. Fifteen years ago, all of that was on the horizon, right? Nobody had really quite achieved that yet.

16-00:11:56

Halvorson:

They were close in Minnesota, actually.

16-00:11:58

Meeker:

Yeah, you were close in Minnesota, you're right.

16-00:12:01

Halvorson:

And Harvard. Harvard Health Plan did some really good early electronic medical record work that they used to support care.

16-00:12:09

Meeker:

What's on the horizon now?

16-00:12:13

Halvorson:

What's on the horizon now? Complete connectivity. Care everywhere. Care everywhere is on the horizon, and that's going to happen. KP is going to be able to provide you, you just went to the clinic, but KP's going to be able to provide you with electronic connectivity that might have kept you from having to go to the clinic for whatever you just went there for. That's the goal—the goal is to have this really robust set of tools that lets care be delivered everywhere. Because KP is a member organization and your file's on file, it can do it in a way that's more complete than anyone else can do it.

16-00:12:53

Meeker:

I want to ask actually about something that happened recently, and I don't know if this is something you played much of a role in. That was the selling of the Ohio Region. The Ohio Region, I think, was one of the first original regions?

16-00:13:07

Halvorson:

No.

16-00:13:10

Meeker:

So, there was Northern California and Southern California, and I think maybe it was one of the first expansion regions?

16-00:13:17

Halvorson:

Yes, it was. Yeah.

16-00:13:19

Meeker:

So, I think they expanded to Ohio and to Colorado about the same time. Ohio has always been a sort of geographic outlier. What were some of the reasons for it changing hands this past year?

16-00:13:38

Halvorson:

Well, it was less than one half of 1 percent of the membership, total KP membership, was in Ohio. So, when you have less than one half of 1 percent of the membership and you have to go through all the regulatory issues and you have to go through all the filing issues, all the positioning issues, it took a disproportionate amount of attention and resources. Executive staff was spending time talking about Ohio when there's nothing else that's one half of one percent of the resources that you'd have, these expenditures on spending time talking about. So, not to be unkind to Ohio, but it was a distraction, at one level. It was not going to grow because Cleveland Clinic is in that market, and Cleveland Clinic fills that space. Cleveland Clinic is a vertically integrated care system. They have the same electronic medical record. They've got the same infrastructure. They're doing the same kinds of things.

So, if you go into Cleveland Clinic's market and you try to be Cleveland Clinic, it's hard to project a future where you gain any ground on Cleveland Clinic. Cleveland Clinic is much, much, much more aggressive and assertive than they were, and so they're reaching out broadly to various markets. So, being in Cleveland, being tiny, and being in the same market as Cleveland Clinic. Interestingly, what we did was we sold the plan to a not-for-profit hospital system that is the biggest competitor for Cleveland Clinic, and all of a sudden, their biggest competitor has a health plan that's a Medicare five-star plan. So, from the Cleveland Clinic perspective, it's actually going to be a little challenging. A plan that they could pretty much ignore is now going to be potentially a challenge to them because their biggest competitor can now use it as a tool. So, it was a really good strategic move for the hospital system that just acquired it. For us, it was not going to have much of a future.

16-00:15:54

Meeker:

Is there a notion that in the remaining regions outside of California, there will be further tightening or growth?

16-00:16:03

Halvorson:

I think growth. Atlanta's an incredibly good market. Cleveland is a really tough market.

16-00:16:10

Meeker:

Well, it's shrinking population.

16-00:16:11

Halvorson:

It's shrinking population. It's poor. The unemployment level's really high. You have all kinds of health issues, and you have Cleveland Clinic. You go to Atlanta, and it's one of the most rapidly growing places in the country.

16-00:16:26

Meeker: Or the DC metro area, I guess?

16-00:16:28

Halvorson: Yeah, the metro area is large and growing, and they're open to having a high level team care as a really good selling point in our market. That market should do well. That should be a good long-term play for KP. The Washington, DC market, we've invested billions of dollars in really wonderful multi-specialty care sites, and those care sites are going to be the Cadillac— Cadillac's in again, now—care sites in that market because in DC, if you're not at KP, it's really hard to find a doctor. It's really hard to get an appointment. The emergency rooms on other care sites are terrible. Urgent care in other care sites is problematic. We've got a twenty-three-minute wait time in our urgent cares now, and we're building these wonderful, multi-specialty sites. We just won the HEDIS, for D.C. We're rated number one in *Consumer Reports*.

So, what we're doing is we're jacking that plan up to be the high performance plan and running some ads that are very powerful ads, that are bringing enrollment. So, I think DC's going to grow as well, and I think Baltimore's going to grow. I think we're going to do some nice investments in the Baltimore market that are likely to be successful. Colorado is a winner, it's doing well. Portland. We are the biggest plan in the State of Oregon now, and we're likely to do well. Hawaii has forever been a two-plan market. It's us and the Blues, and that's it. I don't think that's going to change, but I think we should do fine, there.

16-00:18:26

Meeker: Do you ever envision Kaiser Permanente creeping over the Sierras from Sacramento and reaching into Reno, or perhaps Vegas?

16-00:18:38

Halvorson: At one time in my tenure, I actually talked to the people who ran Sierra about buying that plan in Vegas. It was a good plan and it was a good fit for us. It was our model, basically. They owned the clinics, they employed the physicians. It was a good model. United Healthcare came in and outbid us by an extreme margin and bought it, and they're very happy with it. They are really happy they made that decision because I talked to some of their senior executives who said that they get to go there and learn healthcare delivery in a way that they had not been able to do in all of their other care sites. So, it's a been a wonderful, wonderful learning experience for them. I think they are a better organization nationally because they have the experience now of understanding exactly what issues you really do wrestle with in the delivery of care. [I expect United Healthcare to have to confront expanding into the caregiving business because of their experience in Las Vegas.] It was a good plan. Tony Marlon, who built that plan, was an excellent healthcare executive and he built a good care system and plan.

[brief segment deleted]

16-00:20:29

Meeker:

It has been said that affordability is still an incomplete task. During your tenure, you've made great strides in a whole wide variety of areas, particularly quality and the related issues of technology and access, and also preparing the organization for the new policy landscape. But affordability, many say, is still yet to be achieved. What is your thought on that statement, looking back upon your eleven years at Kaiser?

16-00:21:13

Halvorson:

It's a relatively complex issue because when you look at affordability, when you look at the same product, and when you look at full benefits, when you look at the health plan in part, KP is consistently ten, fifteen, twenty points below the competition in price. So, basically the cost for the same level is significantly better. So if you're measuring apples to apples, if you look at an individual in the small group marketplace and if you look at the products that Blue Shield is selling compared to the products that KP's selling, compared to the KP product price for the same benefits, a \$500 deductible, is going to be ten points or more below the Blue Shield or the Blue Cross product. Colorado, we tend to be below market and comfortable. Oregon, below market. When you look apples to apples, product to product, KP is delivering that product for less money.

The challenge is, is that a lot of people who buy competitors' products are going to \$1,000 deductibles, \$2,000 deductibles, and if you go to a \$2,000 deductible, your premium drops from \$500 to \$300. It might have had a \$550 premium against our \$500 at full benefits, but they go to \$300, when they strip all the benefits out. So, that's part of the challenge. Part of the challenge is to go apples to apples on the product side and then win in price on that side. KP hates going to a \$500 deductible for everybody because you have to collect the money upfront, and if people avoid certain care, there's all kinds of issues. So, the market is continuing to change and the products continue to change. Right now, if KP is going toe to toe with someone else and it's a \$500 deductible in both, and it's the actual prices of the other carrier, one of the things other carriers will periodically do is put in a stink bids and they'll put in prices that are not actually their real cost for delivering that product. That's just a marketing game that gets played in all markets at all times. You don't know anything about real costs from those price differences.

In the old days, when Blue Cross plans ran the country, periodically, for-profit insurance companies would go into a state, enroll people at thirty points below the Blue Cross rate, and then sort through their rates—surge and purge, they used to call it. You surge and then you purge. You surge out to enroll a whole bunch of people, and then you purge out all the high risk groups, give them all 100 percent rate increases, and you try to keep the risk pool. So, surge and purge is a model that some plans still use. In terms of price, the important

thing is to give the right product the right price, and going forward in that is going to be a challenge. Part of KP's advantage, going forward, is going to come from the point I talked about earlier. That's the electronic connectivity.

If the other care is selling a \$2,000 deductible and on the front end of that \$2,000 deductible, if you go to an office visit, it costs you \$150 or \$200 to go to the office. If you go to KP, it may still be \$150 to go to the office, but if you have an electronic visit, it costs you nothing. The new market in healthcare that's going to happen is going to be the electronic market. Right now, in the market, people, instead of paying the \$150 office visit, are buying, for \$40, an e-visit. There's a whole bunch of companies—my old Minnesota health plan actually sells these by the tens of thousands, they sell e-visits all the time for \$30 a visit. That's going to be part of the new dynamic, is the e-visit for \$30. The \$30 e-visit in that setting is not connected with your medical record. It's not connected with the rest of your data, so it's kind of a standalone, naked e-visit. What KP needs to do is sell or give away the e-visit, and if you know you're going to join KP, you're going to have basically the same office visit as if you had Blue Cross coverage fee, or something like it, or maybe a little less. But if you get an e-visit, you're going to have it for nothing or a tiny charge. That's going to be transformational. So, KP's going to have to win the next generation of products, and should be able to do that because the infrastructure and the pieces to do that are being set up.

16-00:26:37

Meeker:

I actually think that my questions are exhausted, and so, while there's certainly opportunity after you review your transcript to do another follow-up session if you feel like there are some glaring omissions, we can absolutely do that. In the meantime, I'm wondering if you have any final thoughts that you'd like to add before we wrap up here today, and we call this interview complete for the time being, at least? Is there anything that you'd like to add? Not to kind of put you on the spot for a grand summary statement, but if there is anything that you would like to add that's not a response to a question, I invite you to do that now.

16-00:27:34

Halvorson:

Well, I would make maybe a comment. Kaiser Permanente, as it exists, has massive advantages over just about everybody else in healthcare delivery and healthcare financing because it is vertically integrated, because it has the data sets, because it has the information flow, because it has all of the pieces necessary for care delivery, and it has access to the best medical science, electronically and in real time. It has the ability to have connectivity between all of the caregivers, team care, and connectivity between the caregivers and the patients. So, all of those pieces are in place right now, and I spent a lot of time with other parts of the healthcare delivery system. I just spent time with a couple of other university systems, talking to them and giving them some advice, and they are so far behind what KP is doing and can do that it's almost not on the same continuum.

I'm feeling good about the fact that we put that infrastructure and that capability in place on my watch, and I'm really looking forward to see how it plays out, and I'm also having absolutely no misgivings about moving on to the next part of my agenda. I'll feel bad if, for some reason, the full potential isn't realized, but I have no reason to believe that it won't be. I think that it's going down the right paths and there's some really good things that are going to happen now, going forward. Now that I've spent a little bit of time and I've gone to a number of other settings, I have to tell you that there is just an amazing lead that KP has right now in terms of infrastructure and process. The fact that it's not-for-profit, so it doesn't have to grow foolishly just to bring stock prices up, is just a real blessing in itself.

To be able to grow at a reasonable rate and to grow at the right pace and to grow at the right time and to do that selectively without stock prices being a factor is just a really liberating financial reality. So, I guess I would summarize by saying Kaiser Permanente is at a good place, going in a good direction, and I feel good about the process. I think there are good people on board as the key leaders who are probably going to make the future a success. I will look forward a decade or two from now to read your transcripts of your interviews with Bernard Tyson. It may be a hologram by then. I hope he enjoys the ride as much as I have enjoyed it. How's that?

16-00:30:13

Meeker: Great. That's excellent, I think.

[End of Interview]